Atlanta Psychiatry and Psychotherapy Associates, LLP
Staff Members
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John Parker, APC
Irene Ferguson, APC
T. Scott Ramsey, APC

Name: _____

Date of Birth:_____ Date:_____

Address:_____

_____

Phone Number:_____

Permission to leave message? Y N

Cell Phone:_____

Work Phone:_____

Social Security Number:_____

Email Address to Send Invoices:_____

Employment:_____

Emergency Contact #1: _____

Relationship:_____

Phone Number & Email:_____

Emergency Contact #2:_____

Relationship:_____

Phone Number & Email:_____

Referred by (if applicable):_____

(Disclaimer: All electronic communications are not guaranteed to be HIPPA compliant and/or secure and/or private. Individuals calling APPA or emailing the APPA front desk assume full awareness and responsibility for their confidentiality and privacy. APPA staff members are not responsible for your confidentiality and privacy from where you are calling us. Please ensure that you call from a securely private place when calling APPA about your mental health concerns.)

Please see our website: AtlantaPsychiatryCare.com for YOUR PRIVACY RIGHTS NOTICE.

Medication List

Please list any prescription medications you are currently taking, including dosage and prescribing physician.

Medication	Dosage	Directions	Prescribing Physician

WELCOME TO ATLANTA PSYCHIATRY AND PSYCHOTHERAPY ASSOCIATES

The following information will be helpful for your appointment:

APPA Clinic address: 2150 Peachford Road Suite A
Atlanta, GA 30338

Contact phone: 770-674-0553
Email contact: appa.frontdesk@gmail.com
(NO TEXT MESSAGES ARE ACCEPTED)

Please bring with you a list of medications that you are on at present. Please arrive 10-15 minutes before your scheduled visit.

Payment is expected at the time of service. Please be aware that some doctors and/or therapists do not participate in health insurance reimbursements.

Mode of payments accepted: Cash, Check, Credit Card

NO SHOW VISITS ARE CHARGED.

Please call at least 48 hours prior to your visit if you need to reschedule or cancel an appointment to avoid a no-show charge.

Thanks for your attention, and we are looking forward to working with you!

Sincerely,

APPA Staff

Atlanta Psychiatry and Psychotherapy Associates, LLP

2150 Peachford Road Suite A
Atlanta, GA 30338
Email: appa.frontdesk@gmail.com
Phone: 770-374-7443
Fax: 770-674-0554

INFORMED CONSENT FOR TREATMENT

I, _____ (name of client), agree and consent to participate in behavioral health care services offered and provided by APPA, a behavioral health provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within:

(1) The scope of the provider's license, certification, or training, or

(2) The scope of the license, certification, and training of the behavioral health care provider(s) directly supervising the services received by the client, or

(3) if the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am able to initiate and consent for treatment and/or legally authorize and consent to treatment on behalf of this individual.

Client's name:_____

Client's Signature:_____

Legal Guardian's Relationship to Client:_____

Legal Guardian's Signature:_____

Date:_____

Atlanta Psychiatry and Psychotherapy Associates, LLP
2150 Peachford Road, Suite A
Atlanta, GA 30338
(770)674-0553

Cancellation Policy, Missed Appointments, Telephone Calls, & Prescription Refills

Cancellation Policy: Please note that last minute cancellations are considered therapy-interfering behavior. Cancellation with less than 48 hours' notice will incur a full-fee charge fee unless rescheduled within the same week. Our doctors are committed to your care and would prefer to see you within the same week, rather than charge an empty fee. We will need to know your reason for cancelling, as we need to ensure that our patients are not at risk for self-harm or the harm of others. You will be liable for any incurred fees under our cancellation policy, even in the absence of a reminder call, and fees must be paid before your next visit. Two or more absences for non-therapeutic reasons will be considered therapy-interfering behavior and may result in the termination of therapy.

Telephone calls requested by the patient from the doctor outside of scheduled appointment time may be subject to a fee which is payable at the time of the phone session or the next scheduled appointment.

Requests for refills on prescriptions after a missed appointment will be subject to a $25 fee and will be filled within 48 hours.

Requests for phone calls to insurance providers or pharmacy management companies for prior-authorization will be subject to a $25 fee.

Special typed reports from various entities may be subject to a fee determined by the amount of physician time to complete the report.

Copies of medical records are subject to a minimum copy fee of $15 and additional fees based upon the number of pages requested.

I have read and understand the policies listed above and acknowledge my responsibility to abide by the requirements and expectations set forth.

Client's Signature: _____ Date: _____

Legal Guradian's Signature (if applicable): _____

Please direct any disputes with this policy to your doctor or clinician to our executive director: Daniel P. David, LMSW, PhD.

Atlanta Psychiatry and Psychotherapy Associates, LLP
2150 Peachford Road Suite A
Atlanta, GA 30338

I, _____, on _____ (date) authorize APPA to bill my (circle one):

Mastercard Visa Discover American Express

for the amount pertaining to services rendered.

