VALDOSTA PSYCHIATRIC ASSOCIATES, LLC

3541 North Crossing Circle Valdosta, GA 31602 229-244-4200

In order to shorten your wait, please return the following to our office ONE WEEK PRIOR to your appointment: If paperwork is not received, your appointment may be cancelled or rescheduled.

- **Completed and signed enclosed forms**
- **A copy of your insurance card and/or authorization for your appointment**
- **Medication list and doctor notes or old mental health records**
- **To protect identity theft, we require a government issued photo ID upon check in**

COMMITMENT TO CARE

Our office is dedicated to providing our patients with the highest quality mental health care. Every decision and every action by our staff is aimed at this goal. We are here to help answer any questions you may have or direct your questions to the appropriate party. By following the guidelines below, we hope to answer some of your questions up front.

***Our office hours are Monday through Thursday from 8:00 a.m. to 6:00 p.m. and Fridays from 8:00 a.m. til noon. Our phone lines are open from 9 a.m. to 5 p.m. If you have an emergency situation during normal business hours, please call our office first and explain the problem to our staff. If the office is closed, go to the emergency room at South Georgia Medical Center, Greenleaf Center, or hang up and dial 911 or GA Crisis Access Line at: 800-715-4225.

We file all insurance plans. We do check benefits prior to your checkout and **require a copy of your insurance card prior to your appointment. Please bring a photo ID and copy of your insurance card to scan into your electronic chart.** We will give you an ***estimate of your cost for the visit upon request; however, **this is an estimate and not a guarantee of payment** and any amount unpaid by the insurance will be your responsibility. Patients are **required to pay any copayment and/or deductible at the time of service** unless prior arrangements are made. If, for any reason, your insurance company cannot be contacted or will not give us the necessary information, you will be asked to pay the bill and we will file your insurance for you. If your insurance company does not pay within 60 days, we will ask you to pay. ***Please make sure to check with your insurance and notify us if you require authorization prior to treatment.*** We accept checks, money orders, cash, debit cards, VISA, MasterCard, American Express, and Discover. Fees are due at the time of service. A **$30.00** service charge will be added to your account for all returned checks. You will be responsible for a minimum **$50** collection fee or percentage of the balance if the account is turned over to collections for non-payment.

***Due to the time involved for our medical providers and clerical staff, it is necessary to charge for ALL forms and letters. This is to be paid in advance and is not billed to your insurance. The cost for drafting letters and completing forms is $50.00 each. (We no longer fill out disability paperwork)

***Because of limited seating, we ask that you not bring anyone with you unless they will be seeing your provider or are required to assist you with transportation. Due to the nature of the practice, please **DO NOT BRING CHILDREN THAT ARE NOT HERE TO BE SEEN.** We ask that you keep children quiet and not allow them to run around the lobby as a courtesy to our patients with severe anxiety. Please do not lie on the furniture or allow children to climb on the furniture

***If you cannot keep a scheduled appointment, give as much notice as possible. Failure to show up for an appointment or failure to cancel your appointment timely (within 24 hours) will be charged a no show fee of $50. These charges are not billed to your insurance company. Charges for missed appointments are at the discretion of each provider.

***Counseling and treatment can be filed on your insurance. The amount of information your insurance company requires depends upon your insurance contract. A legal matter is completely different. Different procedures must be adhered to and different rates apply. Please inform us **NOW** if you know your situation involves legal matters, or if the Department of Family and Children Services are involved.

*****Continued on Back*****

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Patient Initials

***When calling to speak your doctor or therapist, the staff has been instructed to take a message (except in case of an emergency). Be prepared to explain your question or request to the staff so that it can be relayed to the provider. The provider will instruct the staff on how to answer your questions or they will return your call once they are finished with their patients. Please leave a telephone number where you can be reached.

***Your doctor may give you a prescription the day you are here. We now participate with e-prescribing and your prescription may be sent electronically to your pharmacy. It is important for you to notify us if you change pharmacies. You will not be given another prescription without seeing the doctor again. For your protection, we do not fax or mail prescriptions. Take your medication as directed and keep up with the quantity. Be certain you have enough to last until your next appointment. At times our office may call to reschedule an appointment because your doctor has an emergency. If we should call you, check your medications to be sure you have enough to last until the date you return. Your medication is important. It may take up to 24 hours to get your prescription refilled (longer on Fridays).

