

## Policies and Procedures

*Please Read Carefully*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Cancellation/Missed appointments:** You are expected to give 24 hours notice of cancellation of your appointment. **Failure to give 24 hours notice will result in a charge of \$75/visit.** If you are consistently late, cancel or do not show for your appointments, Dr. Pejic reserves the right to terminate treatment.

**Urine Drug Screens:** Patients being treated for addictions will periodically be asked to give a urine sample to test for illicit drugs. This test will cost approximately **\$15/test**. If you refuse the test, Dr. Pejic reserves the right to terminate treatment and refer you to another clinic.

**Records and Letters:** The clinic charges **\$20** to fax/copy your records or to write a formal letter upon request.

**Refills for Prescriptions:** Please call and leave a message if you require a refill for your prescription. Please do not wait until the last pill to make this request. There is a 24 to 48 hour waiting period to receive a refill (unless an emergency). Dr. Pejic must see every patient on maintenance medications every three to four months. For controlled substances (ie Suboxone, Adderall Ritalin) Dr. Pejic must see you every one to two months and cannot call these medications in to the pharmacy.

**After Hours:** For urgent questions after hours, please leave a confidential message at **504.231.3987** indicating the urgency and nature of the call. Your call will be returned as soon as possible.

**Emergency:** For emergencies (such as concerns of harming yourself or others), please **call 911** or go immediately to the nearest emergency room to be evaluated by a physician.

**Bill Procedure:** You will be expected to **pay in full upon completion of your visit**. Failure to pay in full will result in no follow-up appointments until your balance is paid. A receipt for services rendered will be available at each visit and may be used to file a claim with your insurance company. You must request this receipt at the time of your visit. Otherwise, Dr. Pejic will keep your payment record on file.

**I have read and understand the above policies. I contract that I will comply with these policies as a prerequisite to treatment with Nicholas G. Pejic, MD.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**Atlas Psychiatry**  
**Nicholas G. Pejic MD**  
1301 Antonine Street  
New Orleans, LA 70115

## Registration Form

*Thank you for taking the time to fill out this information.  
If any of the fields are inapplicable please mark "N/A"*

<b>Name:</b>	<b>Date of Birth:</b>
<b>Date:</b>	<b>Age:</b>
<b>Address:</b>	
<b>Cell Phone #:</b>	<b>Alternative Phone #</b>
<b>Email:</b>	
<b>Past Treating Doctor</b> Name:  Phone#:	<b>May Dr. Pejic Request Past Medical or Psychiatric Records?</b>  Yes / No
<b>Pharmacy</b> Name:	Phone #:
<b>Emergency/Family Contact</b>  Name:  Phone#:	<b>May Dr. Pejic contact this person to help provide information for your treatment?</b> <i>If "No" Dr. Pejic will only use in case of emergency.</i>  Yes / No
<b>Employer</b> Name:  Work Title:	<b>Did you receive the Notice of Privacy?</b>  Yes / No

Atlas Psychiatry LLC  
**Patient Consent Form**

Name \_\_\_\_\_ DOB: \_\_\_\_\_

**Your signature below grants consent to be evaluated and treated by Nicholas G. Pejic MD**

I also understand that as part of my health care, Nicholas Pejic MD originates and maintains paper and/or electronic records describing his/her health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning care and treatment; a means of communication among health professional who contribute to that care; a source of information for applying diagnosis information to my bill; a means by which a third party payer can verify that service billed were actually provided; and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the Notice prior to signing the consent; the right to object to the use of the disclosed health information for directory purposes; and the right to request restrictions as to how this health information may be used or disclosed to carry out treatment, payment, or health care operations.

I wish to have the following restrictions/amendments to the use or disclosure of my health information (Please leave blank if you do not wish to make any changes):

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I understand that Nicholas Pejic MD is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent, Nicholas Pejic MD may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Nicholas Pejic MD reserves the right to change their notice and practices. Should Dr. Pejic change his notice, he will send a copy of any revised notice to the email address I provided or to my home address.

I understand that as a part of treatment, payment, or health care operations, it may become necessary to disclose this protected health information to another entity, and I consent to such disclosure for these permitted uses.

