



Psychiatry and Transcranial Magnetic Stimulation

Kenneth E. Goolsby, M.D.

Rob Findley, P.A./C.

WELCOME TO OUR OFFICE!

This questionnaire is to assist us in better understanding your situation/problem. We recognize that there are a lot of questions so if you do not understand a particular question or feel uncomfortable answering a question, feel free to leave it blank. We will review this questionnaire and discuss it thoroughly with you in our first appointment.

Treatment with our office is voluntary and can be terminated at any time without penalty. Our goal is to be as helpful to you as possible and to assist you in most effectively dealing with your current problems. If at any time you have any questions, concerns or ways we might improve our services, we would appreciate your input.

As a new patient with our office, you have been scheduled with one of the Physician Assistant's (P.A.) or Psychiatric Nurse Practitioner (A.P.R.N.). The P.A./A.P.R.N. will complete the initial evaluation on the first office visit which will be an approximately 45 appointment. Following your first appointment, the P.A./A.P.R.N. will schedule you with a follow up appointment to monitor your medication(s). The follow appointments will be scheduled for 15minutes unless otherwise directed by your provider. These appointments will be focused on your response to the prescribed medications, any symptoms you may be experiencing, and any side effects from the prescribed medications. WE DO NOT HANDLE THERAPY OR COUNSELING; however, please ask your provider or the front desk for a recommendation to a local therapist/counselor if you are in need of talking to someone in regards to any personal issues you are encountering and we will be happy to provide you with a referral.

I understand that in all cases strict standards of confidentiality and professional ethics will be maintained. Kenneth E. Goolsby, MD & Associates, P.C. (KEG) strive to protect and preserve the confidentiality of the patient's personal, financial, and health information. KEG has provided me with a copy of the "Notice of Privacy Practices".

Signature of Patient, Parent or Guardian

Relationship to Patient

Date

Printed Name

Date of Birth

Patient Information

Today's Date: _____

Patient's Full Name (first middle and last): _____ MadienName: _____

Sex: Male/Female Date of Birth: _____ Race: _____ Language Spoken: _____

Social Security Number: _____ - _____ - _____ Ethnicity (Y/N): Hispanic/Latino _____

Marital Status(Circle One): Single/Married/Widowed/Divorced/Domestic Partnership/Separated

Address: _____
City: _____ State: _____ Zip
Code: _____

Home Phone# _____ Cell# _____ ALT# _____

Driver's License #: _____ State of License or ID Card: _____

Email Address: _____

Preferred Pharmacy Name: _____ Pharmacy
Phone# _____

Pharmacy Location: _____

Employer Name: _____ Work
Contact# _____ Occupation _____

Spouse or Parent Information: (this does not approve release of any medical, financial, or personal information to be released, you must fill out a medical records release for if you want them to have access to your information),

Name: _____ Date of Birth: _____

Best Contact Number: _____ Employer Name _____

Employer Address: _____

Primary Care Physician (medical doctor):

Name: _____ Phone Number: _____

Referral Information:

Please identify how you heard about our office: _____

EMERGENCY CONTACT:

Name: _____ Phone
Number: _____ Relationship: _____

Insurance Information

Primary Insurance Name: _____
ID#: _____

Group Number _____ Effective
Date: _____

Subscriber's Name (as it appears on the
card): _____

Subscriber's Date of Birth: _____ Relationship to
Patient: _____

Patient's Name (as it appears on the
card): _____

Mail Claims
Address: _____

Provider/Member Customer Service
#: _____

Secondary Insurance
Name: _____ ID# _____

Group Number _____ Effective
Date: _____

Subscriber's Name (as it appears on the
card): _____

Subscriber's SSN: _____ - _____ - _____ Subscriber's Date of
Birth: _____ Relationship to Patient: _____

Patient's Name (as it appears on the
card): _____

Mail Claims
Address: _____

Provider/Member Customer Service
#: _____

I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of the below signature shall be as valid as the original signature.

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____

I. PERMISSION FOR TREATMENT: I hereby authorize Kenneth E. Goolsby, MD & Associates, P.C. and its professional staff to treat me for conditions requiring their services.

