Angela F. Arnold, MD, LLC

5505 Peachtree Dunwoody Rd.
Suite 475
Atlanta, GA 30342

Telephone: 404-909-6617
DrAngelaArnold@gmail.com
Facsimile: 678-831-7992

Updated July 2023

PATIENT SERVICE AGREEMENT
POLICIES AND PRACTICES

I am committed to providing professional service of the highest quality. I look forward to working with you. To serve you as responsibly and efficiently as possible, it is important that I inform you of the policies of my practice. Since this is a binding agreement, please take a few minutes to read the policies and we can discuss any concerns or questions you may have, before you sign the Consent for Treatment form. This is a requirement of all new and continuing patients. In addition, please take a few moments to complete the intake forms. These questions are designed to help me best meet your treatment needs.

APPOINTMENTS: SCHEDULING, CHANGES & CANCELLATIONS

Office visits are by appointment only. The general office hours are Monday through Thursday from 9am to 4pm and Friday 9am to 12pm. All appointments must be scheduled through my confidential email address: DrAngelaArnold@gmail.com or by leaving a voice message on my confidential office number: 404-909-6617. You should indicate several dates and times that are most convenient for you. My office or I will contact you on the phone number(s) or email address(es) you have indicated on the "Patient Consent to Receive Mail, Email, Text and/or Telephone Messages" that you will fill out and sign, to answer your request, or directly on the instructions you leave with your request for the appointment.

Both the email and phone messages are checked at least twice daily: Monday through Thursday 9am to 4pm, and on Friday 9am to 12pm.

A scheduled appointment time is reserved only for you. **If an appointment is missed or cancelled with less than 48-hour notice, you will be charged the full session fee.**

FEE SCHEDULE

The fees charged for the medical service my practice and I provide to you are as follows:

Initial Evaluation:	$500
Established patient / 60 minutes	$300
Established patient / 45 minutes	$250
Established patient / 30 minutes	$200
Administrative request / communication	$ 50 per event

PAYMENT POLICY

Payment by cash or check is due at the beginning of the appointment. A check for insufficient funds will incur an additional fee of $35. I currently do not contract with any insurance carriers. However, the invoice/receipt will enable you to file for an insurance reimbursement. Sorry, credit or debit cards are not accepted.

Any patient behind by two session payments will be unable to schedule a new appointment until the account is brought current.

RETURN TELEPHONE CALL POLICY

If you have a life-threatening emergency and cannot wait for a return call you should call 911 or go to your nearest emergency room.

My office and I make every effort to return calls promptly.
The office number is 404-909-6617.

EMAIL POLICY

My email address is: DrAngelaArnold@gmail.com. You may contact me via email for scheduling and refill requests.

Be advised I cannot ensure confidentiality when communicating via email. If you choose to discuss other issues or ask medical questions, you do so at your own risk.

MEDICATION REFILLS

Refills are authorized for current patients in active treatment, keeping regular appointments only.

I provide prescriptions at appointments. However, should a medication refill become necessary before the next scheduled appointment, please call or email with the following information: your name; date of birth; return call phone number; name of the medication with number of milligrams and daily intake; and name and number of your pharmacy.

No prescription/refill will be issued to any patient behind by two session payments until the account is brought current.

CONFIDENTIAL COMMUNICATIONS

Communication with the psychiatrist or other licensed mental health practitioner is always held in the strictest confidence and will not be revealed to outside agencies or individuals without your written authorization. Except as medically required and ethically permitted, and except for certain situations which are dictated by law (i.e. child abuse, imminent threat of danger to yourself or others, or court order), I will never release or communicate any aspect of your treat without your consent.

Information released to insurance companies for reimbursement for service must be sent by you rather than by, or through, my practice.

TERMINATION OF THERAPY

Patients may elect to discontinue treatment at any time. My practice and I reserve the right to terminate treatment if I feel I do not offer the type of care you need, or if you have been noncompliant with the agreed-upon treatment or policies of my practice.

Before you terminate my practice's care for you, I ask that you discuss your decision with me. By the same token, I will discuss issues with you before I elect to terminate you as a patient. If I do terminate your treatment, I will provide you with a referral for continued care.

