peachtree psychiatric professionals, p.c.

peachtree DBT

Date: _____ Referred By: _____

Which professional are you seeing today? _____

## CHILD/ADOLESCENT REGISTRATION INFORMATION

**Full Name**: _____
First MI Last

**Preferred Name**: _____ **Age**: _____ **Date of Birth**: _____ **Gender**: M / F

**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 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.

### 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 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.

**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 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 |
| 11-20 minutes: $130 | 60 minutes: $174.00 | 60 minutes: $184.00 |
| 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: _____

**MEDICATION HISTORY**

**Medication Allergies:** *(Please list any known medication allergies.)*

_____

_____

_____

_____

**Current Medications:** *(Please list all current medications prescribed and over the counter.)*

_____

_____

_____

_____

**Previous Medications:** *(Please list all medications previously prescribed.)*

_____

_____

_____

_____

**MEDICATION REFILL POLICY FOR PSYCHIATRIC PATIENTS**

Part of providing quality care is monitoring medications safely in our patients. Our physicians make every effort during your appointment to provide enough medication refills to reach your next appointment. Once you have requested your last refill to your pharmacy, our physicians require you to schedule a follow-up appointment before the next refill. Therefore, you should schedule your follow-up appointment either at check out or during the month prior to your recommended appointment so that you do not run out of prescription medication.

Medication refills may be requested during regular office hours by calling the office or submitting a request through your pharmacy. Physicians will complete medication refill requests within 24-48 hours of the time the request is made. Prescriptions may only be called in for current patients who maintain their regularly scheduled appointments. *If requesting a stimulant (controlled medication) please call the office for more information. Stimulant medications require specific directions.* Please ensure you provide your name, date of birth, current pharmacy medication information, prescribed medication, and dosing instructions for the prescribed medication when requesting medication refills.

**Refills made from our office outside of regular appointments are subject to a $25.00 charge.**

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

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

**MEDICAL HISTORY**

Primary Physician: _____ Date of Last Physical Exam: _____

Describe any physical problems you are experiencing that require medication or physical care: _____

_____

_____

**Date of Last Menstruation:** _____ **Age of First Menstruation:** _____ **Regular?** Y / N

Describe any symptoms you experience with your menstruation: _____

_____

Number of pregnancies: _____ Describe any difficulties: _____

**Family Medical History:** *Please indicate if the patient or any biological relatives have been diagnosed with the following:*

| | | | Relation to Patient |
|---|---|---|---|
| Cardiovascular Disease: | ☐ Yes | ☐ No | _____ |
| Hypertension: | ☐ Yes | ☐ No | _____ |
| Thyroid Condition: | ☐ Yes | ☐ No | _____ |
| Cancer: | ☐ Yes | ☐ No | _____ |
| Psychiatric Hospitalization: | ☐ Yes | ☐ No | _____ |
| Suicide: | ☐ Yes | ☐ No | _____ |
| Depression: | ☐ Yes | ☐ No | _____ |
| Anxiety: | ☐ Yes | ☐ No | _____ |
| Bipolar Disorder: | ☐ Yes | ☐ No | _____ |
| ADD/ADHD: | ☐ Yes | ☐ No | _____ |
| Personality Disorder: | ☐ Yes | ☐ No | _____ |
| Addiction: | ☐ Yes | ☐ No | _____ |
| Eating Disorder: | ☐ Yes | ☐ No | _____ |

**DEVELOPMENTAL HISTORY**

Was the patient adopted? Y / N Describe any birth complications: _____

Were developmental milestones met within appropriate limits? Y / N

Describe any delays in development: _____

_____

_____

_____

_____

**PREVIOUS TREATMENT**
*Please list from the most recent.*

| Therapists: | Dates: | May we contact them? |
|---|---|---|
| _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | ☐ Yes ☐ No |

| Psychiatrists: | Dates: | |
|---|---|---|
| _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | ☐ Yes ☐ No |

| Psychiatric Hospitalizations: | Dates: | |
|---|---|---|
| _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | ☐ Yes ☐ No |

| Other Treatments: | Dates: | |
|---|---|---|
| _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | ☐ Yes ☐ No |

Please briefly describe the reason for your visit: _____

_____

_____

_____

_____

_____

_____

_____

**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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# CREDIT CARD AUTHORIZATION FORM

For my convenience, the undersigned does hereby authorize Peachtree Psychiatric Professionals, P.C. and/or Peachtree DBT to process the above credit card as "Signature on File" for psychiatric services.

## Process

Transactions executed will read "Signature on File" on the signature like of the credit card voucher. By executing this document, it will not be necessary for me to sign each and every credit card voucher. This authorization is valid until such time as written notice of revocation is received by Peachtree Psychiatric Professionals, P.C. and/or Peachtree DBT. Upon receipt of written notice of revocation, Peachtree Psychiatric Professionals, P.C. and/or Peachtree DBT will charge my credit card for any outstanding balances covered under this authorization form.

Patient Name: _____ Name of Doc./Therapist:_____

Please charge to the following credit card: **MasterCard Visa American Express Discover (circle)**

_____ _____ / _____

**Credit Card Number** **Expiration Date (mm/yy)**

_____**(Visa/MC) 3 digits imprinted at the end of card # in signature panel on the back.**
**Security ID # (American Express) 4 digits imprinted above the right end of the card # on the face.**

_____

**Name as it Appears on the Credit Card (PLEASE PRINT)**

_____

**Cardholders Billing Address as Listed with the Credit Card Company**

_____

**City/State/Zip**

_____

****Please list names of Individual(s) other than the card holder authorized to use this card. (PLEASE PRINT)***

**EMAIL** (to receive confirmation of payment):_____

**I have read this agreement and agree to the terms and conditions stated above.**

**Signature of Cardholder**_____ **Date:**_____