Office Hours:

Office hours are Monday through Saturday by appointment only. Due to the virtual nature of office visits, scheduling of appointment times is highly variable and dependent upon availability and patient preference.

Scheduling Appointments:

Follow-up appointments are typically scheduled at the end of the current appointment. If follow-up is needed between the next scheduled appointments, arrangements can be made via contacting Dr. Strong or utilizing the patient portal.

Appointment Changes/Cancellations:

There is a 24 hour appointment change or cancellation policy. Please be aware you will be charged the full appointment time for appointments changed or cancelled outside of the 24 hour window.

Payment:

Dr. Strong is currently an out-of-network provider and does not contract with any insurance companies. Please contact your insurance company to inquire about benefits and reimbursement rates prior to services being rendered. Upon request patients will be provided an itemized bill that you may submit to your insurance company for reimbursement.

All fees are due at the time of service and patients are required to maintain an active credit card on file. Credit/debit cards are the only acceptable forms of payment at this time.

All charges past due over 90 days may be sent to a collection agency unless arrangements have been made for payment.

Initial Psychiatric Evaluation - $400 (up to o1.5 hour)

- A comprehensive evaluation for the purposes of obtaining history Initial appointments are considered consultations only and are necessary to determine treatment options. Dr. Strong and potential patients will then discuss findings, suggest treatment options and appropriateness of continued care.

Medication Management - $200 (up to 15 minutes)

- Medication management appointments are for established patients only and all patients must have an initial psychiatric evaluation completed by Dr. Strong before medication initiation or continuation if deemed appropriate.

Completion of Forms / Telephone calls

- A flat of $25 will be charged for telephone calls greater than five minutes and $25 per five minute interval. Completion of forms or letters outside of appointment times will be charged a flat fee of $30 per occurrence.

I authorize Be Strong Wellness Clinic, LLC to charge my credit card for psychiatric services as outlined above. I will notify Be Strong Wellness Clinic, LLC in writing if I no longer want my credit/debit card billed.

Cardholder's Full Name:_____

Signature of cardholder: _____ Date: _____

Medication Refills:

Requests for medication refills will be completed within one business day. However, medication refills will not be performed for individuals who repeatedly miss appointments or if there is suspicion of medication abuse.

Please include the following when requesting medication refill:

- Patient name and callback number
- Date of birth
- Name of requested medication
- Dosage
- Frequency of administration
- Pharmacy telephone number

Prescriptions will be maintained for current patients only.

Electronic communication policy7

Dr. Strong will respond to emails received within a 24 hour period, excluding weekends. By sending email you are agreeing to assume inherent risks of security or internet transmission. Dr. Strong cannot ensure confidentiality against purposeful or accidental interception or user error when receiving/sending email. Please do not include sensitive information in your correspondence. All emails will be kept on file and are considered part of your medical record. Emergencies are NOT be communicated via email due a possible delay in reception.

Emergency:

- Emergency psychiatric help is available via calling 911, proceeding to your nearest emergency department or calling the Georgia Crisis and Access Line 24/7 at 1-800-715-4225. Additional resources are listed below.
- National Suicide Prevention Lifeline: (800) 273-TALK
- National Drug and Alcohol Treatment Hotline: (800) 662-HELP
- National Domestic Violence Hotline: (800) 799-7233 OR (800) 787-3224
- National Child Abuse Hotline: (800) 4-A-CHILD
- National Youth Crisis Hotline:(800) HIT-HOME
- National Runaway Switchboard: (800) 621-4000
- Panic Disorder Information Line: (800) 64-PANIC
- Project Inform HIV/AIDS Treatment Hotline: (800) 822-7422

Termination policy:

Dr. Strong aims to maintain a therapeutic and trusting relationship with all patients. At times however Dr. Strong and the patient may determine care should be received by an alternative provider. Patients are not obligated to continue treatment with Dr. Strong and may choose to terminate at any time. Termination of the relationship may also be precipitated by the following:

- Repeated noncompliance with suggested therapy/treatment.
- Threatening of violence, sexual/verbal abuse of any kind directed at Dr. Strong
- Attempts to obtain controlled substances for non-therapeutic purposes, obtaining multiple prescriptions from outside providers or abuse of controlled substances.
- Inability to meet financial obligations for services received.

Patients will be provided a letter of acknowledgment from Dr. Strong with an effective date of termination.

