Fees and Payments

Professional Service and No-Show/Late Cancellation Fees
Dr. Vinson’s practice operates under the company Ubuntu Mental Health LLC. Payment is required at the time of appointments through cash, check or credit card. Dr. Vinson’s private practice does not currently contract with any insurance carriers. Please check with your insurance company as to whether or not you qualify for out-of-network benefits. After payment is received, the receipt emailed to you will include the information needed for you to apply for out-of-network benefits if applicable. All new patients pay the initial evaluation fee in full at the time services are rendered. Generally, fees are due at the time of service unless other arrangements have been made.

If an appointment is canceled with more than two business days’ notice, the patient/guarantor will not be penalized. A first-time cancellation within two business days of the scheduled appointment or a no-show will not be penalized. A second no-show or late cancellation will result in a no-show fee equivalent to half the amount of the visit rate for the time that was allotted. After the third no-show or later cancellation, any subsequent appointments will be paid for in-full at the time of the appointment booking. The fee will not be refunded should a no-show occur, and the payment will be a no-show fee. Exceptions will be determined on a case-by-case basis and are at the discretion of Dr. Vinson.

Fee Schedule
- $240 – 50 minute psychotherapy and/or psychopharmacology appt.
- $470 – 2 hour initial intake appt.
- $160 – 30 minute phone, telepsych. or in-person appt.
- $130 – 20 minute office or phone psychopharmacology appt.

Statement of Party Responsible for Payment
I, the undersigned, understand that payment is due according to the terms detailed in Dr. Vinson’s Practice Policies. I understand that I will receive a receipt electronically, which will record the payee as “Ubuntu Mental Health LLC”. That receipt will include the information needed for me to collect out of network benefits, if applicable, from my insurance company. If, for any reason, I do not pay at the time of the appointment, I understand that I will receive an invoice for the applicable fee. I understand that it is expected that the payment will be completed within 3 business days. I agree that regardless of any insurance coverage, I am financially responsible for all charges generated for this patient. 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 may be referred to a collection agency.

Party Responsible for Payment
First and Last Name (if someone other than the patient, identify relationship to patient):
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Credit/Debit Cards
Dr. Vinson’s practice operates under the company Ubuntu Mental Health LLC. Payment is required at the time of appointments. To expedite the billing process, we ask for a credit card to be kept on file through our secure payment processing system, Square. At the time of your intake appointment, we will ask for the card you would like to have kept on file. If, at the time of your appointment, payment is made with check or cash, the card on file will not be billed. The following section is the consent for using the file on card for fees.

Credit/Debit Card Payment Consent
I authorize Ubuntu Mental Health LLC to charge the credit card that is provided to be kept on file for professional services as outlined in the Policies. I will notify Ubuntu Mental Health LLC in writing if I no longer want my credit / debit card billed. I also authorize Ubuntu Mental Health LLC, to bill the debit/credit card when the patient does not give advance notice for a late-cancellation or no-show, as per the Policies.

____________________________________________  ________________
Signature of cardholder                   Date

Office Hours and Appointments
Office hours and sessions are by appointment only. Dr. Vinson is typically in the office on Monday afternoons, Wed. afternoons, all day Friday and select Saturdays. All first appointments are considered a consultation only. She will let you know if she is in the position to offer treatment services beyond the first appointment. For the purpose of this document “business hours” refers to 9am – 4 pm Mondays through Fridays on days that are not recognized as federal holidays.

Emergencies/After Hours
During normal business hours, our office manager will facilitate setting up appointments and respond to other administrative issues. Calling the office manager at 404-249-0520 x1 is the method of contact for Dr. Vinson during business hours as the office manager will rely clinical queries to Dr. Vinson. If an urgent, but not emergency, clinical issue arises outside of normal business hours and can not wait until the next business day, dial Dr. Vinson’s On-Call number. Active patients will have the number emailed them after the initial appointment. When calling, the On-Call number, leave a message for Dr. Vinson with your name, the patient’s name (if different), the best contact number at that time, and the urgent issue. Dr. Vinson will be notified and return your call as soon as possible. For all emergencies, please access emergency psychiatric help through the Georgia Crisis and Access Line 24/7 at 1-800-715-4225 or by calling 911.

