Neha Khurana, MD Psychiatrist
Georgia Behavioral Health, LLC
GBHPSYCH.COM

4028 Holcomb Bridge Road
Suite 202, Norcross, GA 30092
(678) 861 6463

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.

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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. Dr. Khurana is considered an in network provider for BCBS and Cigna only.

I understand that I will be charged for missed appointments and cancellations with less than 24 hours' notice. Your appointment is reserved for you. If you need to cancel an appointment, please notify me as soon as possible. Appointments not cancelled with at least 24 hours' notice will be billed a no show fee of **$50**.

Full payment is due at the time service is rendered. 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.

I have read and understand the above policies.

_____ _____
Responsible Party's Name Date

_____ _____
Responsible Party's Signature Date

Statement of Confidentiality: Under Georgia law communications between patients and psychiatrists are confidential, and under ordinary circumstances this privilege can be waived only by the patient. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to him or herself, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child abuse. Although legally and ethically bound to break confidentiality under the aforementioned circumstances, I will not do so without attempting to discuss it with you first.

I have read and understand the above policies.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Parent/Guardian's Signature Date

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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

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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 and treatment of him/her by Neha Khurana, MD.

Parents, Informed Consent & Divorce: If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, please note that you may be in violation of a court order if you fail to inform the other parent of your child receiving psychiatric services. Also note to provide consent for treatment of your child you must either have sole legal custody OR have shared legal custody, and if you have no legal custody you cannot provide consent for treatment. By signing below you are stating that you have the legal right to consent for this child. In the case of separation or divorce, any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to attention that are irrelevant to the child's welfare may be kept in confidence.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Parent/Guardian's Signature Date

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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. **It is 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 in to 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 them.

Patient's Signature: _____

Guardian if Minor: _____

Date: _____

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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:_____ Cell Phone:_____

Work Phone:_____ 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): _____

Primary Residence of Child:__ Both Parents_Mother __Father _Other (specify): _____
Relationship Status of Parents:_Never Married_Married/Partnership_Separated_Divorced_Widowed

Please note any custodial or legal arrangements pertinent to the child's medical care:

_____

_____

Emergency Contact Information:

Name:_____Relationship to Patient:_____Address:
_____City:_____State:_____Zip:_____Cell Phone:
(____)_____Work : (____)_____Home: (____)_____

Primary Care Physician:

Name of Pediatrician: _____
Address:_____Phone: (____)_____

Pharmacy Information (If medications are prescribed):

Local Pharmacy Name:_____

Address:_____Phone: (___)_____

School Information:

Name of School (indicate if homeschooled)_____Grade: _____

Address:_____City:_____State:_____Zip: _____

Please identify members of the child's household:

Name	Age	Relationship	Living In the Home (Yes/No)	Occupation

Please describe your reason(s) for seeking treatment at this time (include when the problem started):

_____
_____
_____
_____
_____
_____

How does your child's current problem impact family relationships or family functioning?

_____
_____
_____
_____

Describe how your child gets along with other children? Has your child's current problem affected peer relationships?

_____
_____
_____
_____

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 therapists.

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? Describe

_____

_____

_____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 describe:

_____

_____

Allergies:_____

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 for me to better understand your child and family:

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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_____ Date of Birth _____

I_____, hereby authorize Dr. Neha Khurana to release information from my medical records as described below to

Name:_____

Address:_____
Phone Number:_____ Fax:_____

The request and authorization applies only to the following information:

__Medical History/Physical Exam	_____Laboratory Reports	_____Consultations
__Discharge Summary	_____Summary of Hospitalizations	_____Progress Notes
__Psychiatric Reports/Tests	_____Psychological Reports	_____Teachers' Reports
__Psychiatric Evaluation	_____Medications	_____Social History
__Treatment Recommendations	_____Course of Treatment	___Developmental Hx

Other_____

The purpose of the release of information is: ____Coordination of Care_____Continuation of Care

The release will expire in 12 months unless specified by you. I understand that I can cancel this authorization at any time, except for action that has already been taken.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

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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 information below:

I_____authorize Georgia Behavioral Health to charge my credit card (full name) indicated below for payment of Psychiatric services for the following individual(s):

Print Full Name: _____

Credit card will be charged after each appointment for the amount of services rendered. Authorization can be cancelled at any time with written consent.

Billing Address_____ Phone#_____

City, State, Zip_____ Email _____

SIGNATURE_____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Account Type: Visa MasterCard Amex Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3digit number on back of Visa/MC, 4 digits on front of AMEX) _____