salveointegrative HEALTH

311 Gwinnett Drive, Lawrenceville, GA 30046
3621 Mundy Mill Rd, Oakwood, 30566
Phone #: 770-910-9196 Fax #: 770-910-9197

## Patient Information- 2025

Full Name: ______________________________ Phone: ______________________________

Date of Birth: ______________________________

Address:

City, State, Zip: ______________________________ e-mail address:

Gender (for insurance): ______________________________

Gender Expression: ______________________________

Employed: Y N  Student: Y N  Marital Status: M S D W O

****************************************************************************************

## Pharmacy

Preferred Pharmacy Name: ______________________________

City: ______________________________ Phone# ______________________________

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## Responsible Party (who will be responsible for the bill)

[ ] Same as above

*If different from above, please fill in details below* Relationship to patient: ______________________________

Name: ______________________________

Address: ______________________________

City, State, Zip: Mobile: ______________________________

e-mail address: ______________________________

****************************************************************************************

## Insurance (who holds the insurance policy)

*( ) Check if a copy of the front and back of the insurance card was given to the office*

Primary  Secondary Name of Insurance:  Name of Insurance:

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Relationship to Patient: ____________________ Relationship to Patient: ____________________
ID Number: ____________________ ID Number: ____________________
Insured's Name: Insured's Name:
DOB: DOB:

# Medical History

***Prior and current psychiatric medications:***

| Medication Name | Reason for Medication | Discontinue Date |
|---|---|---|
| | | |
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***Medication allergies:***

| Medication | Reaction |
|---|---|
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| | |

***Other Medical Conditions***

| | |
|---|---|
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______________________________________________ ___________________________

Signature of patient/guardian Date

## Treatment Consent/Authorization for Disclosure

### Consent to Treatment

I, the undersigned, do voluntarily consent and authorize outpatient treatment as judged to be necessary by my clinician. Such treatment may include diagnosis/assessment procedures, psychotherapy and pharmacotherapy. I understand that this consent authorizes the use of standard and customary community standards, and I have been advised of the potential risks and benefits associated with treatment. I understand the practice of medicine, psychiatry and other mental health disciplines is not an exact science and I acknowledge that no guarantees have been made to me concerning my care. Because psychotherapy is a cooperative effort between patient and therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. If I refuse the treatment that is suggested for me or discontinue treatment, I will not hold Salveo Integrative Health or any individual responsible for any consequences resulting from my decision beyond that time.

### Limits of Confidentiality

The contents of a counseling, intake, or assessment session are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this organization not to release any information about a client without a signed release of information. Noted exceptions are as follows:

### Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. In addition, it may be necessary for the health care professional to take steps for the client to be placed in a restricted hospital environment to ensure the safety of the client and of others.

### Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse or neglect, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

### In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

### Professional Misconduct

Other health care professionals must report professional misconduct by a health care professional. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released to substantiate disciplinary concerns.

### Court Orders

Health care professionals are required to release records of clients when a court order has been placed. Clients who are on probation, court ordered to treatment or referred by the Department of Juvenile Justice, Department of Human Resources or the county Juvenile Court may have waived certain rights to confidentiality when entering the treatment program.

### Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

### Audio/Video Taping

In the event it becomes necessary to audio and/or video tape a client for treatment or supervision purposes, a specific consent form for the purpose of audio and/or video will be required. No recordings of any kind will be conducted without the expressed consent of the client.

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**Other Provisions**

**Salveo** does not conduct research on any of their clients. Outcome measures, as it pertains to the effectiveness or non-effectiveness of the treatment services are collected and analyzed to ensure that the best quality treatment is provided. No personal information on any client is disclosed, nor can any client be identified by any of the outcome information collected.

Information about clients may be disclosed in consultations with other professionals to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases, notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couple's sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

**Authorize for Disclosure of Information**

The undersigned hereby authorizes Salveo Integrative Health and its staff to release or disclose information in the medical, business or clinical record of the patient of the following:

- Any private or public entity with which a claim is being filed for a (all or part) of the patient's charges, including any insurance carrier or compensation carrier or any of the respective agents, representatives, and claims processing personnel.
- Any attorney, collection agency or other persons or entities engaged in the collection of responsible party to Salveo Integrative Health.
- Any other healthcare professional staff providing needed care.
- Any person, corporation, public or private agency to the extent necessary for Salveo Integrative Health to obtain and/or maintain licensure, federal and/or state reimbursement for the provisions of health care services or clarification.
- Any public or private utilization review organization needing information by telephone or writing to certify the medical necessity or appropriateness of treatment services under review.
- Any Salveo Integrative Health employee or provider requiring information including patient identity and address in order to provide care and/or maintain the medical records.
- For any release beyond the scope of this consent, the patient will be asked to sign a Release of Information Form.