Scheduling Appointments
Please call the office at 404-249-0520 or email officemanager@loriopsychgroup.com to schedule an appointment. Generally, subsequent follow-up appointments will be scheduled with Dr. Vinson at the close of appointments when possible.
Appointment Changes / Cancellations
If an appointment is canceled by the patient with more than two business day’s notice, the patient/guarantor will not be penalized. A first-time cancellation within two business days of the scheduled appointment will not incur a no-show or late cancellation fee. If, for any reason, the doctor must cancel an appointment, the patient will be advised at the earliest possible time and offered alternate date and times.

Email, Telephone, and Telepsych

Email
By agreeing to communicate via email or internet, you are assuming a certain degree of risk of breach of privacy. Dr. Vinson cannot insure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability and the variable timing of when email will be checked, emails should not include matters of a private nature. It is to be used for coordination purposes, and at no time will clinical decisions or medication changes be made based on email correspondence. Additionally, your doctor will save email correspondence with you and these communications should be considered part of the medical record.

To protect your privacy, be prudent in how you store treatment-related emails. Make sure they are protected from unauthorized access by using and guarding your passwords. Consider deleting any emails that you do not want others to see, followed by emptying your trash or recycle bins. Be aware that emails sent from a workplace computer are the property of the employer. Never send emails of an urgent or emergent nature. Your doctor will check email regularly; however, re-email or call our office if you have not received a reply within 2 business days.

Telephone Policy
Our Office Manager will typically return calls if appropriate as this enables a more timely response than if Dr. Vinson waited until the end of her work day. Routine phone calls made during business hours will be returned within one business day.

Please be advised that this is for brief phone calls only (for example, a question concerning current medication). For more extensive phone calls (10 minutes or more), please schedule a phone appointment with Dr. Vinson through the Office Manager. There will be a routine charge for these phone calls based on the time spent per call. Please note that most insurance companies will not reimburse for phone consultation fees.

Telepsychiatry
Telepsychiatry is an option for select, established patients at Dr. Vinson’s discretion. Patients receiving controlled substances must be seen in person at least annually. By agreeing to engage in telepsych, you are assuming a certain degree of risk of breach of privacy. Dr. Vinson cannot insure the confidentiality of our electronic communications against purposeful or accidental network interception.

Medication Refill Policy

Medication refills may be requested by phone or through http://drssarahvinson.com/meds/. They will be completed within two business days of the request. Please make telephone requests for medication refills with at

Dr. Sarah Vinson/Ubuntu Mental Health LLC Policies and HIPAA Notification

January 1, 2019
least three business days notice. When leaving a voicemail or sending an email, please include the patient’s name, date of birth, name of medication requesting, dosage, how you take it, and pharmacy telephone number. If all of this information is not provided, it may result in a delay in your refill authorization.

Prescriptions may only be called in for patients who are active patients. If you have not been seen in 90 days, you may no longer be active. For your safety, medication refills will not be called in over the weekend except in emergencies.

**Medical Releases of Information and Controlled Substance Registry**

For the purposes of patient safety, every patient who is prescribed medication by Dr. Vinson is required to sign a release of information that permits Dr. Vinson to request the most recent history and physical, problem list, and medication list from any other medical practitioner who is prescribing the patient medication. The release will also allow Dr. Vinson to provide that practitioner with the medications being prescribed by Dr. Vinson. Additionally, for all new patients, our office will check the Georgia controlled substances registry. This registry shows us which controlled substances the patient has prescribed and who prescribed them.

**Termination Policy**

Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge that the doctor be notified in person regarding this decision so that it can be discussed openly and we can assist with next steps. Dr. Vinson retains the rights to discharge a patient from the practice at her discretion. If/when this occurs, Dr. Vinson will communicate this as well as the reason and provide referral information for follow-up care as well as a bridge prescription, if applicable. Patients who do maintain appointments on at least a quarterly (every 90-day basis) are subject to discharge. They may be able to re-establish care, but may have to complete a new intake at Dr. Vinson’s discretion.

**Acceptance of Policies**

*Dr. Vinson is committed to providing professional services of the highest quality and standards. In order to serve her patients efficiently and responsibly, she requires agreements be made as to the policies stated above. Patients/guardians are encouraged to ask any questions related to this document before signing.*

I have read the policies, understand, and agree with them.

Patient Name: _____________________________________________

Patient Signature (if an adult): __________________________________

Guardian’s Name (if applicable): _________________________________

Guardian’s Signature (if applicable): _______________________________

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. Vinson at 770-507-0005. A full copy of this notice is available from Dr. Vinson at DrSarahVinson.com. If you believe your privacy rights have been violated, you can file a complaint with Dr. Vinson 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: ____________

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