ACKNOWLEDGEMENT

I, ___________________________________, have read and understand the agreement between
[print name]

Angela F. Arnold, MD, LLC and agree to be bound by all its terms and policies.

___________________________________	___________________________________
[signature of patient or legal guardian]	Today's Date

___________________________________	___________________________________
Angela F. Arnold, MD, LLC	Dated

ANGELA F. ARNOLD, MD, LLC

5505 PEACHTREE DUNWOODY RD.
SUITE 475
ATLANTA, GA 30342

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DRANGELAARNOLD@GMAIL.COM
FACSIMILE: 678-831-7992

CONSENT FOR TREATMENT

I, ___________________________________, have received a copy, and been given the opportunity to read and ask questions about, Dr. Angela Arnold, MD, LLC's "Patient Service Agreement – Policies and Practices." I understand this Agreement, have signed this Agreement, and give my consent for treatment by Dr. Arnold. I acknowledge that I am personally responsible for any ensuing charges made for service rendered. I authorize Dr. Arnold to provide information regarding my evaluation and treatment to the physician or therapist who referred me to Dr. Arnold.

______________________________	______________________________
[signature of patient]	[today's date]

______________________________	______________________________
Angela F. Arnold, MD, LLC	Dated

ANGELA F. ARNOLD, MD, LLC

CONFIDENTIAL PATIENT INFORMATION

Today's Date____________

____

Last Name First Name Middle Name/Initial

Date of Birth______________ Current Age________ Gender M/F________Nick Name______________________

____

Street Address

______________________________________ Email____

City State Zip

Phone Numbers Home________________________________ Cell______________________________

Work________________________________ Other_____________________________

Primary Care Physician____________________________________Phone_____________________________

Who referred you to Dr. Arnold?____

Emergency Contact______________________________________Phone_____________________________

Relationship to you__________________________________Other phone________________________

Emergency Contact______________________________________Phone_____________________________

Relationship to you__________________________________Other phone________________________

Occupation____Currently Employed? Y/N_______________

Relationship status: Single____ Married____ Domestic Partner____ Separated____ Divorced____ Widowed____

Children? Name(s) and age(s)____

Are your parents alive? Name(s) and age(s)____

Siblings? Name(s) and age(s)____

Religious preference/belief:____

Pets? Name(s) and type____

Do you exercise? What kind and how often?____

____

How do you like to spend your casual time?____

____

Last Name:________________________ Today's Date__________

Please describe your reason(s) for seeking treatment and what you hope the outcome will be. __________

____

____

____

____

____

Current Medications
NAME________________________ #MG______ #Times of day_____For______________
NAME________________________ #MG______ #Times of day_____For______________
NAME________________________ #MG______ #Times of day_____For______________
NAME________________________ #MG______ #Times of day_____For______________
NAME________________________ #MG______ #Times of day_____For______________
NAME________________________ #MG______ #Times of day_____For______________
[if you need more space, please continue your list on the back of this page]

Vitamins and/or supplements you take____

____

____

Allergies?____

Is it possible you're currently pregnant? Y/N_____

Any current medical problem(s)? Y/N_____ If yes, please describe and give the name of the treating physician

____

____

____

____

Any current/past problems with drugs/alcohol? Y/N_____ If yes, please describe________________

____

____

Do you currently use any illegal drugs (marijuana, cocaine, sedatives, amphetamines, narcotics, inhalants or others)? Y/N______

Last Name:______________________________ Today's Date____________

PSYCHIATRIC TREATMENT QUESTIONNAIRE

Are you currently under the care of any doctor for psychiatric treatment of any kind? Y/N_____ If yes, please describe, include name of treating physician(s)____

____

____

Have you been given a previous psychiatric diagnosis? Y/N_____ If yes, what was it?__________________

____

Previous outpatient psychiatric treatment? Y/N____ If yes, please describe/give dates___________________

____

Previous psychiatric hospitalization(s)? Y/N______If yes, please describe/give dates____________________

____

Psychiatric medications you've been prescribed in the past____

____

____

____

Are there other members of your family previously/currently in psychiatric treatment? Y/N_____If yes, please describe and indicate familial relationship____

____

____

Anything else you believe Dr. Arnold should know which would be important to your therapy, please add below:

