peachtree psychiatric professionals, p.c.

peachtree DBT

CHILD / ADOLESCENT REGISTRATION INFORMATION (please print)

Which professional are you seeing today? _____ Date:_____

PATIENT INFORMATION:

Patient Full Name:_____Age:_____ Sex: M / F
(First) (MI) (Last)

Address:_____City:_____State:_____ Zip:_____

Date of Birth:_____ Student? YES NO If yes, Full Time or Part Time

Home Phone:_____ Mobile Phone:_____ Pharmacy Phone:_____

Can we leave messages on voicemail? Yes / No Which Phone? Home / Mobile

School Name:_____ Phone number:_____

School Address/City/State/Zip Code:_____

Emergency Contact Person:_____ Phone number:_____

Pediatrician:_____ Phone number:_____ Referred By:_____

Please provide contact information for both parents.

Father's Name & Contact Info:_____

Mother's Name & Contact Info:_____

GUARANTOR INFORMATION:(IF NOT PATIENT) Relationship to Patient:_____

Full Name:_____
(First) (MI) (Last)

Address:_____City:_____State:_____Zip:_____

Date of Birth:_____(Sex: M / F) SSN:_____Phone number:_____

Employer's Name/Address:_____Phone number:_____

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.

Parent / Guardian 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.**

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 form's are available upon request.

*PARENT/ GUARDIAN CONSENT FOR TREATMENT:

I hereby certify that I have legal custody of the child / adolescent being treated and I am legally empowered to make medical decisions concerning him / her. I hereby give consent for the above child / adolescent to be treated by physicians and / or mental health professionals associated with Peachtree Psychiatric Professionals P.C. I agree that I am personally responsible for ensuring that all charges for services rendered are paid by myself. I authorize Peachtree Psychiatric Professionals, P.C. to provide information concerning the above child / adolescent's treatment to any physician or therapist who referred me to Peachtree Psychiatric Professionals, P.C.

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.

INSURANCE POLICY:

Our practice does not contract with any insurance companies. However, 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.**
Therefore, the following participants are not permitted to submit claims acquired by our practice to any of the above insurance providers for reimbursement.

*CUSTODY AGREEMENT:

If the parents are divorced and the custody is "joint legal," both parents will need to 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, custody agreement must be provided at the initial appointment.

Parent / Guardian Signature:_____ Date:_____

(2nd signature required only if parents are divorced)

Parent / Guardian Signature:_____ Date:_____

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TERMINATION OF TREATMENT:

Patients are under no obligation to continue services should they decide to terminate at anytime. However, we strongly urge that the therapist / doctor be notified in person regarding this decision so that it can be discussed openly.

OFFICE HOURS AND EMERENCIES:

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 your physician or physician-on-call contact you.

APPOINTMENT CHANGES/CANCELLATIONS

Please understand that appointment times are reserved and that appointments cancelled with less than 24 hours notice are charged at the full fee. After hours, you may leave a notice of cancellation with our answering services as well. If for any other reason the therapist must cancel an appointment, the patient will be advised at the earliest possible time.

OFFICE PHONE POLICY:

Please be aware that our physicians and therapists are seeing patients during regular business hours and may not be able to return your call until a later time. When leaving a message for your physician or therapist, please leave both daytime and evening telephone numbers. Please be advised that this is for brief phone calls only. You MUST schedule an appointment for extensive phone calls.

EXTENSIVE PHONE CALL POLICY:

For extensive phone calls, you may call the office and schedule a phone appointment with your physician or therapist. There will be 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.

*Fees for Extensive Phone Calls:

(Charges may very with each physician/therapist)

15 minutes: $50.00
30 minutes: $150.00
60 minutes: $225.00

Parent/ Gaurdian Signature:_____Date:_____

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MEDICATION REFILL POLICY:

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. However, we are aware that emergencies may arise and appointments may have to be scheduled for a later date. In these situations please refer to the following policy listed below.

*Medication refills may be requested during regular office hours by calling the office or submitting a request through your pharmacy. Physicians will complete medication request within **24-48 hours** of the time the request is made. If requesting a stimulant (controlled medication) please call the office for more information. Stimulant medications require specific directions. Please be advised, there may be a charge between **$10.00-$25.00** for a refill.
*Prescriptions may only be called in for current patient who maintain their regularly scheduled appointments. For your safety, medications refills will not be called in over to your medication supply to ensure physicians ample amount of time to complete each medication request. Feel free to call our office with any questions or concerns about the following medication policy.

MEDICATION HISTORY

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

_____
_____
_____

Current Medications: (Please list all current medications.)

_____
_____
_____
_____
_____

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