***After your initial visit with the doctor, you will be scheduled for follow up with your doctor to refill your medications and discuss any concerns about your medications that you may have. In addition, you may be scheduled to see one of our therapists for counseling. The therapist will meet with you for approximately 45 to 60 minutes for counseling and to discuss your treatment progress.

***We do our very best to keep your appointment on time; however, emergency situations arise that are unavoidable. We ask that you be patient and respect the fact we treat emergencies before regular appointments. We will notify you of any delays in scheduling; however, if you have been waiting longer than 15 minutes, we ask that you check with the receptionist to make sure we have not overlooked your appointment. You will be offered another appointment at the earliest time available if you cannot wait to be seen.

***If you are late for your appointment, you may have to be rescheduled. Late arrivals will be rescheduled. You may be charged for a late cancellation of $50 if this occurs. You will be responsible for any charges that the insurance company will not cover regarding a late arrival, late cancellation, or missed appointment.

***<u>**ALL MINORS MUST BE ACCOMPANIED BY A BIOLOGICAL PARENT**</u> We cannot prescribe medications or initiate treatment without a parent or <u>legal</u> guardian present. Legal guardians must provide proof of guardianship in order for us to treat the child without a biological parent present.

***We do not participate with discount drug programs. Your doctor may give you a written prescription. **<u>IF</u>** we have samples, the doctor may try you on a sample and evaluate the response prior to giving you a prescription. But, we do not always have samples. We regret that we cannot furnish all of the medications that our patients need. If you are in a situation that you cannot afford your medication, DO NOT STOP TAKING YOUR MEDICATION! Look and ask until you find assistance. Listed are some options that we know of:

- You can be seen at Behavioral Health Services (Community Mental Health). Your visit and medication are based on your ability to pay
- Talk to your pharmacist. Ask if they know of a program that you might qualify for.
- Call your local Dept. of Family and Children Services and ask if they have a program to help you

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I have read <u>ALL</u> of the above policies or had the above policies read to me on page 1 and 2 of this form. I understand them, agree to them, and consent to treatment at Valdosta Psychiatric Associates.

Patient Name:_____ Date:_____

Date of Birth:_____ Social Security Number:_____

_____

Signature of Patient or Guardian Relationship

Valdosta Psychiatric Associates, LLC

Male
Female **Patient Name**:_____
First Middle Last

Date of Birth_____ **Social Security Number**_____ **Marital Status**_____

Street Address_____
City State Zip Code

Home Phone_____ **Cell Phone** _____

Employer_____ **Work Phone** _____

Email Address

If Patient is a minor, do you have legal custody? If divorced, has either parent had parental rights terminated?

Legal Guardian's Name_____ Relationship to Patient_____

Legal Guardian's Social Security Number_____ Guardian's Date of Birth_____

Is Patient a Full-Time Student? Yes No School_____

******A Parent of Legal Guardian must accompany minor children when seeing the physician. Medications WILL NOT be dispensed without a parent or legal guardian present. Legal Guardians must provide proof of guardianship ******

Emergency Contact_____ **Phone**_____

Emergency Contact Address_____

Relationship to Patient

Insurance Company_____ **Policy Holder Name:**_____
(Name as it appears on the insurance card)

Insurance Address_____ **Phone**_____

Policy/Subscriber Number_____ **Group Number:**_____

Policy Holder SSN: **Policy Holder Date of Birth:**

I request that payment and benefits be made on my behalf to Valdosta Psychiatric Associates, LLC for any services furnished to me by the physicians or therapist. I understand that my signature also authorizes release, if necessary, of any medical, HIV, psychiatric and substance abuse information contained in my records to my insurance or its assignees. I request and authorize treatment at Valdosta Psychiatric Associates, LLC. I understand I am responsible for any deductible, co-payment or any amount not covered by my insurance. I understand that Valdosta Psychiatric Associates LLC turns delinquent accounts over to a third party collector, and I will be responsible for the physician fees, and a $50.00 collection fee. Monthly finance charges may be added to all accounts over 60 days old. A fee of $30.00 (thirty) dollars will be charged for any returned checks.

