NINA KRAM SCHLACHTER, D.O.,P.C.
ATLANTA CENTER FOR WELLNESS

PLEASE READ CAREFULLY, FILL OUT, INITIAL AND SIGN THE FOLLOWING PAPERS.
WE WILL DISCUSS THESE IN OUR MEETING, PLEASE FEEL FREE TO ASK ME IF
YOU HAVE ANY QUESTIONS. THANK YOU.

Date____

Name____ Date of Birth________________

Address____

City______________________________________State_____________________ Zip Code__________

Cell____ Alt Phone______________________________________

SS#____ E-mail____

PLEASE FILL OUT BELOW FOR:

1. EMERGENCY CONTACT and/or
2. INFO IF SOMEONE OTHER THAN PATIENT IS FINANCIALLY RESPONSIBLE and/or
3. IF PARENTS ARE FINANCIALLY RESPONSIBLE, PLEASE ENTER DATA FOR BOTH PARENTS

Name_____________________________________ Date of Birth__________________________________

Relation__________________________________ Cell____

Name______________________________________Date of Birth_________________________________

Relation___________________________________Cell____

LIST ALL MEDICATIONS, DOSES AND TIME OF DOSING; + OTC, SUPPLEMENTS, VITAMINS, PATCHES, ETC
____

____

PHARMACY NAME + PHONE NUMBER

ALLERGIES: MEDS + ENVIRONMENTAL, ETC:

MEDICAL DIAGNOSES AND SERIOUS ILLNESSE:

HOSPITALIZATIONS AND SURGERIES:

Welcome to my practice. I am honored that you chose to make an appointment with me and I will do my best to meet your needs. I am a medical doctor with specialized training and board certification in psychiatry. I am also board certified in family medicine and trained as an osteopathic physician. Although true medical illnesses, psychiatric diagnoses are considered "diagnoses of exclusion." As such, I practice psychiatry from a decidedly holistic point of view. I will want to be aware of and stay abreast of any medical issues and all medication – prescriptions, over the counter and supplements– that you are taking as long as we work together.

Psychiatric treatment and therapy are of the utmost private matters and I will observe the rules of confidentiality always. I will be honest and forthright with you. Through my training, continuing medical education and long standing experience, I will always give you my best medical and therapeutic recommendation. Although, as with all areas of medicine and all types of therapy, outcomes cannot be guaranteed. You and I are working partners in this.

While our relationship is therapeutic and not the same as family or friends, the initial thing you must do is to trust your assessment of whether there is a mutual respect and concern between us; if not, you should move on. If I feel there is not, I will help you move on.
In making appointments, your obligation is to be honest with me. The therapeutic space is one of no judgment; but I can only help to my utmost with the facts as you see and describe them.
Your second obligation is to be on time. I respect your time too, and will do my best to be on time. Because time is a commodity of therapy, the rule concerning time is that if you are late, you lose that amount of time from your session; if I am late, I will make up the time. (Initial)________

You are paying me for my expertise and doing so in increments of time. If you must cancel an appointment, I ask for 2 BUSINESS DAYS notice so that I have a chance of filling that time slot. I have given you that time slot over someone else and if you cancel last minute or do not show up for an appointment, YOU WILL BE CHARGED for the entire missed session. This is not a punishment, but a business necessity.
(Initial)____________________

PAYMENT is expected AT THE TIME of the appointment unless we make other arrangements ahead of time and in the form of a check or cash. If a check is returned, you will incur a $25 BOUNCED CHECK FEE and I will only accept CASH payment thereafter. (Initial)________________
At this time, my practice accepts check or cash; when we start accepting credit cards, a $5 surcharge will be added. If you pay by credit card, please note that you are agreeing to the above mentioned fee being billed to your credit card. (Initial) __________________
If a bill is not paid at the appointment, the statement will be sent home with you. A $25 charge will be added for each month a bill goes unpaid. After 3 months, it will go to a collection agency. (Initial)__________________

PRESCRIPTIONS: I am very meticulous with medicines and will always give you enough until our next appointment. If you lose a prescription or change your appointment and need more medicines, you will INCUR A FEE for this service because I take the time to make sure you get the correct medication, dosage, instructions and any other pertinent information. You MUST CALL if you need a refill or med change; we do not respond to pharmacy calls or faxes. (Initial)_______________________

PAPERWORK and PHONE CALLS OUTSIDE OF SESSION: I always want to help facilitate your reimbursement. If you need to speak with me outside of session or need paperwork, such as a prior authorization, I am glad to assist. If the call or paperwork can be done within a reasonably short time, I will do as quickly as possible. If we need to speak more than a few minutes or the paperwork takes intensive research or otherwise is time consuming, you will be charged in increments of 15 minutes. (initial)___________________

Our mutual goal is to meet your needs during our prescribed appointment time. Phone calls and paperwork that are a few moments and brief, are a part of doing business. If a need arises for more than that, including certain forms or letters that are needed, charges are based on time. This especially holds true for PRIOR AUTHORIZATION requests by your insurance company, especially for medications. This is becoming an increasingly frequent requirement and at times is very time consuming. Again, this is not a punishment, but a business necessity. (Initial)________________________

I respond best to calls or texts, rather than email. I will return messages within 48 BUSINESS hours. If you usually communicate with me via text and do not hear back within that time frame, assume that I did not get the message or am out of the office, in which case, please call to hear the phone message as to when I will be back in the office.
(Initial)______________________

I hereby authorize treatment by Nina Kram Schlachter, D.O.
I am requesting to see Dr. Nina Kram Schlachter outside of my insurance company.
I am aware that if I need to cancel or change an appointment, I need to give 48 BUSINESS hours notice or will be charged a missed session.
I am aware that medication refills or changes in between sessions will incur at a minimum, a $25 charge.
I am aware that there may be a charge for paperwork, including prior authorizations required by my insurance company.
I have reviewed and been offered a notice of Privacy Practices.

Patient____________________________________ Date_________________

If you are a minor or if another person is financially responsible for your charges, they MUST fill out and sign below.

Name____ Date_________________

Address______________________________________ Phone_______________

____