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PATIENT AGREEMENT FOR PSYCHOSTIMULANT THERAPY

1. I, ________________________________, agree that Dr. Angela Arnold, MD, LLC will be the **only prescribing physician** for _________________________ ___________________________________ (also known generally as a stimulant), a medication(s) for managing ADHD, ADD, adjunct therapy for treatment of depression or binge eating disorder. I agree that I will obtain any of my prescriptions for this medication(s) from **one pharmacy**. The only exception would be an emergency or in the unlikely event that I run out of the medication(s) or that the pharmacy should run out of the medication(s). If such an occasion occurs I will notify Dr. Arnold as soon as possible via email at DrAngelaArnold@gmail.com or voicemail at 404-909-6617.
2. I understand the importance of taking the medication(s) at the dose and frequency prescribed by Dr. Arnold. I agree not to increase the dose of the medication(s) without first discussing it with Dr. Arnold. I understand that expected prescription(s) refill dates will be used to promote optimal use of this medication(s). Dr. Arnold will not refill the medication(s) earlier than five (5) days before the due date for the next prescription(s).
3. Dr. Arnold may require random urine testing as a matter of routine monitoring.
4. I will attend all reasonable appointments, treatments and consultations as requested by Dr. Arnold. I will pursue other ADHD consultations/management strategies as necessary and/or prescribed.
5. **I understand that Dr. Arnold will authorize a prescription(s) of the medication(s) for up to three (3) refills, but no longer, without an appointment. I further understand a prescription(s) for this type of medication(s) can only be obtained by written prescription(s) from Dr. Arnold and cannot be refilled via fax or phone call by my pharmacy.**
6. I understand that I should check with my Dr. Arnold or pharmacist before taking other medication(s) including over-the-counter and herbal product(s).
7. I agree to be responsible for the **secure storage** of my medication(s) at all times. I understand the importance of not informing others about my stimulant therapy. I agree not to give or sell my prescribed medication(s) to any other person and

understand it is a felony to do so (O.C.G.A. 16-13-30). I acknowledge that Dr. Arnold is not obligated to replace any medication shortfall.

8. I consent to open communication between Dr. Arnold and any other health care professionals involved in my ADHD management, such as pharmacists, other physicians, emergency departments, etc.
9. I understand that if I break any stipulation(s) listed in this agreement Dr. Arnold reserves the right to stop prescribing stimulant medication(s) for me.
10. I understand that mixing stimulant medication(s) with alcohol or non-prescribed prescription medication(s) or illegal medication(s) is dangerous and potentially life-threatening.

I have received a copy, been given the opportunity to read this agreement and ask questions about, Dr. Angela Arnold, MD, LLC's "Patient Agreement for Psychostimulant Therapy." I understand this Agreement, have signed this Agreement, and give my consent for treatment by Dr. Arnold.

______________________________	______________________________
Signature of Patient or Legal Guardian	Today's Date

______________________________	______________________________
Angela F. Arnold, MD	Dated

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Patient Consent to Receive Mail, Email, Text and/or Telephone Messages

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as telephone messages, email messages, postcards, text messages, or letters).

Medication or other communications: We may use or disclose your health information to provide you with any necessary information to complete initial fulfillment or re-fill of medications as prescribed by Dr. Angela Arnold and presented by you for fulfillment at any licensed dispensary or information about treatment alternatives or other health-related benefits and services that may be of interest to you (such as telephone messages, email messages, postcards, postcards, text messages, or letters).

I agree the practice may contact me electronically via the following communication avenues:

Phone (wireless):______________________________ Phone (other):_________________________

Email:____

Physical address:____

I consent to receive calls, email messages and text messages related to my protected healthcare and other services at the phone number(s) above, including the wireless number provided. I understand I may be charged for text messages/calls by my wireless carrier and that such calls may be generated by an automated dialing system.

I give my permission to receive:

Unsecured appointment reminders via answering machine / voicemail / email / text / letter to my home: Y_____ N____

Unsecured billing or prescription information via answering machine / voicemail / email / text / letter to my home: Y_____ N____

Unsecured treatment alternatives or other health-related benefits and services information via answering machine / voicemail / email / text / letter to my home:: Y_____ N____

Print Patient Name:____ Date:____________________

Signature of Patient/Legal Guardian:____