_____ _____
Signature of Patient or Legal Guardian (Relationship) Date

Who referred you to our office?_____

Have you ever had treatment for a mental or nervous condition before? Yes No

Where were you treated before?_____ **When**_____

Has anyone in your family ever been treated for a mental or nervous condition before? Yes No

Mother Father Brother/Sister Children Grandparents Other

Are you allergic to any medications or ever had an adverse reaction to any medications? Yes No

Please list drug allergies _____

Do you smoke? Yes No (How many packs per day?_____)

Do you drink alcohol? Yes No (How many alcoholic drinks do you consume per week?_____)

Are you involved in an investigation by the Department of Family/Children Services? Yes No

Are you involved in any legal actions or lawsuits? Yes No

Attorney's Name:_____ **Type of Suit**_____
(Divorce, Disability, Motor Vehicle Accident, Workers Comp, Other)

Are you involved in a worker's compensation claim? Yes No

What is your main complaint?_____

_____

How long has this been occurring?_____

List any Medical Condition you are being treated for _____

_____

Are you experiencing any of the following:

Depressed Mood	Relationship/Family Problems	General Stress	Anxiety or Worry
Problems at work	Physical Health Problems	Grief or Loss	Substance Abuse Problems
Nervousness	Inability to Sleep	Panic Attacks	No Interest in Things
Problems at School	Problems with Peers		

Patient Signature:_____ **Date:**_____

To protect identity theft, we require government issued photo identification upon check-in.

NAME: _____ DATE: _____
ADDRESS:_____
PHONE: _____ □ Cell □ Home □ Work
DOB: _____ Age: _____
What Pharmacy do you Use? _____ Street/City_____
Who is your Primary Care Physician? _____

Are you involved in an investigation or legal case currently? □ Yes □ No
Type of Suit:

□ Divorce □ Worker's Comp □ Child Custody □ Professional Board
□ Department of Family/Children Services □ Motor Vehicle □ Other _____

Name of Attorney: _____ **Phone**: _____

CONSENT FOR COMMUNICATIONS

You have the right to request that we restrict how protected health information about you is used or disclosed. Most patients have family members and friends that occasionally become involved in their care. (For example, your spouse calls to confirm your appointment time; OR your adult child calls with questions about your medications.) Please list any restrictions to the information you have regarding how we can communicate with those you have listed below. (Example: Appointments only, financial matters only; Medications Only, etc. If there are no restrictions, please list "NONE" beside their name

Please list below any persons you will allow us to talk with about you. ***(If you prefer we do not speak with anyone, please write "NO ONE" across this section.***

Name	Relationship to you	Phone Number	Restrictions (See instructions below)

How would you like us to communicate with you?
□ Cell Phone #_____ Okay to leave voicemail? □ Yes □ No
□ Home Phone #_____ Okay to leave message on answering machine? □ Yes □ No
□ Mail (Address_____)
□ Email _____@_____

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the manner listed above and authorize Valdosta Psychiatric Associates staff to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information and/or Psychotherapy Information.

_____ Date_____

_____
Signature of Patient/Legal Guardian (Minors 12-17 must sign also)

VALDOSTA PSYCHIATRIC ASSOCIATES, LLC

PATIENT BILL OF RIGHTS

Patient Rights

I have the right to efficient and effective care individualized to my needs. My treatment provider will work with me to develop a treatment plan best suited for me. We will use this plan to help us deal with my problems as quickly and effectively as possible. I have the right to refuse treatment or discontinue treatment.

I have the right to be treated with dignity and respect. I will be treated with respect at all times. I will report any misconduct by my treatment provider including social invitations, suggestive remarks or unwanted touching to the appropriate state agency. I will report any complaints regarding the clerical staff to my doctor/therapist or office manager.

