Gila Herman, PMHNP
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OFFICE POLICIES AND CONSENT FOR TREATMENT

This document contains important information about my office policies. Please read it carefully and feel free to ask any questions you may have. When you sign this document, it will represent an agreement between us.

CANCELLATION POLICY

Please remember that your appointment time is reserved for you. I have a 24-hour cancellation policy. Please note that once an appointment is scheduled, you will be expected to pay for it in full unless you provide 24 hours advance notice of cancellation.

TELEPHONE CALLS

I will make every effort to return calls within 24-48 hours. Calls lasting more than 15 minutes will be billed at a rate of $50/15 minutes. In the event of a psychiatric emergency, please call the Georgia Crisis and Access Line (GCAL) 1-800-715-4225 or call 911.

MEDICATION POLICY

I will make every effort during your appointment to provide enough medication refills to reach your next appointment. Once you have requested your last refill from your pharmacy, I ask that you ensure you have a follow-up appointment scheduled before the next refill. Requests for refills will be fulfilled on case by case basis and may require a phone conversation or appointment before filling. Please allow at least 2 full business days for refills. Prescriptions shall only be called in for current patients who regularly attend their appointments. Please note that I do not prescribe controlled substances (e.g. benzodiazepines like Xanax and Klonopin, stimulant medications for ADHD like Adderall and Ritalin).

PAYMENTS AND INSURANCE

Payments are expected at the time of service. I do not file insurance claims nor do I accept any insurance plans or payments. If you wish, you may file for reimbursement directly with your insurance carrier. If requested, I will provide you with a super-bill which includes the diagnosis code and billing code for the appointment.

INFORMED CONSENT TO TREATMENT

I have read, understood, and had the opportunity to question, and I agree to the above conditions and policies. I agree and consent to participate in mental health services offered by Gila Herman, PMHNP. I understand that 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. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment on behalf of this individual.

Patient Name: _____ D.O.B.: _____

Responsible Party Name: _____ Relationship:_____

Signature: _____ Date:_____

NOTICE OF PRIVACY PRACTICES

I have been provided a copy of Gila Herman's *Notice of Privacy Practices* document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review the document before signing this acknowledgement form.

Patient Name: _____ D.O.B.: _____

Responsible Party Name: _____ Relationship:_____

Signature: _____ Date:_____