

Welcome to my practice. The following information pertains to my practice policies. Please read carefully and let me know if you have any questions that I can answer and discuss with you. I look forward to working with you.

#### **Sessions:**

My initial comprehensive evaluation is up to 60 minutes in length. During this session, I will take the time to get to know you and understand your specific concerns. At the end of the session, I will provide you with my assessment and work with you to develop a treatment plan. This may entail psychotherapy (talk therapy), medication management, education or a combination of these. Some patients may benefit from neuropsychological testing and appropriate referral will be provided. If you are seeing another therapist, I can provide medication management and coordinate care with your therapist. I will also coordinate care with your other providers including primary care physicians and other specialists. Please complete the release of information form at the end of this document for any providers that you would like me to coordinate care with.

If medications are initiated, follow up appointments are required as long as medications are being prescribed. The frequency of these follow up appointments vary depending on response to medications, severity of illness and side effects. Medication management appointments are 15-30 minutes in length.

All paperwork will be filled out in session with the patient and guardian present. This includes any school forms, FMLA, disability applications or any other form of documentation required for work/school/legal purposes.

#### Cancellations and No-Shows:

Your appointment time is reserved for you. Therefore, if you are not able to keep your appointment time, please call as soon as possible to cancel or reschedule your appointment. If you do not provide at least 24 hours' notice of your cancelled appointment or if you fail to show for your appointment, you will be charged a no-show fee of \$50.

#### Contacting Me:

I will answer calls during business hours Monday-Friday. I will return phone calls within 24 hours with the exception of weekends and holidays. If you are experiencing an emergency and cannot wait to reach me, you should call 911 or go to the nearest emergency room. As soon as you are able to do so, please contact me to inform me of the situation.

I will bill your insurance company but you will be asked to pay your co-pay or applicable balance in case you have not met your deductible. Payment will be required prior to the start of the session. Cash or credit cards are acceptable forms of payment. I am not able to process personal checks at this time.

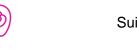


<u>I understand that it is my financial responsibility for services provided until insurance deductible is met and any co-pay thereafter or if my insurance becomes inactive but I continue to seek services from GBH, LLC.</u> Dr. Khurana is considered an in network provider for BCBS and Cigna only.

<u>Iunderstand that I will be charged for missed appointments and cancel lations with less than 2.4 hours' notice.</u> Your appointment is reserved for you. If you need to cancel an appointment, please notify meas soon as possible. Appointments not cancelled with at least 24 hours' notice will be billed anoshow fee of \$50.

<u>Full payment is due at the time service is rendered.</u> I acknowledge responsibility for all fees incurred. All balances 30 days past due will be deemed delinquent. Delinquent accounts must be paid in full before any future services will be provided. We reserve the right to send delinquent accounts to collections if needed.

have read and understand the above policies.	
Responsible Party's Name	Date
Responsible Party's Signature	Date
confidential, and under ordinary circumstances this phere are three clear exceptions in which a psychiatris	break confidentiality under the aforementioned
Parent/Guardian's Signature	 Date
Parent/Guardian's Signature	Date

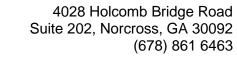


## **POINTS TO REMEMBER**

- 1. Notify me if there are any significant changes in your psychiatric or medical condition, or if an outside provider changes your medication regimen.
- 2. Notify me if you suspect or know that you are pregnant or plan to become pregnant in the near future. Pregnancy will affect treatment recommendations.
- 3. If you feel you are at risk of hurting yourself or others, notify me immediately. If you feel you are an imminent risk and need immediate attention, call 911 or go to your nearest emergency room.
- 4. I welcome emails for non-urgent, administrative communication. Please note that the confidentiality of your email cannot be guaranteed. To discuss medical concerns, please call me.
- 5. If your medication makes you drowsy or slows your reaction time, refrain from driving and notify me. Also, notify me if your medication causes you other significant side effects.
- 6. If you want to increase, decrease, or discontinue your medication regimen, call first. Medication management is a collaborative process. Changes without consultation are potentially dangerous and may interfere with our ability to work together.
- 7. It is advised to not drink alcohol while taking psychiatric medications.
- 8. Notify me if there are any changes to your address, phone number or e-mail.
- 9. I am here to help you. Do not hesitate to call if you have questions or concerns.

