

Darvin Hege, M.D., P.C.
2150-P Peachford Road
Atlanta, Georgia 30338

Phone 770.458.0007 Fax 770.452.1234
www.eveningpsychiatrist.com

General Policies and Procedures / Patient Bill of Rights

Thank you for choosing Dr. Darvin Hege to be of service to you and your family for your behavioral healthcare needs. Please read these policies completely, and if you have any questions, do not hesitate to ask for clarification.

Patient's Bill of Rights: We are happy to provide you with this list of your rights as defined by the American Medical Association:

- | | |
|--|---|
| *Non Discrimination | *Privacy |
| *Information about your diagnosis, prognosis and treatment plan | *Third person present during treatment |
| *Voluntary consent to treatment | *Identification of person providing service |
| *Approximate overall cost and billing information | *Active participation in decision making about your health status |
| *Right to seek another opinion | *Knowledge of the need for continuation of care |
| *Continuing healthcare after discharge from outpatient or inpatient care | *Knowledge of human experimentation |
| | *Expected conduct in the outpatient setting |
| | *Safety |

Appointments: Appointments are scheduled according to each patient's needs and the availability of the physician. The time of your appointment is reserved for you. **You are expected to give 24 hours notice with a staff member or with the answering service if you will not be keeping your appointment, or it will be necessary for you to pay an unkept appointment fee of \$50.00.** Your insurance company will not cover this fee. It is your responsibility.

Office Courtesy: Please consume all food and beverages before you enter our waiting area. **Please do not use your cell phone while in our office. Please do not bring babies and/or children to our office. This policy is (1) for their safety and (2) so that you and Dr. Hege will be able to concentrate on your quality care.**

Maintaining Patient Status: In our area of healthcare, it is very important that you be seen on a regular basis. At the end of each appointment, Dr. Hege will tell you how long a period of time he would like you to schedule a follow-up appointment in the office. We urge you to make the follow-up appointment before you leave our office in order to schedule the most convenient time for you. If you fail to keep and/or maintain follow-up appointments for a period of 120 days or greater, we will conclude that you have terminated the patient-physician relationship.

Fees: You, the patient, or your legal guardian are financially responsible for the total cost of services rendered. Full payment is expected upon arrival at our office and before you are seen by Dr. Hege. If you are unable to pay for your service (i.e., full payment or copay or deductible payment), you will be asked to reschedule for another time. If this happens more than once, you will also be charged a \$50.00 unkept appointment fee.

Phone calls: Emergency calls are handled as a priority. If you are having an emergency of a medical nature, please call 911 immediately. Routine calls will be handled by the office staff. Please leave a message on our voice mail or with our answering service for the office staff to return your call. Calls that require the doctor to call you back will be handled as timely as possible. Please leave a phone number and a time span of when you will be available for a return call. We have a 24 hour answering service if your call is urgent and cannot wait until the office is open. If possible, please call during business hours, 8:30am – 5:30pm, Monday – Friday.

Medication Refills: We handle all refills during your regular scheduled appointments. If a medication refill becomes necessary, please provide us with your pharmacy phone number, medication name and how you are currently taking your medication. We will require you to make an appointment with Dr. Hege, then we will call in enough medication to last until your appointment. We appreciate your cooperation in keeping track of your medication supply in order to avoid running out. Allow 24 to 48 hours for telephone prescriptions. **We do not accept fax requests from your pharmacy.** You need to contact us directly for new prescriptions or additional refills. **There is a \$30 fee for medication refill requests between appointments.**

Confidentiality: Your patient records are strictly confidential. For this reason, no information concerning you as a patient is released without your written consent. Disclosure of information to anyone such as another doctor, an attorney and/or a family member must be requested by written authorization by the patient. In an emergency situation when you, the patient, are at imminent risk of death or serious medical consequence, Dr. Hege will release minimal, critically relevant information to assist in preventing dire medical consequences that may result if that relevant information is not released. In the case of a minor, their legal guardian must sign the authorization. The physician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others and in reports of child or geriatric abuse.

Medical Reports/Correspondence: Disability forms, work excuses, calls to employers, return to work letters, etc. will be provided on a fee basis. **The fee must be prepaid in order for us to complete the requested task.** The fee will be based on time spent preparing the requested information.

We are glad you have chosen us to provide your care. We will make every effort to provide you with quality care and professional support, respect and consideration. If you have any concerns, please bring them to the attention of our office staff immediately.