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The information release may include diagnosis and treatment including, but not limited to mental and physical condition, drug/alcohol and other information requested to determine coverage, medical necessity and other benefits determination.

This authorization may be revoked at any time except to the extent those actions have already been taken. To cancel this authorization, the patient and/or responsible party realizes that they must do so in writing and send it to Salveo Integrative Health.

________________________________ ____________________

**Signature of Patient** **Date**

________________________________ ____________________

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**Signature of Guardian (if patient under 18)** *(if applicable)* **Date**

# Authorization for Forms of Communication

## (How can the clinic communicate with you?)

***Salveo Providers use phone, text, and email to communicate with patients. Please authorize the use of these technologies along with the correct contact information.***

Secure and private communication cannot be fully assured utilizing cell/smart phone (calls and text) or regular email technologies. Due to the nature of our services, staff and clients often communicate using cell phones for calls, voicemail, and text messaging. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Your use of any non-secure technologies to contact Salveo office or staff will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client. Please check below which modes of communication are permitted and which are not permitted. This consent may be altered at any time should circumstances or preferences change. In the event in which the company or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

**Please check where you may be reached by phone/text/mail. Include phone numbers and how you would like us to identify ourselves when phoning you.**

**CELL Phone number:** ______________________________ ☐ **Calls** ☐ **Text**

**EMAIL:** ____________________________________________________________

HOME Phone number: May we say the clinic name? ☐ Yes ☐ No

WORK Phone number: May we say the clinic name? ☐ Yes ☐ No

EMERGENCY Phone number: May we say the clinic name? ☐ Yes ☐ No

Person to Contact:____________________________________________________________

INFORMATION CAN BE MAILED TO THIS ADDRESS: ____________________________________________________________

____________________________________________________________

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the manner listed above and authorize Salveo Integrative Health staff to disclose information only to those individuals listed above and, in the manner, stated for oral and written communications. Any other release of information will require a signed authorization for the Release of Medical Information. This consent and authorization shall expire 1 year from the date of signing unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent and authorization form is to be considered as valid as an original.

____________________________________________ ________________________

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Signature of Patient or Guardian Date

# Policies and Procedures

***Please initial on the lines below to acknowledge that you have read and understand our policies.***

______**INSURANCE:** Benefits quoted are just estimates. **Final copayment, co-insurance, and deductible amounts are determined by your insurance when the claim is processed.** Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor. If your insurance company does not pay for the practice within a reasonable period, we may look to you for payment. If we later receive a check from your insurer, we will refund any over payment to you. You are responsible for informing us of any **insurance changes prior to your appointment**.

______ **PAYMENT FOR SERVICES:** **Payment for services is required at the time of service.** This includes copayments, deductibles, and co-insurance amounts. We reserve the right to reschedule appointments due to inability to pay for services. We accept Cash, Personal Checks and all major Credit Cards.

______**RETURNED CHECKS: There will be a $35 fee for any check returned unpaid, regardless of the reason.** Salveo reserves the right to refuse to schedule appointments or cancel any scheduled appointments until payment is made in full for a return check.

______**APPOINTMENTS:** Appointments are held especially for you, and they are a valuable resource in our practice. If you are unable to keep your scheduled appointment, please provided a minimum of 24hr notice. We charge $**75.00 for No Show Fee or $35 same day cancellation of appointments.** Fees for missed appointments are due at your next appointment. **Appointment reminder calls are attempted as a courtesy for you, but it is your responsibility to keep track of appointment dates and times.**

______**WAITING TIMES:** Our providers do their best to see you in a timely manner. If you are more than 10 minutes late for your appointment, we reserve the right to reschedule your appointment.

______**FORMS AND LETTERS:** Thank you for understanding that our provider's priority each day must be to see the patients in the office, therefore, they will complete forms and letters as time permits. Providers will only fill out forms or write letters after the patient has been seen **at least 6 times consecutively**. Most forms/letters will be completed within 2-4 weeks. Charges vary depending on the provider's time spent on completion. We reserve the right to charge for forms or letters completed by providers. Fees are based on the provider's time required to complete the request and **range from $35 to $300.**

______**MEDICAL RECORDS REQUEST:** Medical records can be sent to another provider free of charge upon completion of a medical records release form. If you would like a copy of your medical records. An admin, search, and retrieval fee **of $25.88** will be charged along with a **coping fee of $.97 for the first 20 pages, $.83 for page 21-100** and **$.66 for every page after 100 pages**.

______**AFTER HOURS CALL/EMERGENCY:** Our voicemail system is available 24 hours a day and 7 days a week. Calls are normally returned during regular business hours, which are Mon-Fri 9am-5pm.

