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

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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 polices 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
*Information about your diagnosis, prognosis and treatment plan
*Voluntary consent to treatment
*Approximate overall cost and billing information
*Right to seek another opinion
*Continuing healthcare after discharge from outpatient or inpatient care
*Privacy
*Third person present during treatment
*Identification of person providing service
*Active participation in decision making about your health status
*Knowledge of the need for continuation of 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 $115.00. Please note that the unkept appointment fee also applies if you arrive late for your scheduled appointment.** 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, you will be asked to reschedule for another time and charged the $115.00 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.

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.

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. The insurance company may want additional clinical information from the prescribing physician. These types of restrictions are between you and your insurance company. If your prescription requires a prior authorization, please ask your pharmacy to manually fax the denial form to our office. **The fee to provide this service is $35.00 and is due at time of the request.** It is an administrative charge for preparing and processing your prior authorization. This charge does not guarantee that your insurance will approve coverage of medication. You will need to contact your insurance company if you are denied coverage of your medication. Please allow applicable processing time for your request. Prior authorizations will be handled in the order they are received and can take 10-14 business days to be processed.

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 (10am – 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 cost of reproducing records is $1.00 per page. The charge for a letter requiring the physician's time is $10.00 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.

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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:_______________________

Email:________________________________Birthday:__________________________ SS#:________________________

Marital Status: (circle) Single / Married / Divorced / Widowed / Separated / Partnered / Other

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 #:_________________________________

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 youby 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 death? **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?____

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

1.____
2.____
3.____
4.____

Zung Depression Inventory

NAME ____ DATE ________________

	False	Somewhat False	Somewhat True	Very True	Key
1. Morning is when I feel the worst.	0	1	2	3	Reversed diurnal
2. I don't eat as much as I used to.	0	1	2	3	Anorexia
3. I don't enjoy sex anymore.	0	1	2	3	Libido reduced
4. My mind is not as clear as it used to be.	0	1	2	3	Concentration reduced
5. It is harder to do things than before.	0	1	2	3	Amotivation
6. I feel hopeless about the future.	0	1	2	3	Hopeless
7. I find it harder to make decisions.	0	1	2	3	Indecision
8. I feel that I am useless and unneeded.	0	1	2	3	Worthless
9. My life is pretty empty.	0	1	2	3	Disinterest
10. I don't enjoy the things I used to do.	0	1	2	3	Anhedonia
11. I feel downhearted and blue.	0	1	2	3	Dysphoria
12. I have crying spells or feel like it.	0	1	2	3	Crying
13. I have trouble sleeping at night.	0	1	2	3	Insomnia
14. I notice that I am losing weight.	0	1	2	3	Weight loss
15. I have trouble with constipation.	0	1	2	3	Constipation
16. My heart beats faster than usual.	0	1	2	3	Tachycardia
17. I get tired for no reason.	0	1	2	3	Anergia
18. I am restless and can’t keep still.	0	1	2	3	Restlessness
19. I am more irritable than usual.	0	1	2	3	Irritable
20. I feel that others would be better off if I were dead.	0	1	2	3	Suicidal idea

Edited by Darvin Hege, MD 2/9/12

MOOD DISORDER QUESTIONNAIRE

Patient:____ 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 the 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