

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? _____

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:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Relationship/Family Problems | <input type="checkbox"/> General Stress | <input type="checkbox"/> Anxiety or Worry |
| <input type="checkbox"/> Problems at work | <input type="checkbox"/> Physical Health Problems | <input type="checkbox"/> Grief or Loss | <input type="checkbox"/> Substance Abuse Problems |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Inability to Sleep | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> No Interest in Things |
| <input type="checkbox"/> Problems at School | <input type="checkbox"/> Problems with Peers | | |

Patient Signature: _____

Date: _____

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

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 have to be 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, 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 or Greenleaf Center, or hang up and dial 911.

***We file all insurance plans. We do check benefits prior to your checkout and **require a copy of your insurance card and photo ID upon signing in**. As a courtesy, a staff member will call you with an estimate of your cost for the visit; 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 keep your account current.

***We accept checks, money orders, cash, debit cards, VISA or MasterCard. 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 **\$50** collection fee if your account is turned over to collections due to 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.

***Because of limited seating, we ask that you do not bring anyone with you unless they will be seeing your provider. If you need someone to drive for you, they are welcome to come in. Due to the nature of the practice, we ask that you **DO NOT BRING CHILDREN THAT ARE NOT HERE TO BE SEEN**.

***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) may be charged the full amount of the session. These charges would be billed to the patient and not the insurance company. Charges for missed appointments are at the discretion of each provider.

***We ask that you do not lie on the sofa or allow your children to lie on the sofa. Please inform our receptionist if you ever find our lobby or restroom in need of attention.

***Counseling and treatment are medical issues and 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. _____

***When calling to speak with a physician or provider, 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. You will not be given another prescription without seeing the doctor again. It is the policy of this office that we do not fax prescriptions. This is for your protection and well being. Take your medication as directed. Keep up with your 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 sessions. The therapist will meet with you for approximately 45 to 50 minutes to discuss your treatment progress. If you are late, your session with your provider may need to be rescheduled.

***We do our very best with respect to keeping 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 after 15 minutes will be rescheduled or the time spent may have to be reduced. You may be charged for a missed appointment 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.

*****ALL MINORS MUST BE ACCOMPANIED BY A BIOLOGICAL PARENT.** We cannot prescribe medications or initiate treatment without a parent or legal guardian present.

***We do not participate with discount drug programs. Your doctor may give you a written prescription. **IF** 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 your local mental health office. 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
- Medicare programs include Together RX 800-444-4106 and Medicare Discount Card 800-459-3911
- Online help resource www.FreeRXinfo.net

I have read ALL of the above policies or had the above policies read to me on page 1 and 2 of this form. I understand them and agree to them.

Patient Name: _____

Date: _____

Date of Birth: _____

Social Security Number: _____

Signature of Patient or Guardian

Relationship

MEDICAL HISTORY

Name:	Date of Birth:
Address:	Phone:

Pharmacy Name:	Location:
Phone Number:	Primary Care Physician:

Please list any **ALLERGIES:**

Please list **ALL Medications** you are taking currently - include dosage and how you take it

Please list **ALL Medical Problems** you are treated for by any other physician

Please list any **Surgery** you have had

I give my permission for Valdosta Psychiatric Associates, LLC staff to contact me pharmacy with questions regarding my past and present medications. They will be calling for information regarding my ongoing treatment.

(Patient or Legal Guardian Signature)

(Date)

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 time will be lost from my session. 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.

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 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

Signature of VPA staff

NOTICE OF PRIVACY PRACTICES
THIS 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 may 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 Associates 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.

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
Attention: Privacy Officer
P.O. Box 3229
Valdosta, GA 31604

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 been given & read the notice of Privacy Practices for Valdosta Psychiatric Associates. I understand this notice is an outline, and I may request a full copy of the Privacy Policy

(Patient Signature)

(Date)

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 stolen, it will be refilled with a copy of a filed police report of theft.
8. If a prescription is lost, it will **NOT BE REFILLED**. It is your responsibility to keep track of your medications.
9. 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 & DOB

Patient Signature

Date

Physician

Pharmacy Name & Phone Number

INTAKE QUESTIONNAIRE

NAME: _____

ADDRESS: _____

_____ **CITY** _____ **ZIP**

PHONE - HOME: _____ **WORK:** _____

WHO REFERRED YOU TO ME? _____

WHO SHOULD BE CONTACTED IN AN EMERGENCY? (NAME AND PHONE):

