Mindspring Health Inc.
1074 Ponce De Leon Avenue NE
Atlanta, GA 30306
404-333-8829 (P)
980-495-8849 (F)
info@mindspringhealth.com

PRACTICE POLICIES

Fee Schedule for Psychiatric Services – payment is due at the time of appointment

- 60-minute: New Patient Intake - $450.00
- 45-minute: Psychotherapy and Medication Management Follow-up Appointment - $337.50
- 25-minute: Medication Management Appointment - $225.00
- >5-min phone or text message services will be billed by the hourly rate ($450/hour).

Patients are required to keep a credit card on file at the time of booking a new patient appointment.

Mindspring Health does not accept any type of insurance. We require full direct payment at the time of your appointment. We would be able to provide you with a super bill for you to seek reimbursement from your insurance company. You may be able to cover some of my fees through your "out-of-network" benefits. We cannot guarantee any insurance reimbursement however and it would be your responsibility to inquire about what will or will not be

Office Hours
Office hours are Monday through Saturday by appointment only. All first appointments are considered a consultation only. We will let you know if we are in the position to offer treatment services beyond the first appointment.

What to Expect When You Begin
We will call you to schedule your initial 60-minute intake appointment. You may receive some additional forms and scales that you may fill out online. Often times it may take a few appointments at the beginning to come up with a plan of care. In rare cases, some patients may need to schedule a 30-minute to 60-minute follow up appointment within a few days of the initial intake for complex cases. You should expect an initial intake appointment and then two to three follow-up appointments in the first three months. This is an average number based on several factors such as stabilization on new medications, assessing medication effect, and assessing any side effects.

New Patient Evaluations and Rescheduling Policies
We want you to ultimately work with a psychiatrist that will be able to provide the utmost care and compassion. New patient appointments are 60-minute appointments. These evaluation slots are limited and scheduled after you are able to complete and submit the practice intake forms for us to make sure that our practice will be a good fit for your individual needs. After we have reviewed your information, if we agree to move forward together, we will schedule an initial session with you and will request a credit card to be placed on file. If you need reschedule/change a new patient evaluation appointment, you must cancel at least 72 hours ahead of time to allow time to fill the slot with someone on the waitlist. If you change or cancel your intake appointment within 72 hours you will be charged the full evaluation rate as a late cancel fee. There will not be an exception to new patient evaluation no show/ rescheduling charges due to the time that we take to prepare for each patient that we see, the limited time slots available, and the time it takes to try and fill that spot with another patient.

Rescheduling Policy for Established Patient
When you schedule an appointment time with us, we make sure my time is reserved for you. If you need to cancel or reschedule your follow up appointment, you must do so at least 48 hours before your scheduled appointment time to avoid the no show fee. Patients will be charged the full session rate when cancellations occur unless notice is given at least two business days in advance. If, for any reason, the doctor must cancel an appointment, the patient will be advised at the earliest possible time. There will be no exceptions made to this policy so please keep this in mind when scheduling your appointments.

Electronic Mail (Email) Policy
By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). We cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we would caution you against emailing anything of a very private nature. Additionally,

your doctor will save your email correspondence and these communications should be considered part of your medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature. Your doctor will make an effort to check email regularly; however, call the office if you have not received a reply within 72 hours.

After Hours Clinical Care and Emergencies
Unfortunately, we are unable to provide emergency or after-hours clinical care. For any non-emergent issues, you will have the ability to leave us a message and/or send us a message through our secure portal. You may also send a text to the messaging service but please note that text messaging is not secure. Please allow up to 24 hours for any messages to be answered. Note that we cannot always provide clinical care or medication changes over the phone. These issues will need to be addressed in person at a follow up appointment. By signing this agreement, you acknowledge that you understand that any after hours emergencies or urgent clinical concerns will require you to call 911 or go to the Emergency Department.

Medication Refills
Please note when you will be out of medication and make an appointment PRIOR to running out of medication. We cannot refill 30-day supplies of medications after 3 months without a scheduled follow-up appointment. If you require several changes to pharmacies between visits you may be charged a fee. If you anticipate problems with your pharmacy, please let me know ahead of time to avoid an issue for all of us.
When requesting a refill, please provide:

- Your date of birth
- Name of medication requested
- Medication dosage
- Pharmacy complete address

Prescriptions Provided
We attempt to limit my prescription of controlled substances.