Medication Refills Between Appointments

We prefer to handle all refills during your regularly scheduled appointments. If a phone refill becomes necessary, please provide us with your pharmacy's phone number, medication name and how you are currently taking your medication. We will require you to make an appointment with the physician, and we will call in enough medication to last until your appointment. We appreciate your cooperation in keeping track of your medication supply in order to avoid running out. Allow 24 to 48 hours for telephone prescriptions. We do not refill medications after regular business hours (8am – 5pm) or on weekends. We do not accept fax requests from your pharmacy. You need to contact us directly for new prescriptions or additional refills.

There is a \$30.00 fee for medication refill requests between appointments.

FMLA Forms/Medical Reports/Correspondence/Disability Forms

While medical reports to insurance companies and employers are necessary for you to access benefits, they are not medically necessary for your treatment. Therefore, we charge for these additional tasks. Please allow 5 to 7 days for completion of your requests after we have all the appropriate releases and/or information to complete the forms.

Below is some general information about medical correspondence.

We must have a signed release from the patient to release information to anyone else. This includes family members, other doctors, insurance companies, and employers. Please make sure you sign our release form at the time of your request.

We must have clear instructions as to what method the information will be conveyed to the other party, i.e. fax, mail, telephone. We need complete fax numbers, phone numbers and/or addresses.

The basic charge for medical reports is approximately \$25.00 per page when we are completing a “pre-printed” form. The cost of reproducing records is \$1.00 per page. The charge for a letter requiring the physician’s time is \$8.00 per minute depending on the length of time spent preparing the information. We require prepayment for these services.

Some insurance companies will pay for medical reports. Many do not. If you think your insurance company will pay, then we urge you to contact them and find out how you can be reimbursed from them.

Tips for patients on disability: Get to know your case manager as soon as possible. Ask when forms will be required. For example, if your initial notice of disability claim is filed in June, when will the next update be expected? We often hear that a person’s disability check does not arrive in the mail, then they call the disability insurance company only to learn some needed information was not provided. Know your benefits, policy requirements and case manager.

Prior Authorization/Quantity Overrides/Non-Formulary Issues with Insurance Companies Regarding Medications

Dr. Hege prescribes medication based on your condition/illness. Sometimes your insurance company limits the availability or free access to certain medications. At times, they may require two copays. These types of restrictions are between you and your insurance company. You need to contact your insurance company if this issue arises. If they require clinical information from the prescribing physician, ask them to fax us a written request. You are required to provide them with your medication history, ID numbers, etc. **If you feel you are unable to handle this time-consuming communication with your insurance company, we will provide it for a fee of \$35.00 per request.**

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ASSIGNMENT FOR BENEFITS

I, _____ authorize Darvin Hege, M.D., P.C. to bill my insurance company for charges incurred during the course of my treatment and to provide any information necessary to process my claims and to collect payment. I authorize my insurance company to honor a photocopy of this authorization and to assign my insurance benefits for these charges to Darvin Hege, M.D., P.C.

Signed: _____ Dated: _____

Witness: _____

INFORMED CONSENT (Adult Patients)

I, _____ have read and understand the policies and procedures for Darvin Hege, M.D., P.C. and I accept the conditions for receiving services from Dr. Hege. I have received a copy of Darvin Hege, M.D., P.C.'s Notice of Privacy Practices and understand that a copy will be available in the waiting area at all times.

Signed: _____ Dated: _____

Witness: _____

**INFORMED CONSENT
Adolescent Patients and/or Patients with Legal Guardians**

If you are signing this Informed Consent as it relates to seeking services for a minor child/adolescent, please answer the following questions (providing names and relationship of each with the adolescent):

With whom (both parents, one parent, other) does the child/adolescent reside? _____

Who has legal custody of the child/adolescent? _____

I(we), _____, parent(s)/legal guardian of _____ accept the conditions for receiving services from Dr. Hege. I(we) have received a copy of Darvin Hege, M.D., P.C.'s Notice of Privacy Practice and policy and procedures.

Signed: _____ Dated: _____

Witness: _____

Date: _____ Referred by (name and number) _____
Do we have your permission to thank them for referring you? Yes or No

Patient Information - Please fill out completely.

Last Name _____ **First Name:** _____ **M.I.** _____

Street Address: _____

City: _____ State: _____ Zip: _____ Gender: Female or Male

Home Phone: _____ Office Phone: _____ Cell: _____

Which number do you prefer us to use for reminder calls, etc? Please circle your choice.