**By my signature, I fully understand and accept the terms of this consent. By my signature, I certify that I am the custodial parent or legal guardian responsible for the medical care of the patient herein named.**

\_\_\_\_\_  
Patient/Parent/Legal Guardian's signature

\_\_\_\_\_  
Date

# Notice of Privacy

*Please Keep For Your Records*

Nicholas G. Pejic, MD  
Atlas Psychiatry LLC  
1301 Antonine Street  
New Orleans, LA 70115

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on October 1, 2008 and remains in effect until I replace it.

1. My pledge regarding medical information: The privacy of your medical information is important to me. I understand that your medical information is personal, and I am committed to protecting it. I create a record of care and services you receive at this office. I need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways I may use and share medical information about you.

2. My legal duty: Law requires us to:

- Keep your medical information private.
- Give you this notice describing our legal duty, privacy practices and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect and to display that notice in the waiting area.

I have a right to:

- Change my privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in my privacy practices and the new terms of my notice effective for all medical information that we keep including information previously created or received before the changes.

Notice of change to privacy practices:

- Before I make an important change in our privacy practices, I will change this notice and make the new notice available upon request.

3. Use and disclosure of your medical information: the following section describes different ways that I use and disclose medical information. Not every use or disclosure would be listed. However, I have listed all of the different ways I am permitted to use and disclose medical information. I would not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to me.

For treatment: I may use medical information about you to provide you with medical treatment or services. I may disclose medical information about you to doctors, nurses, technicians, medical students, physician assistant students, pharmacists or other people who are taking care of you. I may also share medical information about you with your other healthcare providers to assist them in treating you.

For payment: I may use and disclose your medical information to get paid for the services I provide to you.

For healthcare operations: I may use and disclose your medical information for healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials I need to serve you.

For business associates: I may share your medical information with a third party "business associate" that performs various activities (e.g. billing, collection, electronic medical records, transcription). Whenever an arrangement between me and a business associate involves the use or disclosure of your medical information, I will have a written contract that contains terms that will protect the privacy of your medical information.

4. Additional uses and disclosures with opportunity to object: In addition to using and disclosing your medical information for treatment, payment and healthcare operations, I may use and disclose medical information for the following purposes. You have the opportunity to object. If you are not present or able to object, then I may, using professional judgment, determine whether the disclosure is in your best interest.

For promotion: I may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. You may contact me to request that these materials not be sent to you.

Facility directories: Unless you object, I may disclose the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All this information, except religious affiliation, will be disclosed to the people that ask for you by name. Members of the clergy will be told your religious affiliation.

Others involved in your health care: Unless you object, I may disclose to a member of your family, a relative, a close friend, a personal representative or any other person you identify, your medical information that directly relates to that person's involvement in your health care. I will also use our professional judgment to make decisions in your best interest about allowing someone to pickup medicine, medical supplies, x-ray or medical information about you.

Emergencies: In an emergency treatment situation, I will provide you with a Notice Of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

Communication barriers: I may use and disclose your protected health information if I have attempted to obtain acknowledgment from you of our Notice Of Privacy Practices but have been unable to do so due to substantial communication barriers and I determine, using professional judgment, that you would agree.

5. Additional uses and disclosures without opportunity to object: I may use or disclose your medical information in the following situations without your authorization or opportunity to object.

Public health: for public health purposes to a public health authority or a person who is at risk of contracting or spreading your disease.

Health oversight: to help oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or neglect: to an appropriate authority to report possible child abuse or neglect, domestic violence or abuse or neglect of a dependent adult.

Food and drug administration: as required by the FDA to track products.

Legal proceedings: in the course of legal proceedings, under certain circumstances To prevent suicide or significant self-harm.

Law enforcement: for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.

Coroners, Funeral Directors, and Organ Donation: for the Coroner, Medical Examiner or Funeral Director to perform duties authorized by law and for organ donation purposes.

Research: to researchers when their research has been approved by an Institutional Review Board or Privacy Board.

Soldiers, inmates and national security: to military supervisors of armed forces personnel or to custodians of inmates, as necessary. Preserving national security may also necessitate disclosure of protected health information.