FAILURE TO SIGN THIS DOCUMENT AT THE BOTTOM OF PAGE MAY RESULT IN THE APPOINTMENT TO BE RESCHEDULED AT THE DISCRETION OF THE PRACTICE.

II. RELEASE OF MEDICAL INFORMATION: I hereby authorize Kenneth E. Goolsby, MD & Associates, P.C. to release financial, medical and such other information as may be

requested by any insurer or other party who may be liable for any part of the charges for my care. I authorize Kenneth E. Goolsby, MD & Associates, P.C. to contact my employer and insurance carrier to verify coverage by my insurance. My signature shall authorize Kenneth E. Goolsby, MD & Associates, P.C. to obtain copies of medical records from previous treating physicians and/or any facilities where diagnostic testing may have been performed.

III. ASSIGNMENT OF BENEFITS: I authorize payment of benefits directly to Kenneth E. Goolsby, MD & Associates, P.C. for all covered services to be applied against the bill. The undersigned or the patient is responsible for any and all charges not covered under the present insurance policy.

IV. I also understand that Kenneth E. Goolsby, MD & Associates, P.C. will consider a bill past due thirty (30) days from the date reflected on the invoice. All past due bills may be subject to a \$6.00 finance fee per month. It is further agreed that the patient, spouse, or responsible party agrees to pay all costs of collection, including attorney's fees in the amount of 33 1/3% plus court costs and any interest allowable by law, if incurred.

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED REGARDING INSURANCE

COVERAGE IS CORRECT AND THAT THE ABOVE RELEASE AND REQUEST FOR ASSIGNMENT WILL BE HONORED.

Date Authorized Signature (Parent if minor)

I permit a copy of this authorization to be used in place of the original, regardless of the date, until cancelled by me.

KENNETH E. GOOLSBY M.D. & ASSOCIATES P.C.

FINANCIAL POLICY

We are committed to providing you with the best possible psychiatric care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy. It is our OFFICE POLICY TO REQUEST PAYMENT OF YOUR COPAY, DEDUCTIBLE, COINSURANCE, or BALANCES AT THE TIME OF YOUR APPOINTMENT.

Financial Responsibility

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Kenneth E. Goolsby, MD & Associates, PC. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Should any open balances be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection including reasonable attorney's fees.

PAYMENT for Services is DUE AT TIME OF SERVICE

We accept cash, personal check, Visa, MasterCard, Discover, and American Express. Returned checks are subject to a \$25.00 service fee and you will lose your privilege to write checks for any future payments in our office. If you are a self pay patient, your first appointment with our office is \$275.00 and your follow up visits are \$100.00/each. Any balance incurred will be due within 30days and after the first 30days; I agree to pay the \$6.00/month finance charge until my balance is resolved in full.

HMO/PPO Insurance Coverage

COPAYMENT, COINSURANCE, and DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. I understand that it is my responsibility to provide Kenneth E. Goolsby, MD & Associates, PC with

a copy of my current insurance card and if required by my insurance to obtain a referral from my primary care physician. Kenneth E. Goolsby, MD & Associates, PC is not obligated to see patients without a referral if required by the patient's insurance. If I do not have insurance, I will be considered a self-pay patient and I am financially responsible for the total amount of the services provided. I further understand that the office of Kenneth E. Goolsby, MD & Associates, PC does not discount or offer a sliding fee scale for self-pay patients. I agree to notify Kenneth E. Goolsby, MD & Associates, PC immediately upon any changes in my insurance coverage. The office will file your insurance as a courtesy to the patient. I understand that all charges not covered by my insurance company are my responsibility and will be within 30days of receipt of denial to the office of Kenneth E. Goolsby, MD & Associates, PC. I further understand that if my insurance company fails to pay Kenneth E. Goolsby, MD & Associates, PC in a timely manner for any reason, then I will be responsible for prompt payment of all amounts due for my services.

Health Insurance Exchange Policies

If your policy was purchased thru the Health Insurance Exchange, our office will accept your insurance, but please be aware not all the health insurance exchange policies have our office or providers as in-network. Also, if a policy retro-terminates for lack of premium payment from the patient, I understand I will be responsible for the full amount of services rendered within 30days.