I understand that I am responsible for all fees that are not authorized by credit card or reimbursed by my insurance carrier. Outstanding balances over 60 days will result in a suspension of services until account is brought current. My signature below indicates that I am providing authorization to charge my credit card for services rendered.

Please Print Clearly
Name on card: _____

Address:_____

City/State: _____

Zip Code:_____

Card #:_____

Expiration Date: _____ Security Code:_____

Signature:_____

APPA

2150 Peachford Road
Suite A
Atlanta, GA 30338
Phone: 770-674-0553
Fax: 770-674-0554

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. Member Information

I, _____, whose date of birth is (MM/DD/YY) _____,

hereby give permission to APPA

2. Recipient Information
to (please check one or both) ____DISCLOSE TO and/or ____OBTAIN information from

_____
(name of person or title of organization)

Street:_____ City: _____

State:_____ Zip Code:_____

Phone Number:_____Fax:_____

3. Description of Protected Health Information to be Used or Disclosed

____Psychiatric Assessments
____Discharge/Transfer Summary
____Medical/Nursing History
____Lab Reports/Toxicological Reports
____Continuing Care Plans
____Other

4. Expiration of Authorization) - This date (no more than one year from today): _____/_____/_____

5. Your Rights

a. You can choose to end this authorization at any time by writing to APPA. If you make a request to end this authorization, it will not include information that has already been used of disclosed based on your previous permission.

b. APPA does not condition treatment or payment on your signing this form.

c.You do not have to agree to this request to use or disclose your information.

d. You have a right to a copy of this signed authorization. Please keep a copy for your records.

6. Re-disclosure by Recipient

Except as described below, information that is disclosed as a result of this authorization form may be subject to re-disclosure by the recipient and no longer protected by law. APPA has to follow laws that protect your health information, but not all persons or organizations have to follow these laws.

Signature: _____ Date:_____

In order to provide you with an improved professional experience, we are modifying our office policies as of July 1, 2015. Please read the following, initial each section, and sign at the bottom:

___**48-Hour Cancellation Policy**. All clients are responsible to call **48-hours** (2 DAYS) ahead of their appointments for cancellations. Appointments may not be cancelled by email, texts, or voicemails. Clients are required to call the office between business hours and speak with the office administrator. Clients must leave a contact number for the office to reach you when responding to your call. For Monday cancellations, all calls must be made on the previous Thursday to 770-674-0553.

____**Reminder Calls, Texts, and Emails.** We want to make sure that we are clear about sending you reminders. You have an option of getting a phone call, text message, and/or email.

You will need to sign this release form and indicate which forms/methods of contact are acceptable for this office to use when reminding you of your appointments. You are hereby being informed that NO form of communication is 100% HIPPA compliant and that you understand that you are responsible for keeping your health information, including reminder contacts from our office completely confidential and private on your personal private voicemail, texts, or emails.

____**Reminder calls may not be used to cancel or change appointments**. Reminder calls are a courtesy to our valued clients. They are not used to make last minute changes to your schedule. **We charge full fees for missed sessions or for late cancellation made less than 48-hours (2 Days) prior to appointments.**

____**2 Consecutive Missed Sessions may require readmissions paperwork**. We are a mental health practice that understands the seriousness of depression, drug or alcohol addiction, suicidal ideation, personality disorders, and psychotic disorders. Our mandate is to keep you safe and to avoid risks. To protect our patients, APPA encourages and requires regular, routine, and uninterrupted weekly or biweekly sessions depending on your assessment and consent for treatment. 2 missed session without valid reasons may necessitate discharge from our services.

Please fill out this form below:

I, _____, understand and agree to the above conditions of my treatment as indicated by my initials and my signature below. I also give permission for the following 2 forms of communication to be used in communicating reminders and appointment changes with me from this office:

_____**Text Messages:**_____ **(your private number)**

_____**Emails:**_____**(your private email)**

_____**Phone and Voicemail:**_____ **(your private number)**

Signed:_____
Date:_____

Print Name:_____

Beck's Depression Inventory

Circle/highlight the answer that best describes you. This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2.
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

3.
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5.
0 I don't feel particularly guilty
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6.
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7.
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.
0 I don't cry any more than usual.

1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.
0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.
0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.

2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score_____Levels of Depression

1-10_____These ups and downs are considered normal
11-16_____ Mild mood disturbance
17-20_____Borderline clinical depression
21-30_____Moderate depression
31-40_____Severe depression
over 40_____Extreme depression

A PERSISTENT SCORE OF 17 OR ABOVE INDICATES THAT YOU MAY NEED MEDICAL TREATMENT.

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____ .

Interpretation

A grand sum between **0 – 21** indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to "mask" the symptoms commonly associated with anxiety. Too little "anxiety" could indicate that you are detached from yourself, others, or your environment.

A grand sum between **22 – 35** indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not "panic" time but you want to find ways to manage the stress you feel.

A grand sum that **exceeds 36** is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a counselor if the feelings persist.