My treatment provider will make every effort to meet with me at our scheduled appointment time. If my treatment provider is late, he or she will extend our session, if I am willing, or we will make other arrangements by mutual agreement.

I have the right to privacy and confidentiality. All records and communications about me will be treated confidentially in compliance with applicable state and federal laws. These laws may obligate my treatment provider to report suspected abuse, neglect, or domestic violence and those who pose a danger to themselves or others.

Patient Responsibilities

Scheduled appointments are commitments. I will make every effort to be on time for my appointments. If I am late for my appointment, I understand that the appointment may be rescheduled and I will be responsible for any cost of a late cancellation. If I miss an appointment and do not notify my provider at least 24 hours in advance, I understand I may be charged a missed appointment fee of $50.00.

I am responsible to pay for services received. I am aware my insurance plan typically requires me to pay a co-pay or percentage of my treatment fee at the time services are provided. My insurance plan may also have a deductible that is my responsibility. Additionally, certain services may be limited and/or not covered at all by my insurance plan. I understand I am financially responsible for all co-pays, co-insurance amounts, deductibles and all services not covered by my insurance plan. My provider, the office staff, and my insurance plan's representative will help me determine what services my plan covers.

My health is my responsibility. I will contact my treatment provider for any serious situation that arises, even if after normal office hours. I will work with my provider to achieve my treatment goals and will advise my provider of any changes in my condition. I understand that I am responsible for determining if I need authorization prior to my visit and will notify the office if that is needed prior to treatment. If I fail to obtain authorization needed before the visit, I understand I am responsible for the cost of the visit.

I have read or had read to me the above list of Rights and Responsibilities.
I understand them and agree to them.

Patient Name:_____ Date:_____

Date of Birth:_____ Social Security Number:_____

_____

Signature of Patient or Guardian Relationship

CONSENT FOR SECURE COMMUNICATION

Secure and private communication cannot be guaranteed fully with the use of non-secure technology such as cell/smart phones, regular email, or via our website. It is your right to decide whether using this type of non-secure technology may be permitted and under what circumstances. Should you choose to contact Dr. Morgan or your therapist using any type of non-secure technology, it will be considered implied consent (with your permission) that we respond and return messages in the same non-secure manner. In the event that you choose not to allow non-secure modes of communication, we will only be able to contact you on a "home" (land-line phone, wire-to-wire fax, or US Postal Service mail.

I request that all communications (by telephone, mail or otherwise) by Valdosta Psychiatric Associates and/or its staff be handled in the following manner:

For Written Communication, Please communicate to the following address: (please be aware we must have some way to send statements for services or you will be required to pay at the time of service)

_____
_____ (Address)
_____

For Oral Communication, please call the following number:_____

Is the number listed above: □ Home □ Cell □ Work phone □ Other

May we leave a message? Yes No □

Please list any alternate number we may reach you at: _____

I permit communications via: (Check all that apply)

□Text □ Email □ Fax □ Cell Phone □ Video Conferencing/Skype

I understand that I have the right to revoke this authorization ***in writing*** at any time. I request that my confidential information be handled in the following manner and authorize Valdosta Psychiatric Associates staff to communicate to me in the manner stated above. Any other release of information will require a signed authorization for Release of Medical Information or Release of Psychotherapy Notes.

Printed Name of Patient: _____ Date _____

_____
Signature of Patient /Legal Guardian (Relationship to Patient)

SOCIAL MEDIA POLICY – VALDOSTA PSYCHIATRIC ASSOCIATES, LLC

3541 North Crossing Circle, Valdosta, GA 31602
(229) 244-4200

This document outlines our office policy related to the use of Social Media. Please read it carefully to understand how our licensed mental health professionals conduct themselves on the Internet and how you can expect a response to interactions that may occur between you and your doctor, nurse, or therapist using social media or technology. If you have any questions about anything in this policy, please bring it up at your visit. As new technology develops, this policy may be updated to reflect those changes and you will be notified in writing. You may obtain a copy of this policy upon request.

Our primary concern is your privacy and maintaining a professional therapeutic relationship with our patients.