I have read and understand the preceding Points to Remember.

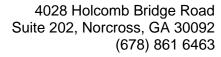
Parent/Guardian's Signature	Date
Parent/Guardian's Signature	 Date





# **CONSENT FOR EVALUATION AND TREATMENT**

I am legal guardian of (Child's Name)	and with full legal authority to consent to
treatment. I hereby consent to psychiatric evaluation	on and treatment of him/her by Neha Khurana, MD.
must inform the other parent of health appointment order if you fail to inform the other parent of your child consent for treatment of your child you must either heand if you have no legal custody you cannot provide that you have the legal right to consent for this child.	elegal custody and your divorce decree notes that you as, please note that you may be in violation of a court dreceiving psychiatric services. Also note to provide ave sole legal custody OR have shared legal custody, consent for treatment. By signing below you are stating in the case of separation or divorce, any matter brought may be revealed to the other parent. Matters which are swelfare may be kept in confidence.
Parent/Guardian's Signature	Date
Parent/Guardian's Signature	 Date





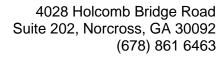
### **Medication and Prescription Policy**

If Dr. Khurana is prescribing medications to you/or your child as part of your treatment, regular follow up visits with her are required to closely monitor for efficacy, safety and potential side effects. Medication management requires working together to ensure the best response to medications. This includes maintaining scheduled follow up appointments.

- You will be prescribed enough medication to last until your next follow-up appointment. Prescriptions will not be called in for patients that cancel/ or miss regularly scheduled medication follow-up appointments.
- If you have to reschedule an appointment, please ensure that you schedule another appointment before you run out of medication. Our office will do our best to reschedule you, but keep in mind it may take several days to weeks to find an appointment that will be conducive to your schedule. <a href="Itists">Itis</a> your responsibility to make sure you do not run out of medicine.
- Controlled Substances Recognize that stimulant medications and Benzodiazepines are considered controlled substances and cannot be called into or faxed to pharmacies. If you lose a prescription or your medication, it is at Dr. Khurana's discretion to issue a replacement. All controlled substances will have to go through the Georgia PRMP in accordance with the guidelines.

Dr. Khurana is committed to providing professional services of the highest quality and standards. In order to serve her patients efficiently and responsibly, she requires agreements be made as to the policies stated above. Patients are encouraged to ask questions before signing.

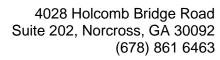
I have read the medication policies, understand, and agree with the
Patient's Signature:
Guardian if Minor:
Date:





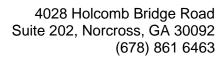
# **NEW PATIENT INFORMATION SHEET**

Date:	Referred By:
Name of Child:Age:	Date of Birth:Male/Female:
Father's Name:	Mother's Name:
Address:	Address:
Address:	Address:
Cell Phone:	
WorkPhone:	Work Phone:
Home Phone:	Home Phone:
E-mail Address;	E-mail Address:
Occupation:	Occupation:
Education (school/degree):	Education (school/degree):
Child's Legal Guardian (s):	
<del></del>	ts_MotherFather _Other(specify): rried_Married/Partnership_Separated_Divorced_Widowed
Please note any custodial or legal arrange	ements pertinent to the child's medical care:
Emergency Contact Information:	
	La Line Barrio
	elationship to Patient:Address State:Zip:Cell Phone:
	Home: ()
Primary Care Physician:	
Name of Pediatrician:	
Address:	Phone: ( )





Pharmacy Informa	tion (If medications	are prescribed):		
Local PharmacyNam	e:			
Address:		Phone: (	)	
School Information	n:			
Name of School (indi	cate if homeschooled)		G	rade:
Address:		City:	State:	Zip:
Please identify mer	mbers of the child's h	ousehold:		
Name	Age	Relationship	Living In the Home (Yes/No)	Occupation
	our reason(s) for seek			
Describe how your corelationships?	hild gets along with oth	er children? Has your o	child's current problem	affected peer

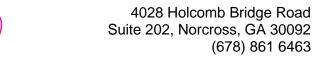




Describe your child's experience and function in school? Are there any problems?
What are your goals for your child's treatment?
What are your child's strengths and/or unique qualities?
What are your child's interests and hobbies?
Psychiatric History:
Is your child currently seeing a psychiatrist and/or therapist?_Yes_No
Name:
Location:
Name:
Location:
Name:
Location:
Has your child received other outpatient psychiatric care in the past? Please provide name of prior providers including psychiatrists and the rapists.



