

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.

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

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.

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:*

	<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: _____
