Practice Policies

Dr. Hasani Baharanyi, M.D.

OFFICE HOURS:

Office hours are on Mondays, Tuesdays, Wednesdays, and Thursdays by appointment only. All first appointments are considered a consultation only. Your doctor will let you know if he is in the position to offer treatment services beyond the first appointment.

EMERGENCIES/AFTER HOURS:

Emergency psychiatric help is available through the Georgia Crisis and Access Line 24/7 at 1-800-715-4225. You can also call 911 or go to your nearest emergency department. For non-emergency psychiatric issues call Dr. Baharanyi 404-249-0520 ext. 3. Leave a message with your name, nature of issue, phone number, and the best time to return your call.

SCHEDULING APPOINTMENTS:

Please call the office at 404-249-0520 ext. 3 during normal business hours to schedule an appointment. Appointments can also be scheduled via email to Dr. Baharanyi at drbaharanyi@loriopsychgroup.com

Generally, follow-up appointments will be scheduled with Dr. Baharanyi at the end of the current appointment. Follow-up appointments can also be scheduled via email or phone (see above).

PAYMENT POLICY:

All appointment fees are due at the time of service. Dr. Baharanyi's private practice does not currently contract with any insurance carriers. Please check with your insurance company as to whether or not you would qualify for out-of-network benefits. If applicable, Dr. Baharanyi can fill out the necessary forms requested by your insurance company.

Dr. Baharanyi accepts credit/debit cards, checks and cash as forms of payment.

All charges that are past due over 90 days may be sent to a collection agency unless arrangements have been made with your physician.

APPOINTMENT CHANGES/CANCELLATIONS:

If an appointment is canceled with at least one business day's notice, the patient/guarantor will not be penalized.

A ***first-time cancellation*** within one business day of the scheduled appointment will not be penalized.

A ***second cancellation*** within one business day of the scheduled appointment will result in a **fee of the full normal visit rate.**

If, for any reason, the doctor must cancel an appointment, the patient will be advised at the earliest possible time.

ELECTRONIC COMMUNICATION POLICY

By agreeing to communicate via email or internet, you are assuming a certain degree of risk of breach of privacy. Dr. Baharanyi 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 email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Call our office if you have not received a reply within 3 days.

TELEPHONE POLICY:

To provide quality care to his patients, Dr. Baharanyi likes to personally return phone calls. Routine calls are generally returned by the next business day. For issues that require a response prior to next business day please call 857-244-0742. For emergencies and crises please see above.

TELEPHONE REFILL POLICY:

Medication refills may be requested between 8:30 a.m. and 4:00 p.m. weekdays and will be called into the pharmacy within one business day of the request. Requests after 4:00 p.m., weekends or holidays will be recorded on the following business day.

When requesting a refill, please provide:

- Patient name
- Date of birth
- Name of medication requesting
- Dosage
- Pharmacy telephone number

Prescriptions may only be called in for patients who are current patients and who maintain their regularly scheduled appointments. For your safety, medication refills will not be called in over the weekend except in emergencies.

TERMINATION POLICY:

Patients are under no obligation to continue services should they decide to terminate at any time. However, patients are encouraged to notify Dr. Baharanyi in person regarding this decision.

ACCEPTANCE OF POLICIES:

Dr. Baharanyi is committed to providing professional services of the highest quality and standards. In order to serve his patients efficiently and responsibly, he requires agreements be made as to 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's name, if the patient is 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. Baharanyi at 404-249-0520 ext. 3. A full copy of this notice is available from Dr. Baharanyi at www.loriopsychgroup.com. If you believe your privacy rights have been violated, you can file a complaint with Dr. Baharanyi or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

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

Signature: _____ Date:_____

SESSION PAYMENT

✓ 90-minute intake appointment for adults	$450
✓ 60-minute child/adolescent intake (interview with parents only)	$300
✓ 60-minute child/adolescent intake (interview with child/adolescent)	$300
✓ 50-minute follow-up psychotherapy appointments (weekly to biweekly commitment)	$250
✓ 50-minute follow-up appointment	$300
✓ 25-minute follow-up psychopharmacology appointment	$150
✓ Phone calls over 10 and under 25 minutes	$50
✓ Phone calls over 25 minutes	$150
✓ Disability and FMLA paperwork	$50

CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES

Visa ☐ MasterCard ☐ Discovery ☐ American Express ☐

Card Number _____ - _____ - _____ - _____ Credit ☐ Debit ☐

Exp. Date: _____ CVV: _____

Name as it appears on card: _____

Billing Address: _____Appt/Unit: _____

City: _____ State: _____ Zip Code: _____

I/we authorize Dr. Baharanyi/Hakiba Wellness Services of America, Inc, to bill the above credit / debit card for professional services as outlined in the Policies. I understand the billing statement will be recorded as "Hakiba Wellness Services of America, Inc."

CREDIT CARD PAYMENT FOR LATE CANCELLATION OR NO-SHOW

I authorize Hakiba Wellness Services of America, Inc. 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.

I will notify Dr. Baharanyi in writing if I no longer want my credit / debit card billed.

Name of Cardholder:_____

Signature of cardholder:_____

Date: _____

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

Name of party responsible for bill: _____

Date of Birth: _____\ _____ \ _____

Phone: _____ Business Phone: _____

Email address:_____

CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES

Visa ☐ MasterCard ☐ Discovery ☐ American Express ☐

Card Number _____ - _____ - _____ - _____ Credit ☐ Debit ☐

Exp. Date: _____ CVV: _____

Name as it appears on card: _____

Billing Address: _____Appt/Unit: _____

City: _____ State: _____ Zip Code: _____

Guarantor-Financial Responsibility Agreement: I, the undersigned, agree that regardless of any insurance coverage, I 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.

Name of Cardholder:_____

Signature of Cardholder:_____

Date: _____