Matthew W. Norman, M.D., LLC

One Riverside, Suite 245, 4401 Northside Parkway, N.W., Atlanta, GA 30327
404-495-5900 fax: 404-920-3464
www.matthewnormanmd.com

PATIENT INFORMATION:

Last Name: _____First: _____MI: _____

Address: _____

City: _____State: _____Zip: _____

Cell Phone: _____Alternate Phone: _____

Email: _____

Date of Birth: _______________ Age: _____ Sex: MALE / FEMALE

Who referred you to this practice? _____

Is it okay to leave a message for you from us (circle one)? YES / NO

If so, what telephone number do you prefer us to use? (_____) _____- _____

PERSONAL INFORMATION:

Patient's Employer: _____Phone: _____

EMERGENCY CONTACT: _____PHONE: _____

Person responsible for charges incurred: _____

Relationship to Patient: _____Phone: _____

If the person responsible for the bill is other than the patient, please complete Guarantor Form.

If Patient is a Minor or Student Dependent:

Mother's Name: _____Phone: _____

Father's Name: _____Phone: _____

INSURANCE INFORMATION (Complete only if you have Medicare or Medicaid):

Dr. Norman have opted out of Medicare. You will be responsible for fees incurred. This requires you and your doctor to enter into a separate contract.

Do you have Medicare (circle one)? YES / NO

Do you have Medicaid (circle one)? YES / NO

Currently, Dr. Norman is not a Medicaid provider and cannot treat Medicaid patients. We can try to provide you with a name of a Medicaid provider.

MEDICAL INFORMATION:

Allergies (Circle one)? YES NO List all: _____

Medications taking at present: _____

Primary Physician: _____Phone: _____

Have you recently had any thoughts of hurting yourself and/or anyone else? YES / NO

RECORD RELEASE AUTHORIZATION:

I hereby authorize Matthew W Norman MD, LLC to furnish information to insurance carriers concerning this illness.

Patient's signature: _____Date: _____

CONSENT FOR TREATMENT:

I hereby agree to be treated by Matthew Norman, M.D. If appropriate, I hereby consent to meet via secure videoconferencing platform. I agree that I am personally responsible for ensuring that all charges for services rendered are paid.

Patient's signature (Parent or Guardian, if minor): _____

Date: _____

CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES

_____VISA _____MasterCard _____American Express _____Discover

_____ _____ _____
Name as it appears on card Sec. Code Billing Zip Code

_____- _____- _____- _____ _____/_____
Credit / Debit Card Number Exp. Date

I/we authorize Matthew W Norman MD, LLC, to bill the above credit / debit card for professional services as outlined in the Policies. I will notify Matthew W Norman MD, LLC in writing if I no longer want my credit / debit card billed.

_____ _____
Signature of cardholder Date

CREDIT CARD PAYMENT for LATE CANCELLATION OR NO-SHOW

I authorize Matthew W Norman MD, LLC to charge the above credit card when the patient does not give advance notice for a late-cancellation or no-show, as per the Policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

_____ _____
Signature of cardholder Date

GUARANTOR INFORMATION (complete only if the patient is NOT paying for the bill):

Name of party responsible for bill: _____

Address: _____

City: _____State: _____Zip: _____

Home Phone: _____Business Phone: _____

Date of Birth: _____\ _____\ _____SS#: _____

Guarantor-Financial Responsibility Agreement

I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% per month of that outstanding balance. I understand that unpaid balances over 90 days past due will be referred to a collection agency.

Signature: _____Date: _____/_____/_____

MATTHEW W NORMAN MD, LLC
POLICIES

OFFICE HOURS:

Office hours are Monday through Friday by appointment only. All first appointments are considered a consultation only. Dr. Norman will let you know if he is in the position to offer treatment services beyond the first appointment.

PAYMENT/INSURANCE INFORMATION:

Fees are due at the time services are rendered. Dr. Norman does not contract with any insurance companies. However, if your insurance company provides out-of-network benefits, you may file your own claims for reimbursement. These claims should be paid directly to you. You will have the option and upon request to receive a statement that contains the necessary documentation to file with your insurance company. We recommend that you contact your insurance company for specific information about your out-of-network coverage for mental health services.

