The Fort Christian Psychiatric Center
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*DISCLAIMER: **A doctor-patient, provider-patient, or therapist-patient relationship is NOT established until the decision is made to create such a relationship at the conclusion of your initial psychiatric diagnostic appointment. Therefore, you will not be considered a patient of Shaw Wendi Fortuchang, M.D., PC / The Fort Christian Psychiatric Center or its associates until then.***

Please read each section very carefully before initialing where highlighted.

Insurance: The Fort Christian Psychiatric Center does not accept insurance. If you wish to be reimbursed by your insurance company, you will be responsible for filing the claim on your own. You will receive a superbill receipt from us via email containing all the information needed by your insurance company, but we cannot guarantee that your insurance company will reimburse for services rendered. **Therefore, it is your responsibility to find out which CPT procedural codes are reimbursable. Further, we do not submit any billing claims to insurance companies. We do not manage any billing-related insurance issues. All insurance company correspondence should be mailed directly to you, not to us! We reserve the right to charge administrative fees related to insurance claims, when applicable.** X_____

Appointments: Our office hours follow the Fayette County School calendar. When Fayette County schools are closed due to inclement weather, we will also be closed. X____

HOURS: Mon-Thu from 7am – 7pm. Appointments are scheduled on Tuesdays, Wednesdays and Thursdays. Monday is an administrative day. We are closed on Fridays and weekends. X____

Scheduling and Punctuality: To provide safe medical care, appointments are scheduled as frequently as the patient's clinical symptoms require. Patients are expected to arrive on time for their appointments. Arriving 10 minutes after your appointment time is considered late. As a courtesy, we will allow late arrivals to be seen up to 15 minutes after the scheduled appointment time, allowing for the remainder of the time to be used (this policy does NOT apply to 15-minute sessions). *Once 15 minutes have elapsed, the appointment will be automatically canceled. The patient's credit card on file will be charged the full cost for the canceled session + the $2 manual transaction fee. X_____

Missed Appointments: Patients who cancel 3 consecutive appointments are subject to termination. Additionally, if a patient has not been seen in 6 months or longer, they may be subject to termination. Patient safety is our top priority at The Fort Christian Psychiatric Center. Making and keeping regularly scheduled appointments, and adherence to the treatment plan are integral components of this safety process—especially when medication is prescribed. The frequency with which appointments are scheduled is an important and methodical medical decision, involving extensive clinical experience and wisdom, sound judgment and guidance from The Holy Spirit. Close adherence to our office policies and pearls of wisdom agreement is vitally important to us as a Christian-centered medical practice, which helps us to ensure the safety of the patients we have been called by God to treat. X_____

Appointment Reminders for Established Patients: It is always the patient's responsibility to remember the date and time of an appointment. However, as a courtesy we will provide an appointment reminder card at the conclusion of appointments. Also, at the bottom of the superbill receipt we send to patients via email, we will write the date, time and length of the next appointment. And, within the body of these emails, we will write the date, time and length of the next appointment. If you miss an appointment due to receiving an email with incorrect information, or because your email goes to junk/spam and never reaches your inbox, you will be held responsible and will be charged the full cost for that session. **Therefore, always write down the date and time of your next appointment**. X_____

Payment Options: We operate on a fee-for-service basis. We accept cash, checks, most major credit cards (American Express, Discover, MasterCard and Visa), debit cards and health savings / flex spending cards. Full payment is expected at the time services are rendered. A $35 fee will be assessed for any returned checks. More than 1 bad check will result in revocation of all check-writing privileges. X_____

Initial Diagnostic Evaluations & Consultations: Initial Diagnostic Evaluations and Consultations are typically conducted in the morning on Tuesdays, Wednesdays and Thursdays. If you choose to cancel your appointment, you must do so at least **48-business hours to the exact date and time of the appointment in order to avoid being charged the full cost. A cancellation made less than 48-business hours to the exact date and time of the appointment will be charged the full cost for the session.** Because we are closed on Fridays, Friday is **not** counted as a business day. All no-shows are charged the full cost for the session and *are not granted another appointment with us*. X____

The Initial Diagnostic Evaluation is always considered an evaluation, not a patient appointment. The decision of whether or not a doctor-patient relationship will be established and whether or not subsequent appointments are scheduled is a decision made by Dr. Fortuchang and The Fort Christian Psychiatric Center. In the event that the initial evaluation does not result in a doctor-patient relationship being formed, names of other mental health professionals will be provided. The individual or their designated guarantor will be responsible for the full payment at the time of the evaluation. X_____