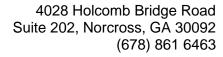
Has your child ever been hospitalized for psychiatric reasons? If so, please provide dates and name of hospitals.
Is
there any family psychiatric history eg. bipolar disorder, anxiety, depression, schizophrenia, substance abuse, learning disorders, ADHD, autism? Please provide condition and which family relative
Developmental History:
How much did your child weight at birth?lbs
Where there any developmental delays including speech/walking/gross or fine motor skills? Describ
Any complications during pregnancy or delivery? If so, please describe
Medical History:
List any significant medical problems such as seizures, head injuries, accidents, hospitalizations:
Any history of chest pain, palpitations, murmurs, fainting, or post exercise symptoms? Please descri
Alleraies:



(678) 861 6463



List ALL medications that your child is currently taking regularly (include over the counter meds/vitamins/herbal supplements) Please also include dosages and how often medication is taken	
Please list other psychiatric medications that your child has taken in the past:	
Any family history of medical problems (include seizures, heart disease, diabetes, cancer, liver disease, stroke, Parkinson's)? If your child is adopted, please answer based on biological history if known	_
Any family history of early heart disease (before age 30)?	_
Please note any other information that you think might be helpful forme to better understand your ch family:	— iildand
	_ _ _
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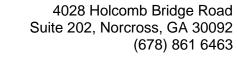




# **CONSENT FOR RELEASE OF INFORMATION**

Please complete for any providers that you would like me to collaborate with including therapists, primary care physicians and other specialists

Patient Name	nt Name Date of Birth	
I, hereby authoriz	ze Dr. Neha Khurana to release infor	mation from my medical
records as described below to		
Name:		
Address:		
Phone Number:	Fax:	
The request and authorization applies o	nly to the following information:	
Psychiatric Reports/TestsPsychiatric EvaluationTreatment Recommendations Other The purpose of the release of information is	Summary of HospitalizationsPsychological ReportsMedicationsCourse of Treatment s:Coordination of Care	Teachers' ReportsSocial HistoryDevelopmental HxContinuation of Care
The release will expire in 12 months unless at any time, except for action that has alre		an cancel this authorization
Signature of Parent/Guardian	Dat	<u>e</u>
 Signature of Parent/Guardian		e





### **Credit Card Authorization Form**

**24 Hour Cancellation Policy**- If Dr. Khurana does not receive notice outside of 24 hours prior to the cancellation of your scheduled appointment you will be charged \$50 no-show fee. Signing this agreement authorizes our office to charge the card listed below for missed appointments.

Please complete the inf	ormation below:		
	_		alth to charge my credit card (full
name) indicated below for	payment of Psychiatrics	services for the fo	ollowing individual(s):
PrintFullName:			
Credit card will be charged to be cancelled at any time validing Address	with written consent.		ervices rendered. Authorization can
City,State,Zip		Email	
SIGNATURE		DATE	
understand that this authorization of my account information or terminal	will remain in effect until I cancel it tion of this authorization. This pa t card and that I will not dispute th	t in writing, and I agreet yment authorization is ne scheduled payments	onform according to the terms outlined above. I to notify the business in writing of any changes in for the type of bill indicated above. I certify that I s with my credit card company provided the
Account Type: Visa	MasterCard	Amex	Discover
Cardholder Name			
AccountNumber			_
Expiration Date			
CVV (3digit number on back	k of Visa/MC, 4 digits on fr	ont of AMEX)	
CVV (3digit number on back	k of Visa/MC, 4 digits on fr	ont of AMEX)	