Medicare

Your deductible is due at time of service. Once your annual deductible has been satisfied, you are then responsible for a 20% coinsurance on all the allowable charges. Payment of the remaining deductible and coinsurance are due at time of service. All our providers are contracted with Medicare and we will be billing Medicare for your services. I hereby authorize and assign all payments of authorized Medicare benefits for my medical services and/or procedures rendered to the patient, directly to Kenneth E. Goolsby, MD & Associates, PC. I hereby authorize Kenneth E. Goolsby, MD & Associates, PC to release medical information as necessary to obtain payment for my services. I understand I am financially responsible for all charges not covered by Medicare for which I have signed an Advance Beneficiary Notice ("ABN").

Worker's Compensation

If you are covered under a Worker's Comp. plan, we must have your adjustor's name, contact number, fax number, an address of where our office bills can be mailed for prompt payment, and approval to be seen for psychiatric services.

Laboratory Billing Procedure

I have been notified that all laboratory procedures/tests are performed outside of the office (blood work, urine drug screens, etc) and will not be included in the charges for Kenneth E. Goolsby, MD & Associates, PC. All lab tests performed by an outside laboratory are billed separately to either my insurance on file or myself. I understand that I may receive a bill from the laboratory company. I will direct any questions regarding a bill or statement from an outside laboratory to the lab directly with the number provided on the bill or statement received. The current outside lab used by Kenneth E. Goolsby, MD & Associates, PC is currently NPL Laboratories (National Premier Laboratories) and their telephone number is 770-506-9985.

No Show Policy

IF YOU ARE MORE THAN 15 MINUTES LATE FOR YOUR APPOINTMENT YOU MAY BE RESCHEDULED. Please contact the office if you're running late, need to change, or cancel your appointment in a timely manner in order to avoid being charged a fee. Please initial the following:

_____ There will be a \$50.00 charge if you fail to show for your scheduled office appointment. I understand this fee is due in full by my next appointment or my appointment may be cancelled. I also understand the electronic telephone reminder calls from the office are a courtesy. If the reminder call is not received it does not waive the no show fee or other fees possible incurred for the patient due to the no show.

_____ There will be a \$35.00 charge for a request for any medication following a cancelled, rescheduled, or no show appointment. I understand this payment is due BEFORE any approved medications will be called into a pharmacy, e-prescribed by my provider, faxed to the pharmacy, or picked up in the office. I also am aware I must be seen for an appointment within 90 days for controlled medications, otherwise the office cannot refill or prescribe the controlled medications until my next appointment due to federal and/or state prescribing laws.

Phone Calls/Phone Consultations

_____ Non-Scheduled Phone Calls that are complex in nature from a provider are charged a fee between \$15.00-\$60.00 at the provider's discretion for their time. This fee must be paid by the patient's next appointment and the provider or front desk on the provider's behalf will let you know if there is a fee due. Any controlled medication changes REQUIRE an appointment with my provider. I understand no controlled medications will be prescribed if the patient has not been seen within our office within the last 90days.

_____ Phone Consultations are appointments that are pre-scheduled with a provider's approval and will be charged a \$100.00 flat fee due at time of the phone consult by credit card over the phone. The phone consultation charge is not covered by most insurance plans; therefore our office does not file this fee to any insurance company. If you would like a claim form to submit to your insurance for possible reimbursement, we will be happy to provide this claim form to you for you to file directly with your insurance company at your request.

Consent for Medical Treatment

I am the patient, OR for a minor child I am the legal parent/legal guardian of the said child, OR the power of attorney appointed to a patient over 18 years of age. I authorize care encompassing the performance of all appropriate procedures and courses of treatment and any medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments and or medications prescribed. I certify that I have the right to receive a copy of this form and that I have read and accept its contents as noted.

Release of Medical Information

I hereby authorize Kenneth E. Goolsby, MD & Associates, PC to release financial, medical and such other information as may be requested by my insurance or other party who may be liable for any part of the fees and charges of my care. I authorize Kenneth E. Goolsby, MD & Associates, PC to contact my insurance to verify my coverage and benefits before every scheduled appointment with their office. I understand that my health, personal, or financial information will not be released to anyone other than my insurance without my written authorization on a HIPPA compliant medical records release form, available on www.goolsbyassociates.com or at the office, and the form will be kept in my chart. (This includes we cannot confirm to a spouse, parent, loved one, friend, or employer anything in regards to your care, medications, or appointments without your written permission or without you present in our office). This is sometimes inconvenient for the patient, but this is part of HIPPA law and is to protect you as the patient.