EMAILS, CELL PHONES, FAXES, MOBILE DEVICES

Secure and private communication cannot be guaranteed fully with the use of non-secure technology such as cell/smart phones, mobile devices, tablets, regular email, or via our website. It is your right to decide whether using this type of non-secure technology may be permitted and under what circumstances. Should you choose to contact Dr. Morgan or your therapist using any type of non-secure technology, it will be considered ***implied consent*** (with your permission) that we respond and return messages in the same non-secure manner, and you agree to take the risk that such communication may be intercepted.

Please be advised that although it is a convenient way to communicate, it is very important that you are aware that computers, email, and cell phones including text messaging without encryption can be accessed by unauthorized people. Some risks include: conversations being overheard; emails can be sent to the wrong recipient; pop-up messages on your cell phone may be viewed by others, and notification services may alert others of your location. Service providers retain a log of all emails and though it is unlikely someone will look at these logs, they can be read by system administers of the internet service provider. Valdosta Psychiatric Associates does not use encryption in our email system, therefore, should you choose to contact us via email, and we ask that you limit your communication to administrative issues only, such as changing appointments or billing questions to protect your privacy. Our fax is secure, and if you need to communicate clinical information, we ask you do so by faxing us at 229-244-4995. If you communicate confidential or private information via text or email, we assume you have made an informed decision and will view this as an agreement to take the risk and will honor your desire to communicate on such matters. We will not initiate contact via text or email without your consent or as stated above.

NEVER USE EMAIL, TEXT OR FAX FOR EMERGENCIES. Emails or faxes may not be checked daily. Due to computer network problems, emails may not be delivered or there may be a disruption in connection. In the event of emergency, please call 911.

SOCIAL MEDIA NETWORKING SITES

Networking sites such as Facebook Twitter, or LinkedIn are NOT secure. It could compromise your confidentiality to use Wall posts, replies, or others means of engaging in conversations on these sites. Exchanges on social networking sites can become part of your legal medical record. This policy serves to notify you that being linked as friends or contacts on these sites can compromise your confidentiality, privacy, and the therapeutic relationship. As in any other public context, you have control over your own description regarding the nature of your acquaintances. If you choose to disclose information regarding your relationship with one of our clinical professionals, you acknowledge that you understand and accept the risk associated with using social networking. We do not accept friend requests from former or current patients to protect your privacy and maintain a professional boundary in the therapeutic relationship.

_____

Initial Above that you have and understand items contained on this page

LOCATION BASED SERVICES

If you use location-based services on your cell mobile device, you may compromise your privacy while attending sessions in the office. We do not list the practice as a check-in location on various sites such as Foursquare, however, it may be found as a Google location and if you have passive Location Based Services enabled, it may show that you are at the location regularly and others may surmise you are in treatment at Valdosta Psychiatric Associates. Please ask your service provider if you are unware of how to disable this setting.

WEBSITE

Our website **www.vpavaldosta.com** is for general information purposes only and should not be used as a substitute for your mental health care. Although we have a contact us link, please note that the webpage is not a secure means of communicating clinical information and should be limited to non-clinical questions.

SEARCH ENGINES

It is not a regular part of our practice to search for patients on Google, Facebook other search engines. Extremely rare exceptions may be made during times of crisis (in the event the doctor or therapist feel you are a danger to yourself or others) and all other means to contact you have been exhausted, a search engine may be used to ensure your welfare. If this occurs, this will be fully documented in the clinical record and discussed with you at your next visit.

FOLLOWING

Our licensed professionals will not follow any client on Twitter, Instagram, blogs or other apps/websites. If there is content you wish to share from your online life, please bring it into the session where it can be explored together. If you follow any of our licensed therapist's blogs, be aware that your privacy may be compromised if you use an easily recognizable name.

BUSINESS REVIEW SITES

You may find our psychiatry and psychotherapy services on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their provider and add reviews or comments. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please be aware that a listing for Valdosta Psychiatric Associates is NOT a request for a testimonial, rating, or endorsement from you as a patient. You have the right to express yourself on any site, but due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative. You are urged to take your privacy as seriously as we take our commitment to your confidentiality. You should also be aware that if you use these sites to communicate with one of our professionals, there is a good possibility it will never been seen. If you choose to write something on a business review site, keep in mind that you may be sharing personally revealing information in a public forum.

