Peachtree Comprehensive Health
TEL 404.351.2008 FAX 404.351.0243 WEB PCHPROFESSIONALS.COM

Date: _____ Referred By: _____

Which professional are you seeing today? _____

## ADULT REGISTRATION INFORMATION

**Full Name**: _____
First MI Last

**Preferred Name**: _____ **Age**: _____ **Date of Birth**: _____

**Gender Identity**: _____ **Pronouns:** _____ **Race/Ethnicity:** _____

**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 Comprehensive Health, 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 Comprehensive Health, 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 Comprehensive Health, 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 Comprehensive Health, 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 treated by physicians and/or mental health professionals associated with Peachtree Comprehensive Health, P.C. I agree that I am personally responsible for ensuring that all charges for services rendered are paid by myself. I authorize Peachtree Comprehensive Health to provide information concerning my treatment to any physician or therapist who referred me to Peachtree Comprehensive Health.

### 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 Comprehensive Health, 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 Comprehensive Health, P.C.

**OFFICE HOURS AND EMERGENCIES**
Front office hours are Monday through Thursday 8:30am to 4:30pm; Friday 8:30am to 2:00pm. 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 FEES**

**New Patients (MD)**
Adults: $500
Adolescents: $550

**New Patients (Therapy)**
Based on the clinician's 45min rate

**Physicians (MD)**
20min session (99212 + 90833): $210
45min session (99213 + 90836): $350
Med Refill (outside of appt): $25

**Therapist (LPC, LCSW)**
20min session (90832): $93
45min session (90834): $185

**DBT Certified Clinician**
20min session (90832 cert): $98
45min session (90834 cert): $195

**Clinical Psychologist (PhD)**
20min session (90832 PhD): $108
45min session (90834 PhD): $215

**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 canceled 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 should be scheduled as telehealth appointments per our regular fee schedule.**

**PHONE CALL POLICY**
There is no fee for phone calls under five minutes. Phone calls between 5-10 minutes will be billed as below. **Extensive phone calls (over 10 minutes) will be billed at our normal appointment rate.** Please be aware that there may be an additional charge for after-hour calls, except for life-threatening emergencies.

**Physician (MD)**
5-10 minutes: $75

**Therapists (LCSW, LPC, PhD, PsyD)**
5-10 minutes: $50

**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: _____

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 patient portal. Please do not request refills through your pharmacy. Physicians will complete medication refill requests within 24-48 hours of the time the request is made. **Refills made outside of your scheduled appointment will result in a $25.00 charge.**

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.

*I have read and understand the policies practiced by Peachtree Comprehensive Health, 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:*

| | | | 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: _____

_____

**CULTURAL FACTORS:** Are there any cultural factors for your provider to be aware of? (e.g., sexual orientation, faith/religious/spiritual background, socioeconomic status, family/relationship structure, national origin, language, [dis]ability status)

_____

_____

_____

**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): _____

_____

_____

_____

_____

_____

_____

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# Telehealth Consent

Peachtree Comprehensive Health offers telehealth to increase access to services and to maintain care if in person meetings between clients and providers are deemed unsafe by public health agencies. Telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations. This service may be provided over the phone or through videoconferencing. All new patients must be available to meet with their therapist in person. Access to telehealth services will be determined by your provider, except in the event of a public health emergency. We are asking for this consent to be signed by all patients in the event of future public health emergencies.

When scheduling a telehealth appointment, we will ask you for your phone number and your email. If you are scheduling a video appointment, you will be sent an email with the log-in procedures. We utilize an encrypted HIPAA compliant version of Zoom to conduct telehealth sessions.

All PCH clinicians have met the state requirements to provide telehealth, and all are licensed to practice in their respective fields. However, there are risks associated with telehealth, including possible breach of confidentiality, lack of some sensory input and non-verbal cues, technology failure, increased difficulty of managing an emergency, and that its efficacy is not as well established by rigorous research compared to services provided in-person. Therefore, it is always our preference to have in-person appointments.

If the technology application being used for telehealth fails, both the provider and the client should make every effort to contact each other to resume the appointment. Optimally the technology issue is resolved but it may be necessary to use alternative means, such as by phone, or to reschedule the appointment if that is clinically appropriate.

We require that you provide us with contact information for a support person that lives with you or close to you and who could assist in an emergency. We also require that you pick one main location and one alternate location that will be used for all your appointments. You must provide us with these addresses so that we can assist appropriately in an emergency. Your location will be confirmed by your provider at the beginning of each appointment. If you are not in the location specified on this consent form, your appointment may need to be rescheduled and a missed appointment fee incurred.

Patient Name: _____

Contact information to be used for telehealth calls:

Phone: _____ Email: _____

My support person is:

Name: _____

Phone: _____

Primary address where you will be for your appointments:

_____

Alternate address (if applicable):

_____

Please read through the information below and sign at the bottom of the page to acknowledge that you have read this material in its entirety and consent to receiving telehealth services, when deemed appropriate, with a provider at PCH.

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telehealth including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am experiencing suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and in person meetings or a higher level of care is required.

6) I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, your provider will contact you to discuss next steps.

*I understand the above information and I have reviewed the notice of privacy practices. I provide my consent for Peachtree Comprehensive Health to provide mental health services to me via telehealth. I will conduct my appointments from the same location every time and I will follow the attached instructions provided.*

Patient (or guardian) 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.*

# Telehealth Patient Instructions

Prior to your first appointment, you will need:

- A computer or laptop that has internet access and an operating system with the latest security updates installed., If you have a PC, ensure that the firewall is active and that your anti-virus software is updated. A computer or laptop is preferable to a phone, although a phone may also be used if necessary.
- A computer camera that provides an adequate view of you and a microphone that will allow your provider to hear you well. Most microphones embedded into computers or phones are sufficient. Headphones are optional.
- A secure internet network with which to have your appointments.
- You will need to download and install Zoom if this is the platform being utilized. Zoom also has a browser plug-in if you prefer. If using Doxy.me, there is no download necessary. Your provider will specify which platform is to be used.
- Please familiarize yourself with how to use the software, camera, and microphone prior to your first appointment.

The telehealth session should, as much as possible, replicate the environment of an in-office session. Therefore for each appointment you must:

- Have the computer and software program ready to go at the time of your appointment.
- Maintain a quiet, private, well-lit space that is free of distractions.
- Be in the same location for every appointment.
- Confirm your location with your provider at each appointment.
- Ensure the camera is set such that it provides an adequate view to assess you as above.
- Ensure the microphone is set such that it allows the provider to hear you well as above.
- Ensure that the volume is set such that you can hear the provider well and consider using the earphones if needed.
- Have your primary phone available in case of technology failure so that phone contact can be
- made with your provider.
- Reach out 24 business hours or more in advance for any cancellations.
- For any child under the age of 18, a parent must be available for their session during the designated time, to join the session if needed.
- Sessions should not be held from a car.

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# CREDIT CARD AUTHORIZATION FORM

For my convenience, the undersigned does hereby authorize Peachtree Comprehensive Health, P.C. 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 Comprehensive Health, P.C. Upon receipt of written notice of revocation, Peachtree Comprehensive Health, P.C. will charge my credit card for any outstanding balances covered under this authorization form.

Patient Name: _____ Name of Provider: _____

Please charge to the following credit card *(circle one)*: ☐ **MasterCard** ☐ **Visa** ☐ **American Express** ☐ **Discover**

_____ _____ / _____
**Credit Card Number** **Expiration Date (mm/yy)**

_____**(Visa/MC) 3 digits imprinted at the end of card # in the 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)**

_____
**Cardholder's 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:**_____