peachtree psychiatric professionals, p.c.

peachtree DBT

Date: ___________________________ Referred By: ____

Which professional are you seeing today? ____

PATIENT INFORMATION FOR SKILLS CLASS/BOOTCAMP (MINOR)

Full Name: ____
First MI Last

Preferred Name: ______________________ **Age**: _______ **Date of Birth**: _________________ **Gender**: M / F

Address: ____
Street City State Zip

Patient's Phone: _____________________________ **Email**: ____
Circle: mobile / home / work

School Name: ______________________________________ **Grade**: _____ **Phone**: _________________________

School Counselor's Name: ____ **Phone**: _________________________

Psychiatrist's Name: ____ **Phone**: _________________________

☐ Check here if you would you like appointment reminders by ☐ email or ☐ text.
Phone number or email to receive appointment reminders: ____

I understand that by opting for appointment reminders, my information will not be used for any reason other than administrative purposes. I also understand that I am still responsible for my appointment and corresponding fees if I do not receive an appointment reminder. Standard texting fees by your mobile provider may incur.

PARENT/GUARDIAN INFORMATION

Parent/Guardian's Name: ____ **Relation**: _______________________

Phone: ______________________________________ **Secondary**: __________________________________

Email: ____
☐ Check here if you would like this email to be included in our mailing list. This will never be sold to third parties.

Parent/Guardian's Name: ____ **Relation**: _______________________

Phone: ______________________________________ **Secondary**: __________________________________

Email: ____
☐ Check here if you would like this email to be included in our mailing list. This will never be sold to third parties.

Emergency Contact (if someone other than patient's parent/guardian): ____

Relation: ___________________________________ **Phone**: ______________________________________

Who has legal medical custody of the patient? ____

If patient's legal guardians are adults other than the parents, or if parents are divorced and custody is "joint legal," appropriate documentation of guardianship and medical custody will be necessary before services are provided.

FINANCIAL GUARANTOR INFORMATION

Full Name: ____
First MI Last

Address: ____
Street City State Zip

Phone Number: ______________________ Date of Birth: __________________SSN: __________________

Employer: ____ Phone Number: ______________________

GUARANTOR AGREEMENT

This agreement will remain in effect until written notice of other payment arrangements are provided to Peachtree Psychiatric Professionals, P.C. The current guarantor will be responsible for any and all charges incurred prior to receipt of notification of other arrangements. If you wish to change your guarantor information, you must have the appointed guarantor complete a separate agreement with Peachtree Psychiatric Professionals, P.C. Change of guarantor forms are available upon request.

I, the undersigned, agree that I am financially responsible for all services provided by Peachtree Psychiatric Professionals, P.C. I am aware that 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 3% of the outstanding balance.

Guarantor Signature: ____ Date: __________________

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.

PARENT/GUARDIAN CONSENT FOR TREATMENT

I hereby certify that I have legal custody of the minor being treated and I am legally empowered to make medical decisions concerning him/her. I hereby give consent for the minor to be treated by the physicians and therapists employed by Peachtree Psychiatric Professionals, P.C. I authorize Peachtree Psychiatric Professionals, P.C. to provide information concerning the minor's treatment to any physician or therapist who referred me to Peachtree Psychiatric Professionals, P.C.

CUSTODY AGREEMENT

If the minor's parents are divorced and the custody is "joint legal," both parents must sign the consent for treatment; however, if the parents are divorced and only one parent signs the consent for treatment, a copy of the custody agreement must be provided to Peachtree Psychiatric Professionals, P.C. This agreement must reflect which parent obtains authority over medical decision making. In this case, the custody agreement must be provided at the initial appointment.

Parent/Guardian Signature: ____ Date: ___________________

Parent/Guardian Signature: ____ Date: ___________________

Both parents' signatures are required only if parents are divorced.

NOTICE OF PRIVACY PRACTICES
I acknowledge that I have read or been offered a copy of the Notice of Privacy Practices for the office of Peachtree Psychiatric Professionals, P.C.

OFFICE HOURS AND EMERGENCIES
Office hours are Monday through Friday 8:30am to 4:30pm. After hours, your calls will be forwarded to our answering service. If an emergency occurs after regular office hours, please call the emergency phone number provided by your therapist.

OFFICE PHONE POLICY
Please be aware that the therapists are seeing other patients throughout the day and may not be able to return your call immediately. When leaving a message for your therapist, please leave the best number at which you can be reached during both daytime and nighttime. Please be advised that this is for brief phone calls only and extensive phone calls must be scheduled in advance.

EXTENSIVE PHONE CALL POLICY
For extensive phone calls, you can schedule a phone appointment with your therapist. There is a routine charge for phone appointments based on the time spent on each phone call. Please be aware that there may be an additional charge for after-hour calls, except for life-threatening emergencies.

30 minutes: $85.00
60 minutes: $170.00

APPOINTMENT CHANGES AND CANCELLATIONS
Please understand that appointment times are reserved and appointments cancelled with **less than 24 business hours notice** will be charged the full service fee. If for any reason the therapist needs to cancel an appointment, you will be advised at the earliest possible time.

INSURANCE POLICY
Peachtree Psychiatric Professionals, P.C. is not a participating provider with any insurance companies. If your insurance policy provides out-of-network benefits, you may file your own claims for reimbursement. Our practice must inform all Medicare, Tri-Care, and Medicaid participants that we have opted out of these plans. Patients participating in these programs are not permitted to submit claims acquired by our practice to any of the above mentioned insurance providers for reimbursement.

TERMINATION OF TREATMENT
Patients are under no obligation to continue services should they decide to terminate at any time. We strongly urge that the therapist be notified in person regarding this decision so that it can be discussed openly and appropriate arrangements can be made.

I have read and understand the policies practiced by Peachtree Psychiatric Professionals, P.C.

Parent/Guardian Signature: ____ Date: ____________________

Please describe your level of concern with the following issues by using the scale below.

0	1	2	3	4	5	6	7	8	9	10
No Concern					*Moderate Concern*					*Extreme Concern*

______ Anger

______ Anxiety/Nervousness

______ Body Image

______ Depression

______ Difficulties Making Decisions

______ Eating Difficulties

______ Education/School

______ Family Discord

______ Fearfulness

______ Financial Problems

______ Impulsivity

______ Physical Problems

______ Problems with Parents

______ Problems with Social Relationships

______ Religious/Spiritual Concerns

______ Self-Harming

______ Sexual Concerns

______ Substance Use

______ Suicidal Thoughts

______ Unhappy Most of the Time

______ Work

______ Worry

Other Problem(s): ____

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