

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: _____

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

Therapists (EdD/PhD)

30 minutes: \$92.00
60 minutes: \$184.00

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: _____

CREDIT CARD AUTHORIZATION FORM

For my convenience, the undersigned does hereby authorize Peachtree Psychiatric Professionals, P.C. and/or Peachtree DBT to process the above credit card as "Signature on File" for psychiatric services.

Process

Transactions executed will read "Signature on File" on the signature like of the credit card voucher. By executing this document, it will not be necessary for me to sign each and every credit card voucher. This authorization is valid until such time as written notice of revocation is received by Peachtree Psychiatric Professionals, P.C. and/or Peachtree DBT. Upon receipt of written notice of revocation, Peachtree Psychiatric Professionals, P.C. and/or Peachtree DBT will charge my credit card for any outstanding balances covered under this authorization form.

Patient Name: _____ Name of Doc./Therapist: _____

Please charge to the following credit card: MasterCard Visa American Express Discover (circle)	
_____	_____ / _____
Credit Card Number	Expiration Date (mm/yy)
_____ (Visa/MC) 3 digits imprinted at the end of card # in signature panel on the back.	
Security ID # (American Express) 4 digits imprinted above the right end of the card # on the face.	

Name as it Appears on the Credit Card (PLEASE PRINT)	

Cardholders Billing Address as Listed with the Credit Card Company	

City/State/Zip	

**Please list names of Individual(s) other than the card holder authorized to use this card. (PLEASE PRINT)	

EMAIL (to receive confirmation of payment): _____	
I have read this agreement and agree to the terms and conditions stated above.	
Signature of Cardholder _____	Date: _____