Cancellation Policy for Established Patients: We have **2 categories** for appointment cancellations:
#1. Appointments scheduled for *less than 12 weeks in the future*. These appointments must be canceled by **48 business hours to the date and exact time of the scheduled appointment**, otherwise patients will be charged the full cost for the session. Because we are closed on Fridays, Friday is not counted as a business day. For example, a 4 PM Monday appointment must be canceled by 4 PM on the previous Wednesday, and a 9 AM Tuesday appointment must be canceled by 9 AM on the previous Thursday. A 1:30 PM Wednesday appointment must be canceled by 1:30 PM on the previous Monday, and a 5:15 PM Thursday appointment must be canceled by 5:15 PM on the previous Tuesday. X_____
#2. Appointments scheduled for *12 weeks or more in the future*. ***This is calculated by counting 12 weeks ahead from the date of the scheduled appointment***. These appointments must be canceled by 1 week to the date of the appointment, ***during or before business hours***, otherwise patients will be charged the full cost for the session. Therefore, a Monday appointment must be canceled by the previous Monday, a Tuesday appointment must be canceled by the previous Tuesday, a Wednesday appointment must be canceled by the previous Wednesday, and a Thursday appointment must be canceled by the previous Thursday. Additionally, these appointments *must be canceled before or during business hours* (**by 7 PM when we close**) otherwise patients will be charged the full cost. X____

No-Shows: No-shows occur when a patient does not contact us to cancel their appointment and does not show up for it. No-shows are always charged the full fee for the missed session and will jeopardize a patient's standing at The Fort Christian Psychiatric Center. Repeat no-shows will result in termination from the practice. Please note that insurance companies do not reimburse these fees. X____

Appointment Cancellation Method: **All appointment cancellations must be made via email to** dr.fortuchang@thefortchristian.com or office@thefortchristian.com, **and/or through our website** www.thefortchristian.com. Therefore, please do not call our office to cancel an appointment. X____
To cancel an appointment via email: you may either write to us (you are solely responsible for ensuring that our email address is entered correctly) or you may reply to an email from us. Please include the date and time of the appointment you are choosing to cancel in the body of the email and in the subject line. **We will not contact you to confirm receipt of the cancellation.** X____
To cancel an appointment via our website: simply log onto it, go to the CONTACT page and submit the form. Please include the date and time of the appointment you are choosing to cancel in the body of the email and in the subject line. **We will not contact you to confirm receipt of the cancellation.** X__
Appointment cancellations must be made during business hours. X_____

Rescheduling a Cancelled Appointment: You must call our office to reschedule a canceled appointment for a new date and time. All appointments are scheduled by telephone. X_____

Telephone Policy: To provide quality care to her patients, Dr. Fortuchang prefers to personally return their calls. Messages left between the hours of 7am and 7pm on Mon through Thurs will be returned within 24 hours. Messages left after 7pm on Thurs will be returned on the next business day (Mon). X___

After Hours, Urgent Matters and Emergencies: An urgent matter is anything requiring Dr. Fortuchang's attention, which can be fully addressed in the office or via telephone (prescription refill, medication questions, a recent non-life-threatening stressor, etc.), but something that cannot wait until the next business day. In other words, it is not an emergency but not something that can wait. X____

An emergency is any life-threatening situation in need of immediate attention, typically requiring a call to 911 or a trip to the nearest emergency room. *Patients must be seen soon after any emergency. X___

During normal business hours, please call the office (770-376-6726) for any urgent matters. X_____

For urgent matters occurring after business hours that cannot wait until the next business day to be addressed, please call our after-hours line (fax line) at 770-376-6727. Your call will be routed to a private voicemail. Please leave a brief message including your name, the patient's name (if different), your telephone number, and the issues concerning you/the patient. If Dr. Fortuchang is unable to answer immediately, you must leave a message if you expect a call back. Your call will be returned as soon as possible from a blocked number. **Do not call the after-hours line for a medication refill.** X___

**Also available to you is the Georgia Crisis and Access Line 1-800-715-4225, and the National Suicide Prevention Lifeline at 800-273-8255. X____
**If you are experiencing a life-threatening emergency call 911 or go to the emergency room. X_____
**Patients are expected to contact us immediately AFTER contacting emergency services. X_____

Medication Refill Policy: While we make every effort during your appointment to provide enough medication refills to last until your next appointment, patients share the responsibility of monitoring their need for a medication refill. Patients should either bring their medication bottles to each appointment OR write down how many pills are left in each bottle AND whether or not any refills remain. X____
We charge $25/medication for all medication refill requests made between appointments. **A good way to avoid this is to either bring your medication bottles to every appointment, OR write down how many pills are in each bottle AND whether or not any refills remain. X____
**Prescriptions are only "called in" for current patients of The Fort Christian Psychiatric Center who maintain their regularly scheduled appointments. X____

WE WILL NOT HONOR MEDICATION REFILL REQUESTS FAXED TO US FROM YOUR PHARMACY. PATIENTS MUST CALL OUR OFFICE DURING NORMAL BUSINESS HOURS TO REQUEST MEDICATION REFILLS. X____
Medication refills will not be called in after hours, over the weekend, or on holidays. X____
**Again, we strongly urge you to pay close attention to your medication supply. We encourage you to make prescription requests during your appointment in order to avoid being charged a $25 fee. X_____

