

Date: _____ Referred By: _____

Which professional are you seeing today? _____

ADULT REGISTRATION INFORMATION

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/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.

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Relation: _____

Phone: _____

Contact Name: _____ Relation: _____

Phone: _____

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.

CONSENT FOR TREATMENT

I have read the policies and understand and agree with them. I hereby agree to be treatment 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 to provide information concerning my treatment to any physician or therapist who referred me to Peachtree Psychiatric Professionals.

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.

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.

Are you a Medicare Subscriber? [] Yes [] No

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 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.

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 every 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

5-10 minutes: \$65
11-20 minutes: \$130
21-31 minutes: \$195

Therapists

30 minutes: \$87.00
60 minutes: \$174.00

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: _____

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.

Patient/POA 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:*

	<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: _____