Disability and/or Prior Authorizations

Dr. Strong does not provide disability paperwork or assess for disability. Dr. Strong will not perform prior authorizations at this time.

Telepsychiatry Consent:

Be Strong Wellness Clinic, LLC only offers telepsychiatry (video conference) appointments to patients over a secure, HIPAA-compliant network. Telepsychiatry offers convenience and accessibility but has inherent risks due to the nature of information transmission through the Internet. The use of telepsychiatry requires that I agree not to operate a motor vehicle or machinery during the appointment due to potential risk of harm to self or others. I understand the provider will not record any telepsychiatry session or allow any other individual to listen, view or record without the expressed written consent of Be Strong Wellness Clinic, LLC.

I have read and agree to meet via a HIPPA-compliant network and I am responsible for all charges for services rendered via my credit card on file.

Patient's Full Name: _____

Authorized Representative's Full Name: _____

Signature: _____ Date: _____

Relationship/authority (if signed by authorized representative): _____

Authorization to Obtain and/or Release Information:

Communication between patient and Be Strong Wellness Clinic LLC will be held in confidence not released without written consent unless required by law (i.e. suspected child/elder abuse, imminent threat of danger to self or others or a court order). I, _____, authorize Be Strong Wellness Clinic LLC to release and/or obtain information for the purpose/s of psychiatric evaluation, medication evaluation and ongoing treatment to/from:

Full Name: _____

Address: _____

Telephone: _____ ____ Cellphone Home

Patient's Full Name: _____

Authorized Representative's Full Name: _____

Signature: _____ Date: _____

Relationship/authority (if signed by authorized representative): _____

HIPPA Form

Notice of Policies and Practices to protect privacy of you and/or your dependent's health information for Be Strong Wellness Clinic, LLC.

This notice describes how psychological and medical information about you and/or your dependent may be used and disclosed, and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• **"PHI"** refers to information in your health record that could identify you.
• **"Treatment, Payment and Health Care Operations"** is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another healthcare provider, such as your family physician, psychiatrist or another psychologist.
• **"Payment"** is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
• **"HealthCare Operations"** are activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
• **"Use"** applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
• **"Disclosure"** applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or healthcare operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or healthcare operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of
protection than PHI.
You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

• **Serious Threat to Health or Safety** – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against danger for you or the intended victim.
• **Child Abuse** – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
• **Adult and Domestic Abuse** – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
• **Health Oversight** – If I am the subject of an inquiry by the Georgia Board of Medical Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.
• **Judicial or Administrative Proceedings** – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
• **Worker's Compensation** – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychiatrist's Duties

Patient's Rights:

• **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
• **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.
• **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about your for as long as the PHI is maintained in the record. An appointment will be scheduled to review these records in my presence so that any issues can be discussed. Normal hourly and/or copying changes will apply. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
• **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. Upon your request, I will discuss with you the details of the amendment process.
• **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.
• **Right to a Paper Copy** – You have the right to obtain a paper copy of the notice from me upon request.
Psychiatrist's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such

changes, however, I am required to abide by the terms currently in effect.
• If I revise my policies and procedures, I will notify you at the mailing address you provided.

V. Complaints

If you are concerned of privacy rights violation, or you disagree with a decision about access to your records, you may contact Be Strong Wellness Clinic, LLC. You may also send a written complaint to the Georgia Composite Medical Board or to the Secretary of the U.S. Department of Health and Human Services.

VI. Restrictions

I will limit the uses or disclosures that I will make as follows:
- I will not release the contents of "Psychotherapy Notes" under any circumstance with the following exceptions:

If you file a lawsuit or ethics complaint against me, I may release "Psychotherapy Notes" for use in my defense
- When the following "Uses and Disclosures with Neither Consent nor Authorization" apply:

• Child Abuse
• Adult and Domestic Abuse
• Health Oversight
• Judicial or Administrative Proceedings
• Serious Threat to Health or Safety

VII. Effective Date: this notice will go into effect May 4, 2022.

Acknowledgment:

I have read and been given a copy of the policies to receive treatment at Be Strong Wellness Clinic, LLC. I hereby agree to be treated by Be Strong Wellness Clinic, LLC and accept all policies in their entirety.

Patient's Full Name: _____

Authorized Representative's Full Name: _____

Signature: _____ Date: _____

Relationship/authority (if signed by authorized representative): _____