Termination Policy
Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge that the doctor be notified regarding this decision so that it can be discussed openly. If you have failed to make your follow-up appointment and have not communicated with your provider, we will assume you have left our care after 3 months. We will reach out with a termination letter just saying that, if you would like to return for an appointment then let us know, but otherwise our clinical relationship has been terminated at your discretion.

Emotional Support Animals
We do write letters for emotional support animals in our practice. An additional fee may be charged.

Disability
We may fill out FMLA/disability paperwork on a case-by-case basis after an established relationship.

Telepsychiatry
Considering changes in daily life and healthcare since the COVID-19 pandemic, telepsychiatry (video-conference) appointments are available in addition to in-person appointments. Mindspring Health offers telepsychiatry (video conference) appointments to patients over a secure, HIPAA-complaint network. Under some circumstances, these appointments may also be conducted by phone. If you are interested in telepsychiatry, please ask your provider if he feels that this would be appropriate for your treatment. In order to conduct telepsychiatry, you agree to be within the State of Georgia during the appointment. You also agree to not operate a motor vehicle during the appointment. Therapy conducted online is technical in nature and problems may occasionally occur with internet connectivity. If something occurs to disrupt any scheduled appointment, the doctor will call the patient back by the phone number provided. A patient must

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be seen a minimum of once a year to maintain therapeutic services. A telepsychiatry scheduled appointment has the same late cancel/no show policy as an in-office appointment.

Paperwork
We can provide basic short form letters quite easily if you notify us of this ahead of time. For any longer requests you may be charged $25-100 per packet of paper depending on the length of time outside of your appointment time it will take to complete.

We know all of these policies seem overwhelming at first, but we always try to be as understanding and as flexible as possible to provide the best service for our patients. We encourage all of our patients and families to communicate their needs with us. Please do not hesitate to ask about any concerns or questions you may have.

Payment/Insurance Information
Fees are due at the time services are rendered. Mindspring Health does not contract with any insurance companies. However, if your insurance company provides out-of-network benefits, you may file your own claims for reimbursement. These claims should be paid directly to you. You will have the option and upon request to receive a statement that contains the necessary documentation to file with your insurance company. We recommend that you contact your insurance company for specific information about your out-of-network coverage for mental health services. If you wish to receive a statement to be used for reimbursement purposes, these statements will be automatically emailed by our online accounting system. Your signature below will authorize the use of email for

Sincerely,

Mindspring Health Inc.

Acceptance of Policies
Mindspring Health Inc. is committed to providing professional services of the highest quality and standards. In order to serve our patients efficiently and responsibly, we require that agreements be made regarding the policies stated above. Patients are encouraged to ask questions before signing.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

I have read the policies, understand, and agree with them.

_____	_____	_____
Patient Name	Signature	Date

Guardian if a Minor: _____

HIPAA Notice of Privacy Practices

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NOTICE OF PRIVACY POLICIES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

EFFECTIVE AS OF 1/1/2024

This information is being provided as required by the federal Health Insurance Portability and Accountability Act (HIPAA). This notice describes how information and records I have about you may be used and disclosed and describes your rights and obligations regarding the use and disclosure of that information. Please read it carefully.

I. Confidentiality

I have a duty to maintain privacy for your health information and to provide you with this notice. You will be asked to sign a Consent Form. Once you have signed the Consent Form, I may use or disclose your Protected Health Information (PHI) for purposes of diagnosis, treatment, obtaining payment, or to conduct healthcare operations. For example, if you are filing a claim with your insurance company, I may share information such as your diagnosis and treatment plan with them in order to secure your reimbursement. As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Medical Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, physical exam and labs, prognosis and progress. If you request that I disclose information about you, I will require your written authorization to do so (unless the disclosure is related to the limits of confidentiality outlined below). You may revoke your authorization by contacting me in writing at any time.

II. Limits of Confidentiality

Possible Use and Disclosure of Medical and Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality. Some are exceptions created voluntarily by my own choice, and some are required by law. I may use or disclose records or other information about you without your consent or authorization in the following circumstances:

•To Avert Serious Threat to Health or Safety: I may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

•Adult Abuse or Neglect Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected, or exploited, I am required to make a report to Adult Protective Services

.•Child Abuse or Neglect Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Georgia law to report the matter immediately and provide relevant information to Child Protective Services.