Form Completion Fee

Due to the large volume of forms that we are required to complete, our office charges \$50.00 for disability paperwork. Payment for completed paperwork requested is due before your forms will be released to you, your disability insurance, or employer. We also must have a Release of Medical Information form on file so we can legally release your information as well. Any paperwork requiring notarization can be completed in our office, but will incur a \$10.00 fee

due at the time the paperwork is notarized. Financial records requests (ex: yearly payments for tax records) will also be subject to a \$10.00 fee.

Privacy Policy

I have received a copy of Kenneth E. Goolsby, MD & Associates, PC's privacy policy and have been given the opportunity to have my questions, if any, answered.

Financial Agreement

Our billing department or Practice Administrator will be happy to work with you in regards to understanding your bill or payments due at time of service to the best of our ability. However, your insurance is a contract between you and your insurance or your employer and the insurance company. We are not involved as a party to that contract. You are ultimately responsible to be aware of the services, diagnosis, benefits, and if your plan has a maximum amount of allowed visits. If you exceed the annual amount of visits on your insurance there is no way for our office to know how many other providers or offices you have seen within the year, you are ultimately responsible to let us know when you have reached your office visit max and that we need to file a prior authorization for services. A filed prior authorization for service does not guarantee the insurance will approve additional office visits and if they deny you will be considered a self-pay patient for the remainder of the year and charged \$100.00 per visit which is due at time of service.

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES IS RENDERED.

Collection actions will be taken for any unpaid charges and/or fees not paid within 120 days of EOB/EFT receipt by the office or if self pay from the date of service. If your insurance has not paid your claims with 120 days post service date, you may be responsible for the charge amount billed to your insurance and then have to get involved for insurance to pay your claims. If you pay for services and then insurance pays, the patient will be reimbursed immediately, as long as, the recoupment period has passed from your insurance and the balance to patient and insurance is at \$0.00. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact our billing department or practice administrator promptly for assistance in the management of your account and to set up a payment plan.

I do hereby authorize the release of information necessary to file a claim with my insurance company and assign the benefits otherwise payable to me, to Kenneth E. Goolsby, MD & Associates, PC. In the event that I receive a payment directly to me by my insurance for services rendered by Kenneth E. Goolsby, MD & Associates, PC (this is common with Blue Cross Blue

Shield – Federal plans), I agree to remit the payment directly to Kenneth E. Goolsby, MD & Associates, PC immediately.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Parent, Guardian, or Legal Representative Name: _____

Patient Name _____ Date _____

CONTROLLED MEDICATION WAIVER LETTER

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking prescribed potentially by the practice of Kenneth E. Goolsby, MD & Associates, P.C. This is to help both you and your provider to comply with the law regarding controlled pharmaceuticals. I understand that this Agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my psychiatric specialist undertakes to treat me based on this Agreement. (This is to include any and all controlled medications, regardless of drug classification). I understand that these drugs could be useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal governments. Because my psychiatric specialist is prescribing such medication to help manage my psychiatric diagnosis and symptoms, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of this agreement, and at the sole discretion of my psychiatric specialist or the medication utilization review committee, may result in the termination of our physician//PA/NP-patient relationship. In this case, my provider will stop prescribing all control medicines. Also, a drug-dependence treatment program may be recommended.

1. I agree to take the medication only as prescribed and to contact my physician before any changes are made. I understand that when taken otherwise, they can cause overdose and death.
2. I will not request or accept a prescription for ADD/ADHD, anxiety, sleep, or opioid/pain management medicines from any other physician or individual while I am receiving such medication from my psychiatric specialist.
3. If I have side effects that are related to any of my prescribed medication. I will tell my doctor immediately.