Outside Food & Beverages: Because this is a physician's office, we do not allow outside food and beverages (excluding water) in our office. **Please do not bring these items with you.** X_____

Photocopies: I agree that photocopies and electronic copies of this form are as valid as the original. X_____

Email Policy: We use email to receive appointment cancellations and to send superbill receipts. Email containing clinical information is strictly prohibited and goes directly against our office policy. Clinical concerns and urgent matters are to be addressed via telephone by calling our office. X____
Note: By choosing to communicate via Email or Internet, you are assuming a certain degree of risk of breach of privacy. The Fort Christian Psychiatric Center cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. We will save email correspondence with you and they will be considered part of the medical record. Therefore, you should consider that any electronic communication may not be confidential and will be included in your medical chart. X_____

Policy for Termination of Treatment: Patients are under no obligation to continue services should they choose to terminate treatment. However, it is required that we be notified, *in writing*, in order to properly begin the termination process. Similarly, The Fort Christian Psychiatric Center reserves the right, under any circumstances (including choosing to go against medical advice, failure to adhere to the treatment plan, office policies and pearls of wisdom agreement, etc.) to terminate the doctor-patient relationship at the discretion of Dr. Fortuchang. Patients with inactive charts for 6 months and longer are subject to termination. A formal letter of termination will be mailed to the home address on file. X____.

Terminations occur for a reason. Therefore, it is our policy not to re-establish the doctor-patient relationship—regardless of how the termination process was initiated. **Please note that patients are fully responsible for any and all outstanding balances at the time of termination. X_____

Policy Changes: The Fort Christian Psychiatric Center reserves the right to change/modify/amend/update our office policies at any time. You will be notified of any changes. The updated version will always be available on our website and at our front desk for your review. X_____

Prior-Authorization, Records, Forms and Other Fees: Medical records: $25/request. X____
Completion of forms (school, camp, work, jury duty, prior authorization): $35/form. X____
Requests for medication refills made between appointments: $25/refill. X____
Manual credit/debit card transaction for payment of services: $2/use. X_____
Telepsychiatry services: $10 fee + the cost of the session X_____

Session Fees: Our fees are subject to change to keep pace with inflation, business overhead, and other factors to the discretion of Shaw Wendi Fortuchang, M.D, P.C. / The Fort Christian Psychiatric Center. X____

Consent for Treatment at a Christian-Centered Medical/Psychiatric Facility: I have read and initialed the office policies of The Fort Christian Psychiatric Center (TFCPC). I understand them and I agree to adhere to them. I understand that TFCPC is a Christian, Bible-based practice. I understand that The Bible, Scripture and prayer are used as the foundation for the treatment—as is dictated by The Holy Spirit. I hereby consent to be treated by physicians and/or mental health professionals associated with The Fort Christian Psychiatric Center and Shaw Wendi Fortuchang, M.D., P.C. I understand this consent does not constitute a guarantee about the results of my treatment. I understand that I can terminate this consent for treatment at any time. I also understand that my doctor, prescribing provider, therapist or counselor may terminate consent for treatment at any time, and will discuss the reasons with me if this should occur. Potential reasons include misuse of prescribed medications or mental health services, failure to reimburse for services rendered, failure to keep appointments or repeated cancellations of appointments, etc. I agree that I am personally responsible for ensuring that all charges for services rendered are paid by me, at the time services are rendered. X_____

Statement of Confidentiality: Under Georgia law communications between patients and psychiatrists are confidential, and under ordinary circumstances, only the patient may waive this privilege. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to him or herself, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child abuse. Although legally and ethically bound to break confidentiality under these circumstances, we will attempt to discuss with you first. X_____

I authorize The Fort Christian Psychiatric Center (TFCPC) to provide information concerning my treatment to any physician or therapist who referred me to TFCPC, as well as to my primary care physician for the sole purpose of collaborating fasting baseline lab work when needed. X_____

ACCEPTANCE OF THE OFFICE POLICIES OF TFCPC: We are committed to providing professional services of the highest quality and standards, and we consider it an honor to serve you. In order to provide our patients with the most efficient and responsible care, we require agreements be made to the policies stated above.

I have read and initialed the office policies of The Fort Christian Psychiatric Center (TFCPC) in their entirety. I understand them, I agree with them, and I will adhere to them. X_____

I have read and signed the Pearls of Wisdom of The Fort Christian Psychiatric Center (TFCPC) in their entirety. I understand them, I agree with them, and I will adhere to them. X_____

Signature of Patient/Guardian: _____
*This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney (POA).
Printed Name of Patient/Guardian: _____ Date: _____
(POA Signature (if applicable): _____ Date: _____)