Patient Information Form

Name: _____

Date: _____

Birth Date: _____/_____/_____ Age: _____

Address:_____

City:_____ State: _____
Zip:_____

Home Phone:_____ Cell Phone _____
Employer Name _____Work Phone: _____
Email Address:_____
Preferred Method of contact: (email, home, cell, work)_____
*Appointment reminders will be sent out one week and one day before appointment, via email- so please provide an email in which this can be securely transmitted.
Marital Status: S M W D Partner
Spouse/Partner Name _____
Phone Number:_____

Emergency Contact Information:
Nearest Relative not living with you, whom we may contact in case of emergency:

Name:_____

Relationship:_____
Phone Number:_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

□ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

□ The day-to-day healthcare operations of the practice.

□ Patients files are stored on a cloud EMR that is HIPAA compliant.

□ The practice uses a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by confidentiality rules of HIPAA.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Pratices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

Intown Atlanta Psychiatry

Treatment Consent Form

Lauren Robinson, APRN
My Responsibilities to You as Your Provider:
I. **Confidentiality**
With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your treatment. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a session with you.
You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to ensure confidentiality.
If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. There are many risks associated with emails, including, but not limited to:
• Email can be circulated, forwarded and stored in numerous paper and electronic files.
• Email can be immediately broadcast worldwide and be received by unintended recipients.
Email is easier to falsify than handwritten or signed documents.
• Email can be intercepted, altered, forwarded, or used without authorization or detection.
• Email may be used to introduce viruses into computer systems.
• Email can be used as evidence in court.
• All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider.
Any email I receive from you, and any responses that I send to you, may be printed out and kept in your treatment record or EMR. Email should never be used for emergency problems. In the event of an emergency, call 911.
The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.
4. If you tell me of the behavior of another named health or mental health care provider that informs me that this person has either a. engaged in sexual contact with a patient, including yourself or b. is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires me to report this to their licensing board. I would inform you before taking this step. If you are my client and a health care provider, however, your confidentiality remains protected under the law from this kind of reporting.

II. **Other Rights**

You have the right to ask questions about anything that happens in treatment. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right provider for you. You are free to leave treatment at any time.

My Training

I have a Masters in Nursing from Vanderbilt University, earned in August 2002. I have a Family Nurse Practitioner certification and recently completed my post Master's degree in Family Psychiatric Mental Health. I am licensed in the state of Georgia as an FNP and PMHNP. I believe in a holistic approach to psychiatry. I will focus on the mind body connection. I also will explore pharmacology options that I think may be beneficial to your treatment. I will also work closely with your therapist to establish the best treatment options available for you.

A nurse practitioner in the state of Georgia may prescribe under a collaborative agreement with a designated psychiatrist. My collaborative agreement is with Bharatkumar Patel, MD. Due to the collaborative nature of my practice, Dr. Patel is available for consult at any time regarding your case. He will also evaluate your records based on state protocol. I may want him to evaluate you directly from time to time, and in that case you would make an appointment to be seen in his office, which is located at 4015 S. Cobb Drive, Suite 110, Smyrna, GA 30080 . If at any time, I would like to have Dr. Patel evaluate you, I may tape our session, but will only do so with permission from you at the time of the taped session.

If I feel that your treatment is outside my scope of practice, I will refer you directly to Dr. Patel or another provider that I feel is suited for your individual circumstances. Treatment usually ends

after an agreed upon termination date. If I have not had an appointment with you in over 6 months, it will be considered that you have terminated treatment. If you do violence to, threaten, verbally or physically, or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from treatment, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for treatment.

I am away from the office a couple of times during the year for vacations or to attend professional meetings. If I am not taking and responding to phone messages during those times I will haves someone cover my practice. You will be informed of my absences and detailed messages will be left on my voicemail about who to contact during these absences. I am available for brief between- session phone calls during normal business hours. If you are experiencing an emergency when I am out of town, or outside of my regular office hours (after 5 pm weekdays or over the weekend), please call 911.

Your Responsibilities as a Patient

You are responsible for coming to your session on time and at the time we have scheduled. You are responsible for paying for your sessions at the agreed upon rate, on the date of service. The only payment accepted is cash, check, or credit card. A returned check will be charged 50.00 in addition to the visit. If you have any questions about these rates, please feel free to ask.

If for some reason you incur debt, and refuse to pay, I reserve the right to give your name and the amount due to a collection agency. I look forward to working with you. Please feel free to contact me with any questions or concerns.

Patient Consent to Treatment

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I understand the security risks involved with using email and will hold the provider harmless and not liable for improper disclosure of confidential information that is not caused by provider's intentional misconduct. I understand my rights and responsibilities as a client, and my provider's responsibilities to me. I understand that I the use of medication in treatment comes with risks that have been explained to me, and I will ask any questions about medications that I have prior to or during treatment. I understand the collaborative relationship of Lauren Robinson, APRN and Bharatkumar Patel, MD.

I agree to undertake treatment with Lauren Robinson, APRN. I know I can end treatment at any time I wish and that I can refuse any requests or suggestions made by Mrs. Robinson. I am over the age of eighteen.

Signed:_____

Date:_____