•Coroners, Medical Examiners and Funeral Directors: I may release health information to a coroner or medical examiner to assist in identifying a deceased person or determine a cause of death.
•Family and Friends: I may disclose limited health information to a family or friend if I can infer based on my professional judgment that failure to do so may result in serious harm to you. I may disclose certain information in a treatment setting if I receive verbal authorization. For example, I may disclose personal information to your spouse if you bring your spouse with you into the treatment room.

•Health Oversight: I may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with certain laws.

•Information not Personally Identifiable: I may disclose limited health information about you in a way that does not personally identify you or reveal who you are. I may use this information to evaluate services or treatment offered by my office.

•Law Enforcement: I may disclose health information in response to a court order, subpoena, warrant, summons or similar process.

•Lawsuits and Disputes: If you are involved in court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order or subpoena, or similar process. I will make all efforts to tell you about the request or to obtain an order protecting the health information requested.

•Military, Veterans, national Security and Intelligence: If you are or were a member of the armed forces or part of the national security or intelligence communities, I may be required to release health information about you to military command or other government agency; I may also release information about foreign military personnel to appropriate foreign military authority.

•Organ and Tissue Donation: If you are an organ donor, I may release health information to organizations that handle organ procurement or organ, eye or tissue s transplantation or to an organ donor bank, as necessary to facilitate such donation and transplantation.

•Public Health Risks: I may disclose personal health information about you for public health reasons if I believe doing so may prevent or control disease, injury, or disability / or report births, deaths, non-accidental physical injuries, suspected abuse or neglect, reactions to medications or problems with products.

•Research: I may use and disclose health information about you for research projects that are subject to a special approval process. I must have your written consent if the research will have access to personally identifiable information.

•Workers Compensation and Disability: I may release health information about you for worker's compensation and disability programs.

III. Patient's Rights and Physician's Duties

Patient Rights:

•Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing and tell me: 1) what information you want me to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the

limits to apply.

•Right to Receive Confidential Communications by Alternative Means and Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at a certain phone number, or that I do not leave voice mail messages or use email correspondence). To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

•Right to Inspect and Copy: You have the right to inspect and request copies of information that may be used to make decisions about your care. Usually this includes demographic and billing records but does not include psychotherapy notes. To inspect and/or receive copies of information, you must submit your request in writing. If you request a copy of information, I may charge a fee for the cost of copying, mailing or other supplies associated with your request. I must respond to your request within fifteen days of receipt. HIPAA places restrictions on a patient's right to access records related to mental health treatment. I may deny your access to PHI under certain circumstances, but in some cases, you may have the decision reviewed. I may also refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding.

•Right to Amend: If you feel that health information about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by me. Your request for amendment must be in writing and must provide a reason supporting tour request. I may deny your request if you ask me to amend information that: 1) was not created by me; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate complete.

•Right to an Accounting of Disclosures: You generally have the right to request an Accounting of Disclosures I have made of information about you. You must submit your request in writing to the above address. Your request must state a time period for the disclosures, which may not be longer than six year and may not include dates before July 1, 2019.

•Right to a Copy of this Notice: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically. You may ask for a copy of this notice at any time. I reserve the right to change my policies and/or this notice.

Physician Duties:

•I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

•I reserve the right to change the privacy policies and practices described in the notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will notify current patients and post the new policies in the waiting area. Other uses and disclosures of Protected Health Information will be made only with your written authorization. After such authorization is given, you may revoke that authorization at any time. This Notice may be amended as needed to comply with federal, state, and professional requirements. Special Restrictions for Mental Health, Substance Abuse, and HIV/AIDS Treatment. Federal law has placed restrictions on access to mental health records, substance abuse records, and records relating to diagnosis and treatment of HIV/AIDS. I will comply with all applicable regulations if I maintain records about you that fall under these categories.

IV. Complaints

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If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me directly at the office address or phone number. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

V. Effective Date and Changes to Privacy Policy

This notice will go into effect January 1, 2022. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will notify patients of changes in person or by email and closed patient cases can, if interested, call and ask if our policies have changed and obtain a copy by mail or view one on my website.

_____	_____	_____
Patient Name	Patient Signature	Date