peachtree psychiatric professionals, p.c.

peachtree DBT

Date: _____ Referred By: _____

Which professional are you seeing today? _____

PATIENT INFORMATION FOR THERAPY APPOINTMENT (ADULT)

Full Name: _____
First MI Last

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

Address: _____
Street City State Zip

Primary Phone: _____ **Secondary Phone**: _____
Circle: mobile / home / work Circle: mobile / home / work

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

Employer: _____ **Phone**: _____

Psychiatrist: _____ **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.

EMERGENCY CONTACT INFORMATION

Contact Name: _____ **Phone**: _____

Relation: _____

Contact Name: _____ **Phone**: _____

Relation: _____

I authorize Peachtree Psychiatric Professionals, P.C. to communicate with my emergency contact if there is reason to believe my well-being is at risk.

Patient Signature: _____ Date: _____

FINANCIAL GUARANTOR INFORMATION

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

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.

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.

Patient Signature: _____ Date: _____

MEDICAL HISTORY

Primary Physician: _____ Date of Last Physical Exam: _____

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

_____

Current Medications:

_____ _____ _____

_____ _____ _____

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 rate 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

_____ Marital Concerns

_____ Physical Problems

_____ Problems with Children

_____ 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): _____

_____

_____

_____