

Date:	Refer	red By:			
A DI II T	DATHENIT INICODATA	FION FOR C	ZILLE CLAS	SS/BOOTCAMD	
	PATIENT INFORMAT			SS/BOOTCAMP	
Full Name:	First		MI La:		Last
Preferred Name:		Age:	Da	te of Birth:	
Gender:	Pronouns:		Race/Ethnicity:		
Address:	Street		Q'.	9	
			City	State	Zip
Primary Phone:	rcle: mobile / home / work	Secondary	Phone:	Circle: mobile / home	· / work
Email Address: Check h	nere if you would like this email	il to be included i	n our mailing lis	t. This will never be solo	l to third parties.
Psychiatrist/Therapist 1	Name:		Ph	one:	
Pharmacy Name:			Phone:		
☐ Check here if you would	d you like appointment remi	inders by \square em	ail or 🔲 text.		
Phone number or email to r	eceive appointment reminde	ers:			
	for appointment reminders, m hat I am still responsible for m reminder. Standard texting	iy appointment ar	nd corresponding	g fees if I do not receive	
	EMERGENCY C	CONTACT IN	FORMATIO)N	
Contact Name:			Re	lation:	
Phone:			<u></u>		
Contact Name:			Re	lation:	
Phone:					
I authorize Peachtree	Comprehensive Health, I reason to belie			y emergency contact	if there is
Patient Signature:				Date:	

FINANCIAL GUARANTOR INFORMATION

(if the person responsible for payment is not the patient)

Full Name:					
First	M		Last		
Address:		- CI	g		
Stree	et	City	State	Zip	
Phone Number:	Date of Birth:		SSN:		
Employer:		Phone Number:			
GUARANTOR AGREEMENT This agreement will remain in eff Peachtree Comprehensive Health incurred prior to receipt of notific information, you must have the agreement will remain in eff Comprehensive Health, P.C. Cha I, the undersigned, agreement Comprehensive Health, P.C. I am	Fect until written notice of oth , P.C. The current guarantor cation of other arrangements. ppointed guarantor complete nge of guarantor forms are a that I am financially response.	will be responsible If you wish to cha a separate agreeme vailable upon reque sible for all service	e for any and all chainge your guarantor ent with Peachtree est. s provided by Peach	rges htree	
that unpaid balances over 30 do	** *		· ·		
Guarantor Signature: This must be the signature of the person sa			Date:		
CONSENT FOR TREATMEN I have read the policies and under mental health professionals assoc responsible for ensuring that all c Comprehensive Health to provide referred me to Peachtree Compre	rstand and agree with them. I iated with Peachtree Compre harges for services rendered information concerning my	ehensive Health, P. are paid by myself	C. I agree that I am f. I authorize Peacht	personally ree	
TERMINATION OF TREATM Patients are under no obligation to urge that the physician/therapist to and appropriate arrangements car	o continue services should the notified in person regarding				
INSURANCE POLICY Peachtree Comprehensive Health insurance policy provides out-of- practice must inform all Medicare Patients participating in these pro above mentioned insurance provi Are you a Medicare Subscriber	network benefits, you may fire, Tri-Care, and Medicaid pargrams are not permitted to sudders for reimbursement. ? [] Yes [] No	lle your own claims rticipants that we h	s for reimbursement have opted out of the	t. Our ese plans.	
If yes, additional forms may need	to be signed.				
Patient/POA Signature:			Date:		

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.

PHYSICIAN APPOINTMENTS

When initiating medications, adult patients are often seen more frequently (every 1-2 weeks) and once stabilized, adult patients need to be monitored approximately everything three months. Over time with stabilized adult patients, appointments may extend to six months for medication monitoring.

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.

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.

Patient/POA Signature:	Date:	
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5 8 0 1 2 3 4 6 7 10 Extreme Concern No Concern Moderate Concern Physical Problems ____ Anger _____ Anxiety/Nervousness _____ Problems with Children **Problems with Parents** Body Image Depression Problems with Social Relationships Difficulties Making Decisions _____ Religious/Spiritual Concerns _____ Eating Difficulties _____ Self-Harming Education/School _____ Sexual Concerns _ Family Discord Substance Use Fearfulness _____ Suicidal Thoughts Financial Problems Unhappy Most of the Time _____ Impulsivity ____ Work _ Marital Concerns ____ Worry Other Problem(s):

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