316 & 328 Alexander Street
Suites 6 & 12
Marietta, GA 30060

1708 Peachtree Street, Suite 530
Atlanta, GA 30309

200 Glen Eagles Court, Suite 14B
Carrollton, GA 30117

Office: 470-338-3488
Fax: 678-581-0146
TriadPsych.org

Triad Psych, P.C.

PATIENT INFORMATION

Name: _____ DOB: _____/_____/_____

INSURANCE AND FINANCIAL INFORMATION

Person Responsible for Charges:

Name: _____

SS#: _____-_____-_____
This field is REQUIRED in the event you or your child's financial obligation is not met per our financial agreement. As a last resort we will initiate collections with Transworld Systems only after exhausting all other means.

Relationship to Patient: _____ Insured's DOB: _____/_____/_____

FINANCIAL POLICY

Payment is expected at time of service, unless there is a previous agreement for payment. PLEASE NOTE: It is the responsibility of the patient/responsible party to see your insurance guidelines for PRECERTIFICATION are followed. All insurance co-payments are to be collected at time of service, unless other arrangements have been made. As a courtesy, our software will send you a reminder text or email 48 hours before an appointment, failing to respond to said reminder does not constitute a notification of cancelation. Full charge of $100.00 for appointments will be made to patient and or responsible party if the office is not notified 24 hours in advance regarding cancellation. Dissatisfaction with services does not excuse obligation to pay for services. All court/forensic work will be paid for in advance by party initiating service. Patient/responsible party will be responsible for all legal and collection fees on balances including magistrate court charges if it is handled through those means. I have read and understand this statement. _____please initial.

Signature: _____ Date: _____

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CONSENT TO TREATMENT

I consent to have Triad EduPsych, PC perform evaluation, assessment, psychotherapy or related services as deemed appropriate. I understand that I may be offered a referral for other mental health services as needed. I understand this statement _____ please initial.

If services are for a minor, do you have medical decision making authority? Y N _____ please initial.

If "NO" to the above statement, who has medical decision making authority? _____

CONFIDENTIALITY

Information regarding your treatment will not be released unless there is written consent **OR** an indication that clear and immediate danger to self or others exists **OR** you disclose sexual or physical abuse or neglect of a child or elderly person._____please initial.

Consent for Use & Disclosure of Protected Health Information(PHI)

I hereby give my consent for Triad Psych to use and disclose Protected Health Information (PHI) about me or my child to perform treatment, payment and healthcare operations (TPO). I have the right to review with my clinician Triad's privacy practices and modify them in agreement with Triad management. With this consent, Triad Psych may call my home, cell phone or other alternative location and leave a message with a person or voice mail in reference to any items that assist the practice in administering TPO such as appointment reminders, insurance items and any calls pertaining to me or my child's clinical care including test results, etc. With this consent, Triad Psych may use un-encrypted e-mail to my home or other alternative location any items which assist the practice of in administering TPO, such as appointment reminders and statements. I have the right to request that Triad Psych restrict how it uses or discloses my PHI to administer TPO. However, the clinic is not required to agree to my requested restrictions, but if it does it is bound by this agreement. With my signature I am consenting for Triad Psych to use and disclose my PHI to administer TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Triad Psych may decline to provide treatment to me or my child. _____ please initial

TERMINATION/FINISHING WELL

How we finish is just as important as how we begin. We'll begin to discuss termination when your goals move towards completion. If you start to think about wrapping up therapy prior to this, bring it up to discuss in session. I ask that you give a minimum 2 session notice which allows one session for us to explore you or your child's termination readiness and a final session to process the journey, progress and identify specific *"take-aways"from* the work you've accomplished._____please initial

GUARANTEE OF PAYMENT

I give my personal guarantee of payment for all charges herein incurred. I attest that all of the above statements are true. I authorize release of information to my insurance company.

Signature Patient/Responsible Party: _____ Date: _____

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CREDIT CARD POLICY

I am hereby entering into a contract for Triad Psych's professional time and services when I set an appointment. I understand that by entering this contract for the clinic's professional time I am specifically contracting for the clinic's services to prepare for my session in advance. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and consultations with other professionals as agreed in writing by me to assist with my treatment. I understand that Triad's cancellation policy requires 24 hours advance notice in order to be released from the contract for their time and services of preparation for my session. I agree that if I fail to cancel my appointment before the 24-hour minimum time period prior to my session I will be charged for the missed session and the services provided in preparation of $100.00. I hereby authorize Triad EP, PC, DBA Triad Psych to charge the following card if I indeed fail to observe this cancellation policy and I understand I am paying for preparation services rendered and time contracted for when I set the appointment.

As well I understand that often insurance companies do not pay or do not fully pay claims submitted at their contracted rate due to issues with deductibles, eligibility and other factors. Triad will make every good faith effort to submit your claims and receive reimbursement from your insurance carrier. Yet in certain circumstances claims cannot be recovered despite our clinic's best efforts. I also grant permission for Triad Psych to charge this card on file to compensate Triad for their contracted rate with my insurance carrier if all reasonable attempts to file with such carrier have failed.

Visa / Mastercard / Discover (please circle)
Name on the credit card
_____

Credit card number _____

Expiration date_____ CVV code (last 3 digits on the back of the card) _____

Zip code to which billing statement is mailed_____

I have read and understand the above credit card policy for services provided by Triad Psych provided by Triad EP, PC.

Please have all consenting adults sign below.

_____
Signature **Date**