4. I am also responsible for notifying my psychiatric specialist immediately if I need to visit another physician or emergency room for an issue where I may be prescribed a controlled substance.
5. I understand that ALL medications are strictly for my own use. I will not share, sell or trade my medication with anyone. If children are in the house, a childproof top is mandatory.
6. I agree to submit to urine drug screens at any time as determined by my psychiatric management specialist to detect the use of both prescribed and non-prescribed medication. I may also be requested to bring my medication in at any time for the psychiatric specialist to inspect.
7. Abuse of our staff cannot and will not be tolerated. Physical and/or verbal abuse, threats, harassment, or excessive annoyance of our staff (including multiple phone calls, i.e. more than three (3) on the same day), regarding the same question or request, will unfortunately necessitate discharging the patient from our practice. If physical threats, verbal threats, or harassment occur, the proper authorities will be notified and you will be fully prosecuted by the law.
8. If you leave your appointment before the physician, PA, or NP has completed the entire visit. You may still be responsible for any charges billed to your insurance or if you are self pay, you will be responsible for the \$100.00 self pay fee.
9. I will not drink alcohol, use illegal drugs (ex: marijuana, cocaine, heroin, etc.) or take over the counter medications without talking to my doctor.
10. I understand that if I miss 3 scheduled appointments without proper cancellation notice, I may be discharged from the practice.
11. I understand that if I miss my appointment or are more than 10 minutes late your appointment will be rescheduled, and I will not receive medication.
12. I should not drive or operate heavy machinery if I feel impaired in any way from any medications, even including over-the-counter medication.
13. I am responsible for keeping track of the amount of medication remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Lost or stolen medicines will likely not be replaced if they are controlled substances due to the new prescription laws as of 2018.
14. I will receive no controlled medications from any other doctor except in any emergency. (ER or admitted to hospital) I will notify my doctor right away if treated by the ER or by another physician's office with any controlled medications.
15. Prescriptions must be filled at the same pharmacy (as designated below). I will update my record of pharmacy should it change.

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____

Mail Order Pharmacy Name: _____ Phone #: _____

Mail Order Pharmacy Address: _____

18. Refills will only be made during regular office hours 9am-5pm, Monday through Friday, and certain medications, such as those prescribed for ADD/ADHD, can be picked up only in person. Refills requested on nights, holidays or on weekends will not be made available until the next business day. Any physical medications delivered to our office must be picked up in person and will not be mailed.

19. Refills shall not be made if I "run out early", "lose a prescription" or spill or misplace my medication. Please use extreme caution to handle your prescriptions with care.

20. Refills shall not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least 72 business hours ahead to schedule pick-up for my prescriptions.

21. I will tell my doctor all of my past medical history including a history of alcoholism, prescription drug abuse, or illegal drug abuse.

22. I will bring my pill in original bottles to each visit if requested by my provider.

23. I authorize the release of any information and medical records by the psychiatric specialist, his or her designee, and my pharmacy to other healthcare providers, pharmacist, my family, my employer, my insurance company or other reimbursing agencies. I also authorize the pain management specialist, his or her designee, and my pharmacy to contact any legal authority, or regulatory agency to obtain or provide information about my care or actions if the pain management specialist feels it is necessary and to cooperate fully with any city, state or federal law enforcement agency, including the Georgia Board of Pharmacy and Drug Enforcement Administration, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my pain management specialist to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

24. I will take appropriate steps not to become pregnant while I am in prescribed psychiatric medications without my providers knowledge. I also understand that if I became pregnant, or if I am suspicious that I am pregnant, I will notify the doctor and staff of the office immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold

Kenneth E. Goolsby, MD & Associates, PC, its shareholders, officers, directors, employees, contractors and agents harmless for injuries to the embryo/fetus/baby.

25. I understand that no agreement can anticipate all events in medical treatment which may arise and that me and my heirs, will hold harmless Kenneth E. Goolsby, MD & Associates, PC, its shareholders, officers, directors, employees, contractors and agents for all resultant problems. This Agreement supersedes and replaces all previous agreements.

By signing below, I certify that I have read the above Information, I have received a copy of the patient/provider contract and any of my questions regarding my psychiatric medication management treatment have been referred to my specific provider. I hereby give my consent to participate in psychiatric medication management services at this time.

Patient signature: _____ Date: _____

Witness: _____ Date _____