

Are you currently taking medications for psychiatric, nervous or emotional problems?
YES / NO

If YES, then list below:

Have you previously taken medications for psychiatric, nervous or emotional problems in the?
YES/NO

If YES, please list past medications below:

Have you been previously hospitalized for psychiatric reasons?
YES/NO

If YES, please list *when, where* and *duration* of each hospitalization:

Have you previously/currently seeing a therapist? YES/NO
If YES, please list who you are/were seeing:

Please list any **MEDICAL PROBLEMS**:

Are you taking medications for medical purposes (not psychiatric medications)?
YES/NO

If YES, please list medications you are taking below:

DRUG ALLERGIES (and reaction to drug):

Please list any **SURGERIES (with dates)**:

Are there **Family Members** with a history of Psychiatric/Emotional difficulties?
YES / NO

If YES, please list (e.g. father, mother, paternal grandfather, etc) below:

SOCIAL HISTORY:

Are you currently a student? Yes No

Please list your grade level and/or highest level of education: _____

Are you working? Yes No

If "Yes," please describe your work: _____

Are you full time or part time? _____

If "No," when did you last work: _____

Are you receiving disability? Yes No

Members currently living in household: _____

SUBSTANCE USE HISTORY:

Do you drink alcohol? Yes No

If yes, how much and how often do you drink? _____

When was your *last* drink? _____

Have you previously experienced withdraw symptoms related to using or stop using alcohol (e.g. the "shakes," sweats, nausea, blackouts, seizures, etc.) Yes No

If yes, please detail the symptoms you experienced: _____

Do you *currently* use any illicit drugs (including marijuana)? Yes No

Have you *previously* used any illicit drugs? Yes No

If you answered "Yes" to either of the above questions, please describe the type and amount of any *past or current* drug use: _____

When was your last use of drugs (including marijuana)? _____

Have you previously been in a detox for drugs or alcohol? Yes No

If Yes, please give number of times, when, and where: _____

Have you previously participated in an alcohol or drug treatment program? Yes No
If "Yes," please describe your treatment: _____

Do you have any pending/current legal issues? Yes No

For Child and Adolescent Patients:

Birth and Developmental History

Did mother use drugs, prescribed meds, tobacco or alcohol during pregnancy? Yes No
If yes, please describe use: _____

Please list any complications during pregnancy and/or delivery (mother of patient): _____

Please list ages of patient: when patient first began walking, first word, and speaking in full sentences: _____

Please list if patient received(s) special services (e.g. OT, PT, speech therapy, special educational services, and include dates): _____

Has social services (e.g. DFACS) been involved with you or your family? Yes No
If Yes, please explain: _____

Guarantor Information (complete only if the patient is NOT paying the bill):

Name of person responsible for bill: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Tel.: _____ Work Tel.: _____

Date of Birth: _____ \ _____ \ _____ SS#: _____

Employer: _____

Address: _____

City: _____ State: _____ ZIP: _____

The Guarantor will need to sign pages 6 and 7.**RECORD RELEASE AUTHORIZATION:**

I hereby authorize Psychiatric Consultants of Atlanta to furnish information to insurance carriers concerning this illness/accident.

Patient's signature: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____ Date: _____

CONSENT FOR TREATMENT:

I hereby agree to be treated by physicians and/or mental health professionals associated with Psychiatric Consultants of Atlanta, P.C. I agree that I am, or the Guarantor is, personally responsible for ensuring that all charges for services rendered are paid. I understand payment is due at the time of service and failure to pay my bill may result in termination of treatment. A late fee of 6% *per annum* may be assigned to any outstanding balance 30 days or more overdue. I authorize Psychiatric Consultants of Atlanta to provide information concerning my treatment to any physician or therapist who referred me to Psychiatric Consultants of Atlanta.

Signature of Patient Date_____
Signature of Parent/Guardian (if applicable) Date_____
Signature of Guarantor (if applicable) Date

OFFICE POLICIES

1. Missed appointments will adversely affect treatment outcome. Patients (or Guarantor) will be charged \$50 when a cancellation is not made within 24 hours of the scheduled appointment. “No shows” will be charged \$50 for the missed appointment. If, for any reason, the doctor must cancel an appointment, the patient will be advised at the earliest possible time.
2. Full disclosure, at least to the extent possible, is essential to effective psychiatric treatment. Our doctors cannot adequately help you if they cannot become familiar with your medical and psychiatric history (including past/current psychotherapists and psychiatrists). Consent to review your medical and psychiatric history and to discuss your care with other clinicians is a condition of treatment.
3. Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge that the doctor be notified in person regarding this decision so that it can be discussed openly.
4. Psychiatric medications can be very effective and well tolerated if used properly. A few medications do have the potential to become habit-forming or abused. In order to minimize the likelihood of this happening, we require that you do not permit anyone else to prescribe you any of the medications that you receive from our doctors except in the case of an emergency. Treatment will need to be terminated if you cannot agree to this.
5. Your first appointment is an evaluation. Your doctor will let you know if they are in the position to offer services beyond this first session.
6. Any unpaid monies greater than 90 days past due may be turned over to a commercial collection agency. If this occurs, you will be responsible for all monies owed *and* total fees charged by the collection agency including cost of any legal fees.

Signature(s) below indicate understanding and agreement with all of the above policies

Signature of Patient

Date

Signature of Parent/Guardian (if applicable) Date

Signature of Guarantor (if applicable)