
**Psychiatric Consultants of Atlanta, P.C.**
**1835 Savoy Drive**
**Suite 101**
**Atlanta, Georgia 30341**
**Phone: 770-234-0981 Fax: 770-234-0252**
**www.pcatl.com**


**CONTACT INFORMATION AND PERSONAL DATA**

Name: _____ Date of Birth: ____ Age___
Last First Middle
Today's Date: _____ Referred By: _____
Home Address: _____ City: _____ State: ___ ZIP: _____
Home Tel.: _____ Business Tel.: _____ Fax: _____
Mobile Tel.: _____ Email address: _____
At what telephone number may we leave messages? _____

Emergency Contact: Name: _____ Tel.: _____
Is the patient solely responsible for paying the bill? YES / NO
If NO, then complete "Guarantor Information"
If the patient is less than 18 years old, or is an adult who has been adjudicated incompetent, please list the legal guardian(s). The guardian(s) will need to sign pages 4, 5, and 6.
Name: _____ Tel.: _____
Name: _____ Tel.: _____

Name and telephone number of primary care physician: _____
Name and telephone number of pharmacy: _____

**REASON FOR EVALUATION:**

_____
_____
_____
_____
_____
_____

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)