**Bethany B. Davis, M.D.**

**New Patient Information**

The following information pertains to my financial policy. I hope this will answer any questions you may have, but if you have any questions or special concerns please do not hesitate to discuss them with me **at the first session.** Please acknowledge your understanding of this policy by signing at the end of this form. If you would like a copy of this form for your records I will be happy to provide one for you.

My fee for the initial diagnostic session is $300.00. My fee is $275.00, per therapy hour which usually consists of 45-50 minutes. Medication management is $175.00 for 15-20 minutes. I accept cash, check, VISA and MasterCard for your convenience.

I am not in-network for any insurance company and full payment is due at the time service is rendered. An insurance receipt is available for your convenience in submitting your insurance claims. Collection of insurance benefits or any other arrangement regarding third party payment is your responsibility. **Please discuss exceptional circumstances with me at the first session**.

There is a $50 fee for prescriptions that require prior authorization by your insurance company.

**Since your appointment time is reserved for you, please notify me as soon as possible if you find that you must cancel an appointment. Appointments not canceled with at least 24 hours notice will be billed at the usual fee of $275.00 for therapy and $175.00 for medication management. Monday appointments must be cancelled by 12:00 noon the Friday before to avoid charges.**

I acknowledge responsibility for all fees incurred, and if it is necessary, I consent to have my account collected through and attorney or collection agency. All balances 90 days past due will be turned over to a collection’s agency who will, if necessary, report unpaid balances to the credit bureau. I also agree that I will be responsible for all costs of litigation including attorney’s fees.

**Statement of Confidentiality:** Under Georgia law communications between patients and psychiatrists are confidential, and under ordinary circumstances this privilege can be waived **only** by the patient. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to him or her self, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child abuse. Although legally and ethically bound to break confidentiality under the aforementioned circumstances, I will not do so without attempting to discuss it with you first.

I have read and understand the above policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date

**Patient Information:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Work Cell

SEX: \_\_\_\_\_ Male \_\_\_\_\_ Female

MARITAL STATUS: S M D W DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POSITION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can a message be left at Home? \_\_\_\_Yes \_\_\_\_No Work? \_\_\_\_Yes \_\_\_No Cell? \_\_\_\_ Yes \_\_\_\_ No

REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I contact this person? \_\_\_\_Yes \_\_\_\_No

Have you been in therapy before? \_\_\_Yes \_\_\_No For your current problem? \_\_\_\_Yes \_\_\_\_No

If so, Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Home Cell

**Primary Care Physician Information (OPTIONAL)**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For purposes of continuity of care, may we contact your physician to let him/her know of your visit today?

Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

If yes, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to send a general statement notifying my primary care physician of my visit today. The information sent will be used for coordination of care, and will be limited to a brief description of the problem area and/or diagnosis, and a general outline of treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

Please send completed documents to [documentsBBD@yahoo.com](mailto:documentsBBD@yahoo.com) . This email is for sending/receiving documents only.

**EMAIL POLICY**

Communicating via email assumes 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). I cannot insure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, I 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. You may submit documents and forms to the [documentsbbd@yahoo.com](mailto:documentsbbd@yahoo.com) email address assuming the same risks as stated above. Alternatively, you may mail the documents to the doctor.

I have read and understand the policy above.

\_\_\_ I do wish to receive documents including, but not limited to, receipts and invoices via email.

\_\_\_ I do not wish to receive documents including, but not limited to, receipts and invoices via email.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date