Worker's Compensation: to comply with workers' compensation laws.

Compliance: to the Department of Health and Human Services to investigate my compliance.

In general, I may use or disclose your protected health information as required by law and limited to the relevant requirements of the law.

Your Rights: you have the right to:

Inspect and copy your protected health information: In most cases you have the right to look at or get a copy of health information about you. I will charge you photocopy fees as allowed by law. However, I may refuse to provide access to certain psychotherapy notes or information for a civil or criminal proceeding.

Request a restriction of your protected health information: You may ask us not to use or disclose certain parts of your protected health information for treatment, payment or healthcare operations. You may also request that

information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. I am not required to agree to a restriction that you may request, but if I do agree, then I must act accordingly except in case of an emergency.

Request to receive confidential communications from me by alternative means or at an alternative location: I will accommodate reasonable requests. I may also condition this accommodation by asking you for information as to how payment will be handled or specifications of an alternative address or other method of contact. I will not request an explanation from you as to the basis for the request.

Ask me to amend your protected health information: You may request an amendment of protected health information about you. If I deny your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information.

Receive an accounting of certain disclosures we may have made: This right applies to disclosures for purposes other than treatment, payment or healthcare operations. It excludes disclosures we have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: If you are concerned that I have violated your privacy rights or you disagree with a decision I made about access to your records, you may contact the person listed below. You may also send a written complaint to the US Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Nicholas G. Pejic, MD  
Atlas Psychiatry LLC  
1301 Antonine Street  
New Orleans, LA 70115  
504.899.1682

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)		DOB	SSN	
ADDRESS		Phone		
CITY	STATE	ZIP		
PROVIDER AUTHORIZED TO RELEASE OR RECEIVE THE PROTECTED HEALTH INFORMATION:		ENTITY OR PERSON RECEIVING OR SENDING THE PROTECTED HEALTH INFORMATION:		
<b>Atlas Psychiatry LLC</b> <b>Nicholas G. Pejic MD</b> <b>1301 Antonine Street</b> <b>New Orleans, LA 70115</b> <b>Office: 504.899.1682</b> <b>Fax: 504.891.3039</b>		NAME		
		ADDRESS		
		CITY	STATE	ZIP
		ATTENTION:		
This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed Date: _____ Event: _____				
Purpose of this Disclosure: <input type="checkbox"/> Continuing Treatment <input type="checkbox"/> Personal <input type="checkbox"/> Legal <input type="checkbox"/> Applying for Social Security Disability <input type="checkbox"/> Insurance <input type="checkbox"/> Other: _____				
<b>PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE</b>				
<b>Description</b>		<b>Start Date</b>	<b>End Date</b>	
<input type="checkbox"/> All PHI in the record				
<input type="checkbox"/> Office Notes				
<input type="checkbox"/> Laboratory Tests				
<input type="checkbox"/> X-Ray Tests / Reports				
<input type="checkbox"/> Itemized Billing Statement				
<input type="checkbox"/> Other:				
The following information will be released when included in the above information unless you indicate otherwise:				
<input type="checkbox"/> AIDS or HIV test results		<input type="checkbox"/> Psychiatric or mental care / treatment		
<input type="checkbox"/> Alcohol, drug or substance abuse treatment		<input type="checkbox"/> Other (specify):		
I understand that: <ol style="list-style-type: none"> <li>1. I may refuse to sign this authorization and it is strictly voluntary.</li> <li>2. This authorization includes reviewing and/or copying all or portions of my medical record. I release Atlas Psychiatry LLC and Nicholas G. Pejic MD, my physician, from any responsibility or liability of releasing this information.</li> <li>3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.</li> <li>4. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.</li> <li>5. Letters to revoke this authorization should be addressed to Nicholas G. Pejic MD, 1301 Antonine Street, New Orleans, LA 70115</li> <li>6. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.</li> <li>7. I have the right to receive a copy of this form after I sign it.</li> </ol>				
Signature of Patient:		Date:		
Signature of Patient's Representative (if necessary):		Date:		
Representative's Relationship to Patient:				