______ **PRESCRIPTION REFILLS:** All prescriptions refills request should be handled during scheduled office appointments, by leaving a message on the prescription refill line, or requesting a refill through your pharmacy. **Refill requests left on the prescription line will be handled within 3 business days** (excluding holidays or weekends). Refills will not be called in for patients who have not been seen in the last 60 days.

______**MEDICATIONS NOT PRESCRIBED FOR NEW PATIENTS:** This clinic will not prescribe Suboxone, Adderall, Xanax, Ativan, Klonopin, Ambien and Benzos Vyvanse or any stimulants to new patients

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_____**MEDICATION CHANGES:** Will only be addressed during scheduled appointment times. If you are having side effects or urgent issues with the medication you are taking, this can be addressed over the phone to the support staff. After hours issues will need to be directed to urgent care or emergency facilities. Children accompanied by other than their parent/guardian will not be eligible for medication changes.

______**URINE DRUG SCREENS:** UDS are a necessary part of therapy and per DEA regulations anyone 18 years or older can and will be urine drug screened when being prescribed controlled substances. The cost associated with this testing in our clinic is **$50.00**. Insurance companies do not cover the cost of the UDS, so it is the patient's responsibility to pay this cost up front.

_____**TELEMEDICINE:** If necessary, Salveo's nurse practitioners and psychiatrists may provide care via online video chat called telemedicine. If participating in this type of care, you understand that all HIPPA regulations and confidentiality policies apply as well as all other Salveo policies and procedures. Coverage for this service will vary depending on your insurance coverage and could change throughout the year. Salveo will require a credit/debit card to be put on file for all telemedicine appointments for copays, co-insurance and deductible. Any required deposits will be collected prior to the visit. If payment is not collected, the appointment may be subject to cancellation.

_____**TERMINATION OF CARE:** Salveo's goal is to provide services to patients until the patient and the physician/therapist feel treatment goals have been accomplished. Patients may wish to terminate their care with Salveo at any time. **Patients who have not been seen for more than 6 months, will be considered self-terminated, and their chart will be closed.** Salveo may find it necessary to terminate the patient/provider relationship for non-payment of account balance, or due to inappropriate behavior or conduct toward administrative or clinical staff. Salveo will make all notifications of termination of care in writing.

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## Release of Information (Who can Salveo talk to regarding your treatment?)

***Salveo CANNOT discuss ANY information about your treatment or your visits to the clinic without your authorization. Please indicate below who can ask questions on your behalf.***

(For example, your spouse calls to confirm your appointment time; OR your adult child calls with questions about your medications.) Please list any restrictions to the information we can communicate about you with those you have listed below. Please list below any people you will allow us to talk with about you. (If you prefer, we do not speak with anyone, please write "**NO ONE**" across this section.

| Name | Relationship | Phone Number | Restrictions *(appointment information, medication questions, billing questions, or none)* |
|---|---|---|---|
| *Example: Jane Doe* | *Mother* | *777-000-0000* | *Appointment Only* |
| | EMERGENCY CONTACT | | none |
| | | | |
| | | | |
| | | | |
| | | | |

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| | | | |
|---|---|---|---|
| | | | |

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the manner listed above and authorize Salveo Integrative Health staff to disclose information only to those individuals listed above and, in the manner, stated for oral and written communications. Any other release of information will require a signed authorization for the Release of Medical Information. This consent and authorization shall expire 1 year from the date of signing unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent and authorization form is to be considered as valid as an original.

Signature of patient/guardian ______________________ Date ______________

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## Consumer Rights & Responsibilities

**Receipt and Acknowledgment of Notice**

*I have read the following summary of Consumers' Rights & Responsibilities, I have been given the opportunity to ask questions, and I have been given a copy of this for my records.*

Signature of patient/guardian ______________________ Date ______________

## Consumer Rights & Responsibilities (Patient Retains These Pages)

Your rights as a consumer, including confidentiality of your participation in evaluation and treatment services, will be observed in accordance with O.C.G.A. 37-3-166, 37-4-125, 37-7-166, DHR Rules and Regulations for Consumer Rights, Chapter 290-0-9; 42 U.S.C. 290dd-2, and SALVEO Consumer Rights and Responsibilities Policy #2330, SALVEO program policies and any other applicable laws, regulations, and policies, including the federal Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. A summary of these rules and regulations will be reviewed with you and are available for inspection at each service location. You also will be *provided with* a copy of the SALVEO HIPAA Privacy Notice. This information will be reviewed on an annual basis with you.

Every program participant at SALVEO has human/civil/personal rights to be respected and honored. In addition, it is the responsibility of all program participants to act in a manner that respects the rights of others. SALVEO is committed to the protection of individual rights and to providing services within an environment that is characterized by dignity and respect of all persons, and is responsive to the unique needs, abilities, and characteristics of each person served by the organization.