ACKNOWLEEMENT OF REVIEW OF SOCIAL MEDIAL POLICY

By signing below, you are indicating that you have read this document (both pages), understand your rights as a client/patient, and accept the responsibility as stated. You may request a printed copy of the Social Media Policy, and all questions regarding these policies have been answered to your satisfaction.

Printed Name of Patient:_____ Date:_____

Signature of Patient/Legal Representative:

_____

NOTICE OF PRIVACY PRACTICES

THIS PRIVACY NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES:

Treatment: Our Staff members may disclose your health information to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, laboratory test results and treatment will be available in your medical record to all health professionals who may provide treatment or who may be consulted to treat you.

Payment: Your health information may be used to seek payment from your insurance plan or from other sources such as credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the service provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Valdosta Psychiatric Associates. For example, we may allow access to your medical information to students working with us; we use a sign-in sheet at registration; we my call you by name from the waiting room.

Law Enforcement: Your health information may be disclosed to Law Enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: We may disclose your health information to public health agencies as required by law. For example, we are required to report certain communicable diseases to the State's Public Health Department.

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation or the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain right under Federal Privacy Standards. These include:

- The right to request restrictions on the use and disclosure of your health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information. (**Patient Access is limited with regard to psychotherapy notes**)
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Valdosta Psychiatric Responsibilities and Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of Privacy Practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by changes in Federal or State laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by Federal Regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer.

_____

Patient Initials

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

VALDOSTA PSYCHIATRIC ASSOCIATES
ATTN: JENNY KENYON
P.O. BOX 3229
VALDOSTA, GA 31604

OR

DHHS
Office of Civil Rights
61 Forsyth St. SW, Suite 16T70
Atlanta, GA 30303-8909

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concerns to the same address listed above. You will not be penalized or otherwise retaliated against for filing a complaint.

A COPY OF THE ENTIRE PRIVACY PRACTICE POLICIES IS AVAILABLE UPON REQUEST.

I have read and/or received a copy of this privacy notice _____ _____
Patient Signature *(Date)*

Name:_____ **DOB:** _____

INTAKE QUESTIONNAIRE

Medical History (check all that apply)

□ Allergies/Seasonal	□ Anemia	□ Arthritis
□ Asthma	□ Back Pain (Chronic)	□ BPH
□ Cancer (type)_____	□ COPD/Emphysema	□ Diabetes □ Type I □ Type II
□ Disc Disease □ Lumbar □ Cervical	□ Fibromyalgia	□ GERD / Gastritis
□ Gout	□ Hearing Loss	□ Heart Disease
□ Hepatitis	□ Hernia	□ High Cholesterol
□ HIV	□ Hypertension	□ Hypotension
□ Hyperthyroidism	□ Hypothyroidism	□ Irritable Bowel Syndrome
□ Kidney Disease	□ Kidney Stones	□ Liver Disease
□ Lupus	□ Migraine Headaches	□ Obesity
□ Parkinson's Disease	□ Seizure Disorder	□ Sleep Apnea
□ Sexually Transmitted Disease	□ Stroke/TIA (History of)	□ Testosterone (Low)
□ Traumatic Brain Injury	□	□ No Medical Problems

Other Illnesses not listed above:_____
_____
_____

Surgical History

□ Appendectomy	□ Back □Lumbar □ Cervical	□ Bariatric Surgery	□ Brain
□ Cardiac Value	□ Cardiac Bypass	□ Ear/Nose/Throat	□ Gall Bladder
□ Gastric Bypass	□ Hernia Repair	□ Hip Replacement	□ Hysterectomy (Partial)
□ Hysterectomy (Total)	□ Kidney Stones Removed	□ Kidney Removed	□ Knee Replacement
□ Prostate	□ Rotator Cuff	□ Shoulder	□ Tubal Ligation
□ Wrist	□	□	□

Other Surgeries not listed above: _____

Medications

Please list all medications you take daily including dosages and how often:

