Peachtree Comprehensive Health

Date: _____ Referred By: _____

CHILD/ADOLESCENT PATIENT INFORMATION FOR SKILLS CLASS/BOOTCAMP

Full Name: _____
First MI Last

Preferred Name: _____ **Age**: _____ **Date of Birth**: _____

Gender: _____ **Pronouns:** _____ **Race/Ethnicity:** _____

Address: _____
Street City State Zip

Patient's Phone: _____ **Email**: _____

School Name: _____ **Grade**: _____ **Phone**: _____

School Counselor's Name: _____ **Phone**: _____

Psychiatrist/Therapist Name: _____ **Phone**: _____

Pharmacy 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 Comprehensive Health, 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 Comprehensive Health, 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 Comprehensive Health, 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 Comprehensive Health, P.C. I authorize Peachtree Comprehensive Health, P.C. to provide information concerning the minor's treatment to any physician or therapist who referred me to Peachtree Comprehensive Health, 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 Comprehensive Health, 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.

TERMINATION OF TREATMENT

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

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
Both parents' signatures are required if parents are divorced.

INSURANCE POLICY

Peachtree Comprehensive Health, 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.

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 Comprehensive Health, 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 inform the answering service and they will have the physician/therapist-on-call contact you.

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

PHYSICIAN APPOINTMENTS
When initiating medications, children need to be seen more frequently (every two weeks to every month depending on the medication). Once stabilized, children need to be monitored on a quarterly basis (every three months). On occasion, for an older adolescent, follow-up appointments may extend to six months.

FRONT OFFICE PHONE POLICY
Please be aware that physicians/therapists are seeing other patients throughout the day and may not be able to return your call immediately. When leaving a message for your physician/therapist, please provide the number at which you can be reached during both daytime and nighttime. Please be advised 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.

Physician	**Therapists**	**Therapists (EdD/PhD)**
5-10 minutes: $65	30 minutes: $87.00	30 minutes: $92.00/$100.00
11-20 minutes: $130	60 minutes: $174.00	60 minutes: $184.00/$200.00
21-31 minutes: $195		

FORMS AND LETTERS
If you need a form/letter completed during your appointment time, please let your physician/therapist know at the beginning of the session so that time is allowed to complete the paperwork. *There is no charge for forms/short letters that may be completed during your appointment time.* For other forms, letter, summaries of treatment, the amount charged will depend on time spent, ranging from $25 for a more basic letter to $50 for more complex letters.

Parent/Guardian Signature: _____ Date: _____

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): _____

_____

_____

_____

_____

_____

_____