BRIEFLY DESCRIBE THE REASON(S) FOR SEEKING HELP: _____

AGE: _____ **DATE OF BIRTH:** _____ **SS#** _____

PLACE OF BIRTH: _____

PLACE(S) RAISED: _____

FATHER: LIVING _____ **AGE:** _____

DECEASED _____ **AT WHAT AGE:** _____

OCCUPATION: _____

BRIEFLY DESCRIBE YOUR FATHER: _____

MOTHER: LIVING _____ **AGE:** _____

DECEASED _____ **AGE** _____

OCCUPATION: _____

BRIEFLY DESCRIBE YOUR MOTHER _____

IF YOU WERE NOT RAISED BY YOUR NATURAL PARENTS, PLEASE EXPLAIN:

BROTHERS AND SISTERS: (PROVIDE NAME, AGE OCCUPATION, MARITAL STATUS AND WHERE THEY LIVE)

CULTURAL BACKGROUND: (ITALIAN, IRISH, GERMAN, ETC)

IN WHAT RELIGION WERE YOU RAISED? _____

PRESENT RELIGIOUS AFFILIATION AND FREQUENCY OF ATTENDANCE:

HAS ANY RELATIVE LISTED ABOVE (F,M,S,B,)EVER HAD PROBLEMS WITH OR BEEN TREATED FOR MENTAL OR EMOTIONAL PROBLEMS, SUICIDE ATTEMPTS, DRUG OR ALCOHOL ABUSE? PLEASE EXPLAIN: _____

ARE YOU MARRIED - DIVORCED - SEPARATED - SINGLE? _____

NUMBER OF TIMES MARRIED: _____

LIST MARRIAGES STARTING WITH THE PRESENT OR MOST RECENT FIRST: (PROVIDE DATES OF EACH MARRIAGE AND WHY IT TERMINATED)

CHILDREN: (PROVIDE NAME, AGE, OCCUPATION, MARITAL STATUS AND WHERE THEY LIVE)

LIST THE MEMBERS OF YOUR CURRENT HOUSEHOLD: _____

LIST YOUR OTHER SIGNIFICANT RELATIONSHIPS: _____

HAVE ANY OF YOUR FAMILY MEMBERS LISTED ABOVE (CHILDREN, MEMBERS OF YOUR CURRENT HOUSEHOLD) EVER HAD PROBLEMS WITH OR BEEN TREATED FOR MENTAL OR EMOTIONAL PROBLEMS, SUICIDE ATTEMPTS, DRUG OR ALCOHOL ABUSE? PLEASE EXPLAIN:

HIGHEST GRADE COMPLETED: _____

PRESENT OCCUPATION: _____

PRESENT EMPLOYER: _____

HOW LONG HAVE YOU BEEN AT YOUR PRESENT JOB? _____

PAST EMPLOYMENT: _____

INTERESTS AND HOBBIES: _____

CURRENT SUPPORT SYSTEM: (FRIENDS, CLUBS, ETC)_____

HAVE YOU EVER HAD PROBLEMS WITH OR BEEN TREATED FOR MENTAL OR EMOTIONAL PROBLEMS, SUICIDE ATTEMPTS OR DRUG OR ALCOHOL ABUSE? PLEASE EXPLAIN:

DO YOU DRINK?_____

FREQUENCY:_____

QUANTITY:_____

DO YOU USE ILLICIT DRUGS?_____

FREQUENCY:_____

QUANTITY:_____

HAVE YOU EVER THOUGHT ABOUT SUICIDE?_____

HAVE YOU EVER MADE A SUICIDE ATTEMPT?_____

DO YOU PRESENTLY HAVE THOUGHTS OF SUICIDE?_____

HAVE YOU EVER THOUGHT OF HURTING SOMEONE ELSE?_____

DO YOU PRESENTLY HAVE THOUGHTS OF HURTING SOMEONE ELSE?_____

HAVE YOU EVER BEEN ACCUSED OF ABUSING ANOTHER PERSON?_____

DESCRIBE ANY RECENT CHANGES IN YOUR EATING HABITS:_____

DESCRIBE ANY CHANGES IN YOUR SLEEP PATTERNS:_____

ARE YOU PRESENTLY EXPERIENCING ANY MAJOR MEDICAL PROBLEMS? PLEASE EXPLAIN:

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? (INCLUDE NAME, DOSAGE AND LENGTH OF USE)

MILITARY HISTORY: (LIST BRANCH OF SERVICE, LENGTH OF SERVICE AND TYPE OF DISCHARGE)

LEGAL: (LIST PAST AND PRESENT LEGAL PROBLEMS)_____

SEXUAL PROBLEMS: (LIST PAST OR PRESENT SEXUAL PROBLEMS)_____