If you wish to receive a statement to be used for reimbursement purposes, these statements will be automatically emailed by our online accounting system. Your signature below will authorize the use of email for this purpose.

Patient's signature:_____

Date: _____

In addition, Dr. Norman has opted out of Medicare. If you have Medicare, you can be seen on a Private Contract basis, in which no Medicare claims are made. Please click here to download the contract.

We do not accept Medicaid.

PRIOR AUTHORIZATIONS

Should your pharmacy or insurance company request a "precertification" or "Prior Authorization" for prescriptions or ask that the doctor contact the insurance company by phone, please note that this is not possible. Instead, please do the following:

1. Ask your pharmacist to initiate the precertification themselves by going online to the website www.covermymeds.com. This is the only way Prior Authorizations (PAs) can be processed by our office. If your pharmacy will not do this, it might be beneficial to change pharmacies.

TELEPSYCHIATRY

In addition to in-person appointments, Dr. Norman also offers telepsychiatry (video conference) appointments to patients over a secure, HIPAA-complaint network. Under some circumstances, these appointments may also be conducted by phone. If you are interested in telepsychiatry, please ask Dr. Norman if he feels that this would be appropriate for your treatment.

In order to conduct telepsychiatry, you agree to be within the State of Georgia during the appointment. You also agree to not operate a motor vehicle during the appointment.

Therapy conducted online is technical in nature and problems may occasionally occur with internet connectivity. If something occurs to disrupt any scheduled appointment, the doctor will call the patient back by the phone number provided.

A patient must be seen a minimum of once a year in order to maintain therapeutic services.

A telepsychiatry scheduled appointment has the same late cancel/no show policy as an in-office appointment.

APPOINTMENT CHANGES/CANCELLATIONS:

Patients will be charged the full session rate when cancellations occur unless notice is given at least one business day in advance. If, for any reason, the doctor must cancel an appointment, the patient will be advised at the earliest possible time.

ELECTRONIC MAIL (EMAIL) POLICY

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). We cannot insure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we would caution you against emailing anything of a very private nature. Additionally, your doctor will save your email correspondence and these communications should be considered part of your medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature. Your doctor will make an effort to check email regularly; however, call our office if you have not received a reply within 72 hours.

EMERGENCIES & PHONE POLICY

Should you wish to contact Dr. Norman between scheduled sessions, you are encouraged to call or email. Dr. Norman will make every attempt to return messages within one business day.

If you are experiencing a life-threatening emergency and require immediate assistance, please call 911, proceed to the nearest emergency room or call the Georgia Crisis Line at (800) 715-4225. You should then notify Dr. Norman. Every effort will be made to return your call promptly.

MEDICATION REFILL POLICY:

Medication refills will generally be sent to the pharmacy within two business days after the request is made. When requesting a refill, please provide:

- Your date of birth
- Name of medication requested
- Medication dosage
- Pharmacy complete address

Prescriptions may only be refilled for patients who are current patients and who maintain their regularly scheduled appointments.

TERMINATION POLICY:

Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge that the doctor be notified in person regarding this decision so that it can be discussed openly.

ACCEPTANCE OF POLICIES:

Matthew W Norman MD, LLC is committed to providing professional services of the highest quality and standards. In order to serve our patients efficiently and responsibly, we require that agreements be made regarding the policies stated above. Patients are encouraged to ask questions before signing.

I have read the policies, understand, and agree with them.

Patient's signature: _____

Guardian if a Minor: _____

Date: _____

NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record. Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment or health care options.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by the physician will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the treatment. In that way the physician will know how you are responding to treatment.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to: request a restriction on certain uses and disclosures of your information, obtain a paper copy of the notice of information practices upon request, inspect and copy your health record, amend your health record, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

This organization is required to: maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

For additional information about our health information practices or to report a problem, you may contact Dr. Norman at 404-495-5900. A full copy of this notice is available from Dr. Norman or at www.matthewnormanmd.com. If you believe your privacy rights have been violated, you can file a complaint with Dr. Norman or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

My signature below indicates that I have read the notice of privacy practices.

Signature: _____ Date: _____