Allergies

Please list any drug or non-drug allergies you have:

Name: _____ **DOB: _____**

Habits

Do you smoke cigarettes currently? □ Yes □ No How much per day? _____
Have you smoked in the past? □ Yes □ No
Do you use Oral Tobacco? □ Yes □ No

Do you Drink Alcohol? □ Yes □ No How much per week? _____

Please check all stressors you are experiencing currently

□ Economic/Financial	□ Education/School	□ Family Conflict	□ Grief/Loss
□ Legal Problems	□ Medical Illness	□ Work	□ Living Situation
□ Social Environment	□ Substance Abuse	□ Marital Conflict	□ Family Disruption due to divorce or separation
□ Personal Injury	□ Relationship		

Please give a brief description of the reason you are here today: _____
_____
_____
_____
_____

Please check any symptoms you are now experiencing

□ Anxiety
□ Anger
□ Appetite Disturbance
□ Behavior Problems
□ Decreased Concentration
□ Decreased Energy
□ Decreased Pleasure and Interest in things
□ Depressed Mood
□ Feelings of hopelessness, helplessness or worthlessness
□ General Stress
□ Grief/Loss
□ Uncontrolled Fear or Phobia
□ Unexplained or chronic pain
□ Thoughts of hurting someone else
□ Hallucinations (hearing voices, seeing things)
□ Falling Asleep during the daytime
□ Impulsiveness
□ Insomnia (trouble fall sleep or staying asleep)
□ Irritability
□ Isolating (staying away from others)
□ Mania (unusually hyperactive, talkative)
□ Memory Impairment
□ Nightmares
□ Panic Attacks
□ Sexual Dysfunction
□ Thoughts of hurting myself
□ Rapid weight loss or weight gain

Please list any other symptoms not listed above:
_____
_____

Name: _____ DOB: _____

Past Psychiatric History

Have you ever been treated by a psychiatrist or counselor in the past? □ Yes □ No

□ **Out Patient Treatment**

Provider:	Dates of Treatment:
Provider:	Dates of Treatment:
Provider:	Dates of Treatment:

What were you being treated for?_____

□ **Inpatient Treatment**

Facility Name:	Type of Admission	Date/Year
□	□ Voluntary □ Involuntary	
□	□ Voluntary □ Involuntary	
□	□ Voluntary □ Involuntary	

□ Reason for Admission:

□ Depression	□ Drug/Alcohol	□ Manic Episode	□ Psychotic Episode
□ Severe Anxiety	□ Suicidal Ideations	□ Suicide Attempt	□ Violence/Assaultive Behaviors

Family History

Has anyone in your family ever been treated for psychiatric condition or Substance Abuse? □ Yes □ No

□ Family History is unavailable

Family Member	Type of problem
□ Mother	
□ Father	
□ Spouse	
□ Brother	
□ Sister	
□ Son	
□ Daughter	
□ Maternal Grandmother	
□ Maternal Grandfather	
□ Paternal Grandmother	
□ Paternal Grandfather	
□ Aunt	
□ Uncle	
□ Other?	

Name: _____ DOB: _____

Father: □ Living □ Deceased (Age _____)
Brief Description of your Father: _____
_____
_____

Mother: □ Living □ Deceased (Age _____)
Brief Description of your Mother: _____
_____
_____

Siblings: □ # Living _____ □ # Deceased _____

If you were not raised by both of your biological parents, please explain:
_____
_____
_____
_____

What is your cultural background: (Hispanic, Italian, German, Irish, etc) _____

Substance Abuse History

Do you have a history of Substance Abuse? □ Yes □ No

Type of substance Used	Quantity Used	Frequency of Use

Have you experienced any of the following as a result of your drug or alcohol use?