**YOU HAVE THE RIGHT:**

1. To services without discrimination on account of race, religion, sex, ethnicity, age, sexual orientation, disability or cultural background.
2. To exercise all fundamental human, civil, constitutional, and statutory rights to which you are entitled as a legally competent citizen unless such rights are limited under due process of law.
3. Informed consent or refusal or expression of choice regarding service delivery, release of information, concurrent services, composition of service delivery team, involvement in research projects.
4. To be treated in a manner that respects your individual dignity and always protects your health and safety.
5. Be fully informed about the course of your care and decisions that may affect your treatment
6. Revoke your consent for treatment at any time
7. Timely and accurate information to assist you in making sound decisions about your treatment
8. Be fully involved as an active participant in decisions pertaining to your treatment

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9. Have an individual identify in writing that will direct and coordinate your treatment. Consumers served have the right to access guardians, self-help groups, advocacy services and legal services at any time. Access will be facilitated through the person responsible for the consumer's service coordination
10. Request a change in individual directing and coordinating our treatment, if you so desire
11. Receive services in an environment that is free of all forms of abuse, including, but not limited to, (a) financial exploitation, (b) physical abuse and punishment, (c) sexual abuse and exploitation, (d) psychological abuse including humiliation, neglect, retaliation, threats and exploitation, and (e) all forms of seclusion and restraint
12. Have information about your treatment and your confidentiality protected to the greatest extent allowed by federal and state confidentiality laws and regulations
13. File a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort
14. Investigation and resolution of alleged infringement of rights.
15. Have family members, friends or others involved in your treatment with your consent and approval
16. Receive services that comply with all applicable federal and state laws, rules and regulations
17. File a grievance with an outside third party if you feel that the organization has not satisfactorily addressed any concerns you have or, does not adequately address any formal grievance you submit
18. To request a transfer to another program if you believe you are not receiving care that meets your needs and preferences. Consumers served have the right to request and receive outside (other than Salveo. employees) professional consultation regarding their treatment at their own expense.
19. You may also have additional rights afforded to you based on federal, state, and local regulations. Your service coordinator will advise you of any additional rights that you may have.
20. To be informed of the benefits, side effects and risks of psychotropic medications in a manner and language that you can understand.
21. The right to review and obtain copies of your records for a fee by contacting your team leader. Disclosure of psychotherapy notes that your physician or authorized staff feel is not in your best interest may be excluded (Georgia Code 31-33-2). If access to any information is denied, you have the right to have the denial reviewed by another licensed professional identified by **Salveo**.

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY PRIVACY PRACTICES**

1. To access or inspect your health care information unless a physician determines that the record review would be detrimental to your wellbeing.
2. To obtain a copy of your health care information for as long as the information is retained. (A reasonable fee may be charged for copying.)
3. To request in writing that SALVEO and its programs restrict the use and disclosure of your confidential health care information.
4. To receive a copy of the notice of the SALVEO HIPAA privacy practices.
5. To make a reasonable request in writing to receive phone, written or e-mail communications from Salveo. and its programs by alternative means or locations.
6. To request a list of when and to whom your health care information was released without your authorization within 6 years of your request for non-routine disclosures made on or after April 14, 2004.
7. To request an amendment to your health care information.

**CONSUMERS' RESPONSIBILITIES**
**AS A CONSUMER OF SALVEO AND ITS PROGRAMS, IT IS YOUR RESPONSIBILITY:**

✓✓ To show consideration and respect towards staff, other consumers and the property of others.

✓✓ To provide accurate information of past and present complaints, past illnesses and hospitalizations, medications, and any perceived risks in your care and unexpected changes in your condition.

✓✓ To meet financial obligations agreed to with SALVEO and its programs.

✓✓ To participate in developing your individualized resiliency/recovery/treatment or service plan including expressing any concerns about your ability to follow the proposed care plan and to ask questions when you do not understand.

✓✓ To take medications as prescribed.

✓✓ To accept the consequences of not following the treatment and service plan.

✓✓ To support the program by participating to the best of your ability and by being on time for all scheduled appointments and activities.

✓✓ To comply with the rules of the service location.

✓✓ To respect the confidentiality, privacy, and property of others who are receiving services with you.

✓✓ To report changes in your condition to those responsible for your care and welfare.

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***COMPLAINTS***

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Attn: Dana Stephens-Craig, Salveo Integrative Health, 311 Gwinnett Drive, Lawrenceville, GA 30046. (770) 910-9196.

You may also contact the Division's Privacy Coordinator by telephone at (404) 657-6423, facsimile (404) 657-6424, or by mail to 2 Peachtree Street NW, Room 22.240, Atlanta, Georgia 30303-3142, for further information about the complaint process or this notice. **You will not be penalized for filing a complaint.**

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