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: _____ **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 treatment 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) $220
45min session (99213 + 90836) $350
Med Refill (outside of appt) $25

Therapist (LPC, LCSW)
20min session (90832) $95
45min session (90834) $195

DBT Certified Clinician
20min session (90832 cert) $103
45min session (90834 cert) $205

Clinical Psychologist (PhD)
20min session (90832 PhD) $110
45min session (90834 PhD) $220

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 everything 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 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 10minutes) 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

Patient/POA Signature: _____ Date: _____

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 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): _____

_____

_____

_____

_____

_____

_____

Peachtree Comprehensive Health

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 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:**_____