

Date: _____ Referred By: _____

Which professional are you seeing today? _____

PATIENT INFORMATION FOR THERAPY APPOINTMENT (MINOR)

Full Name: _____
First MI Last

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

Address: _____
Street City State Zip

Patient's Phone: _____ **Email:** _____
Circle: mobile / home / work

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

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

Psychiatrist's 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.

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.

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: _____

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:*

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relation to Patient
Cardiovascular Disease:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hypertension:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Thyroid Condition:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Psychiatric Hospitalization:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Suicide:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Depression:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anxiety:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bipolar Disorder:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
ADD/ADHD:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Personality Disorder:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Addiction:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Eating Disorder:	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: _____