Birthdate: _____ SS #: _____

Marital Status: (circle) Single / Married / Divorced / Widowed

Employer/School Name and Phone number: _____

Spouse's Name and daytime phone number: _____

Responsible Party: Provide info on who is responsible for paying for the service (if different)

Name: _____ SS# _____

Address: _____ Phone: _____

Relationship to Patient? _____

Emergency Contact: (Name/number/relation) _____

****Insurance Information: Please provide insurance card for copying.**

Name of Insured: _____ ID# _____

Insured's date of birth: _____ Relationship to pt _____

Name of Insurance Co: _____

Phone number and address: _____

Employer of Insured: _____ Group # _____

Have you contacted your insurance for authorization? **Yes or No** Authorization # _____

Phone number for authorization if different from insurance phone # _____

**If you have more than one insurance company, please request an additional form from the office staff.

TREATMENT HISTORY

Name: _____

Date: _____

Thank you for answering these questions. Your answers will greatly enhance the value of your therapeutic session. This history will provide a complete synopsis of your situation.

Have you had any counseling or psychiatric care in the past? YES NO
 Have you had any psychiatric hospitalizations in the past? YES NO
 if Yes, please give approximate dates: _____

Have you ever been on medication for nerves, anxiety, depression or insomnia? YES NO
 If yes:

Medication name	Did it Help?	What Problems with it?

Have you had out-patient therapy? YES NO
 Number of therapies: _____
 Last therapist name: _____
 Date of last visit: _____

Have you had any other type of psychological therapy? Please circle type if yes. YES NO
 Marital or family therapy, ECT, group therapy, hypnosis, other

Have you ever felt you ought to cut down on your drinking or drug use? YES NO

Have people annoyed you by criticizing your drinking or drug use? YES NO

Have you ever felt bad or guilty about your drinking or drug use? YES NO

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? YES NO

Have you had any hospital or outpatient treatment for alcohol or drugs? YES NO

Have any blood relatives had a problem with alcohol or drugs? YES NO

Have any blood relatives suicided or had a psychiatric hospitalization? YES NO

Have you been diagnosed as manic-depressive, or considered to possibly be? YES NO

Have you ever been on Lithium? YES NO

BEHAVIORAL HEALTHCARE PROBLEMS HISTORY

Name: _____

Have you had panic attacks, hyperventilation or anxiety or nervousness? YES NO

Describe: _____

Do you do a lot of hand washing or going back and checking windows, doors, stoves, etc? YES NO

Describe: _____

Are you bothered with thoughts that keep coming back into your mind? YES NO

Describe: _____

Have you had any traumas, catastrophes, or bad accidents? YES NO

List: _____

Have you had any losses or deaths? YES NO

List: _____

What are your current stresses? _____

List: _____

Have you been Abused? YES NO

How	By Whom	When
Physically		
Sexually		
Emotionally		

Do you have sexual concerns? YES NO

Have you attempted suicide? YES NO

How many times? _____
 Last time: _____ First time: _____

Have you become violent? YES NO

To property? _____ How? _____
 To People? _____ Who? _____

Have you been arrested? YES NO

What were the charges? _____

Have you had an eating disorder, or made yourself throw up to lose weight? YES NO

MEDICAL HISTORY

Name: _____

Hospitalizations:

Year	Condition

Surgeries:

Year	Type

Other serious medical conditions: _____

Current medicines:

Name	Dosage	Schedule

Are you allergic to any medicines? **YES** **NO**

Have you ever had a seizure? **YES** **NO**
If so, when was the last time? _____

Have you had a loss of consciousness? **YES** **NO**
If so, when was the last time? _____

Names of the doctors you have seen in the last 3 years:

- 1 _____
- 2 _____
- 3 _____
- 4 _____

MOOD DISORDER QUESTIONNAIRE

Patient name: _____ Date: _____

Has there ever been a period of time when you were not your usual self and...

Circle yes or no by each statement/question.

- | | | |
|----------|--|-----------|
| a | You felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble. | Yes or No |
| b | You were so irritable that you shouted at people or started fights or arguments? | Yes or No |
| c | You felt much more self confident than usual? | Yes or No |
| d | You got much less sleep than usual and found you did not really miss it? | Yes or No |
| e | You were much more talkative or spoke much faster than usual? | Yes or No |
| f | Thoughts raced through your head or you could not slow your mind down? | Yes or No |
| g | You were so easily distracted by things around you that you had trouble concentrating or staying on track? | Yes or No |
| h | You had much more energy than usual? | Yes or No |
| i | You were much more active or did many more things than usual? | Yes or No |
| j | You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | Yes or No |
| k | You were much more interested in sex than usual? | Yes or No |
| l | You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | Yes or No |
| m | you spend money that got you or your family in trouble? | Yes or No |

If you checked yes to more than one of the above, have several of these ever happened during the same period of time? Yes or No

How much of a problem did any of these cause you - like being unable to work; having family, money, or legal troubles; getting into arguments or fights?