□ Arrests	□ Consuming more than intended	□ Blackouts	□ DUI
□ Employment Issues	□ Family/Marital Conflict	□ Feeling guilty	□ Financial problems
□ Fighting	□ Health Problems	□ Increased Tolerance	□ Increased tolerance
□ Unintentional Overdose	□ Physical Health Problems	□ Seizures	□ Withdrawal Symptoms

List any other consequences not listed above: _____

Name: _____ DOB: _____

Education History

□ Currently in school – **Grade** _____	□ Less than a high school education	□ Graduated from high school
□ GED Obtained	**HIGHEST GRADE COMPLETED**? _____	□ Associates Degree
□ College Degree	□ Some College	□ Professional Degree
□ Technical Degree	□ Master's Degree	

Employment History

Employment Status:

□ Full-time □ Part-time □ Unemployed □ Retired □ Disabled □ Homemaker

Name of Employer: _____ How long at your current job?_____

Occupation: _____

Legal History:

Are there any current or pending legal cases you are involved in? (Arrests, Civil Actions, Custody, Divorce, etc.) Please explain:

_____

_____

_____

Are there any previous arrests? □ Yes □ No

Military Service History:

□ Never been in the military	□ Active Duty Military	□ Parent is active duty military
□ Spouse is Active Duty military	□ Retired from the military	□ Honorably discharged from military
□ Veteran	□ Medically discharged from military	□ Dishonorable discharge

Branch of Service:

□ Air Force	□ Army	□ Marines	□ Navy
□ National Guard	□ Reserves	□ Coast Guard	

General Social History:

Marital Status:

□ Single/Never married	□ Married	□ Divorced
□ Separated	□ Widowed	□ Partnership/Serious Relationship

Current level of satisfaction in the relationship is

□ not applicable.	□ very Satisfied.	□ somewhat satisfied.	□ dissatisfied.

Number of Marriages _____ **Number of Children: _____**

List the Names and Ages of Children

Name: _____ DOB: _____

Residential Status:

□ Own A home	□ Rent	□ Live w/parents	□ Foster Care
□ Homeless	□ Nursing Home Facility	□ Live w/roommate(s)	

Housing Conditions are:

□ Excellent	□ Good	□ Fair	□ Poor

List the members of your current household:

Social Supportive Network:

□ Supportive Family	□ Friends	□ Religious Congregation	□ Co-workers
□ Internet-based	□ Social Services	□ Sponsor	□

Cultural:

□ Caucasian	□ African-American	□ Hispanic	□ Asian
□ Native American	□ Bi-Racial	□ Indian	□

Sexual Orientation:

□ Heterosexual	□ Homosexual	□ Bi-Sexual	□ Transgendered

Religion

□ Denomination:	□ Participate in religious activities	□ Do not participate in religious activities

CONTROLLED SUBSTANCE POLICY

As part of your treatment, your physician may order medications for you. Many of these medications can have serious side effects if they are not managed properly. You will be made aware of any side effects from medications that we have prescribed for you. Please read the following agreement **CAREFULLY** and ask your doctor/nurse if you have any questions:

1. I agree to follow exact dosing instructions prescribed by my physician.
2. I agree to keep all appointments required by my physician. If I miss an appointment, I understand that a follow up must be made before any prescriptions will be refilled or changed.
3. I agree to maintain all prescriptions at the same pharmacy, unless reasonable circumstances occur.
4. Refill requests are to be made during office hours only. Mon-Thurs 9:00 am to 4:00pm. Fridays 9:00 a.m. to 11:00 a.m.
5. Refill requests must be made in **ADVANCE** (7 days). If my physician is out of the office, I understand that my prescription **will not** be filled until they return.
6. **NO CONTROLLED SUBSTANCES WILL BE FILLED DURING EVENINGS, WEEKENDS OR HOLIDAYS!**
7. If a prescription is lost or stolen, it will **NOT BE REFILLED**. It is your responsibility to keep track of your medications.
8. I understand that any misuse of my medications will be reported to the appropriate authorities and I can be terminated from the practice.

I agree that I have read and fully understand this controlled substance contract. I will ask my physician if I have any questions regarding the potential risk of dependency, addiction and side effects of the medications given to me. I do understand that a breach of this contract will result in my termination from Valdosta Psychiatric Associates, LLC.

Patient Name: _____ D.O.B.: _____

_____ Date: _____

Patient Signature

Physician: _____

Pharmacy Name: _____ Phone #: _____