No Problem Minor Problem Moderate Problem Serious Problem

BECK INVENTORY

Patient: _____ Date: _____

Instructions: This is a questionnaire. Please read all four statements by each number. Then pick out the one statement in that group which best describes the way you feel today, that is, right now! Circle the number (0, 1, 2, or 3) beside the statement you have chosen. If several statements in the group seem to apply equally well, circle each one.

- 1 0-I do not feel sad.
1-I feel sad.
2-I am sad all the time and I can't snap out of it.
3-I am so sad or unhappy that I can't stand it.

- 2 0-I am not particularly discouraged about the future.
1-I feel discouraged about the future.
2-I feel I have nothing to look forward to.
3-I feel that the future is hopeless and that things cannot improve.

- 3 0-I do not feel like a failure.
1-I feel I have failed more than the average person.
2-As I look back on my life, all I can see is a lot of failures.
3-I feel I am a complete failure as a person.

- 4 0-I get as much satisfaction out of things as I used to.
1-I don't enjoy things the way I used to.
2-I don't get real satisfaction out of anything anymore.
3- I am dissatisfied or bored with everything.

- 5 0-I don't feel particularly guilty.
1-I feel guilty a good part of the time.
2-I feel quite guilty most of the time.
3-I feel guilty all of the time.

- 6 0-I don't feel I am being punished.
1-I feel I may be punished.
2-I expect to be punished.
3-I feel I am being punished.

- 7 0-I don't feel disappointed in myself.
1-I am disappointed in myself.
2-I am disgusted with myself
3-I hate myself.

- 8 0-I don't feel I am any worse than anybody else.
1-I am critical of myself for my weaknesses or mistakes.
2-I blame myself all the time for my faults.
3-I blame myself for everything bad that happens.

- 9 0-I don't have any thoughts of killing myself.
1-I have thoughts of killing myself but I would not carry them out.
2-I would like to kill myself.
3-I would kill myself if I had the chance.

- 10 0-I don't cry any more than usual.
1-I cry more than I used to.
2-I cry all the time now.
3-I used to be able to cry but now I can't cry even though I want to.

(over)

- 11** 0-I am no more irritated now than I ever am.
1-I get annoyed or irritated more easily than I used to.
2-I feel irritated all the time now.
3-I don't get irritated at all by the things that used to irritate me.
- 12** 0-I have not lost interest in other people.
1-I am less interested in other people than I used to be.
2-I have lost most of my interest in other people.
3-I have lost all of my interest in other people.
- 13** 0-I make decisions about as well as I ever could.
1-I put off making decisions more than I used to.
2-I have greater difficulty in making decisions than before.
3-I can't make decisions at all anymore.
- 14** 0-I don't feel I look any worse than I used to.
1-I am worried that I am looking old or unattractive.
2-I feel that there are permanent changes in my appearance that make me look unattractive.
3-I believe that I look ugly.
- 15** 0-I can work about as well as before.
1-It takes extra effort to get started at doing something.
2-I have to push myself very hard to do anything.
3- I can't do any work at all.
- 16** 0-I can sleep as well as usual.
1-I don't sleep as well as I used to.
2-I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3-I wake up several hours earlier than I used to and cannot get back to sleep.
- 17** 0-I don't get any more tired than usual.
1-I get tired more easily than I used to.
2-I get tired from doing almost anything.
3-I am too tired to do anything.
- 18** 0-My appetite is no worse than usual.
1-My appetite is not as good as it used to be.
2-My appetite is much worse now.
3-I have no appetite at all anymore.
- 19 YES OR NO** I am purposely trying to lose weight by eating less
0-I haven't lost much weight, if any lately.
1-I have lost more than 5 pounds.
2-I have lost more than 10 pounds.
3-I have lost more than 15 pounds.
- 20** 0-I am no more worried about my health than usual.
1-I am worried about my physical problems such as aches, pains, upset stomach or constipation.
2-I am very worried about my physical problems, and it is hard to think of much else.
3-I am so worried about my physical problems that I cannot think about anything else.
- 21** 0-I have not noticed any recent change in my interest in sex.
1-I am less interested in sex than I used to be.
2-I am much less interested in sex now.
3-I have lost interest in sex completely.