AR PSYCHIATRIC AND COUNSELING CENTER

3312 D North Oak St. Ext.,Valdosta, GA 31605

CHILD/ADOLESCENT INTAKE FORM

CHILD'S NAME: _____
LAST FIRST MIDDLE

CHILD'S ADDRESS: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

CHILD'S D.O.B.: _____/_____/_____ AGE: _____ GRADE: _____ SCHOOL: _____

CHILD'S SSN: _____ MOTHER'S MAIDEN NAME:_____

PRIMARY CARE PHYSICIAN: _____ E-MAIL ADDRESS: _____

CHILD IS LIVING WITH: ❒ NATURAL PARENTS ❒ ADOPTIVE PARENTS ❒ ONE PARENT ALONE
☑ PARENT & STEP PARENT ❒ OTHER: _____

STATUS OF PARENTS: ❒ MARRIED ❒ DIVORCED ■ WIDOWED ❒ UNMARRIED ❒ SEPARATED
❒ OTHER (SPECIFY): _____

PARENT 1: _____ ❒ BIOLOGICAL ❒ ADOPTIVE ❒ STEP

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ CELL PHONE: (_____) _____ WORK PHONE: (_____) _____

Is parent employed outside the home? Y☑N☐ Does parent live with child/adolescent? Y☐N ☑ OCCUPATION: _____

PARENT 2: _____ ❒ BIOLOGICAL ❒ ADOPTIVE ❒ STEP

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ CELL PHONE: (_____) _____ WORK PHONE: (_____) _____ Is

parent employed outside the home? Y☐N☐ Does parent live with child/adolescent? Y ☐N ☐OCCUPATION: _____ *IF*

OTHER CAREGIVERS, PLEASE LIST BELOW:

CAREGIVER'S NAME: _____ RELATION TO CHILD/ADOLESCENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ CELL PHONE: (_____) _____ WORK PHONE: (_____) _____

Insurance Company:_____Policy Holders name :_____(As it appears on the card) Insurance

Address : _____Phone#_____

Policy/Subscriber Number :_____ Group Number:_____

Policy Holders SSN :_____Policy Holders Date of Birth:_____

A COPY OF YOUR DRIVERS LICENSE and INSURANCE CARD IS NEEDED

PAYMENT OF SERVICES IS HANDLED PRIOR TO YOUR SESSION

I request that payment and benefits be made on my behalf to AR Psychiatric & Counseling Center, LLC for any services furnished to me by its physicians or providers. I understand that my signature also authorizes release, if necessary, of any medical, HIV, psychiatric and substance abuse information contained in my records to my insurance or its assignees. I request and authorize treatment at AR Psychiatric & Counseling Center, LLC. I understand I am responsible for any deductible, co-payment or any amount not covered by my insurance. I understand that AR Psychiatric & Counseling Center, LLC, turns delinquent accounts over to a third party collector, and I will be accessed a collection fee of $50.00 dollars. Monthly finance charges may be added to all accounts over 60 days old. A fee of $30.00 dollars will be charged for any returned checks.

_____ _____ _____
Signature of Patient or Legal Guardian Relationship Date

SNAP-IV Parent Rating Scale

Name: **Date:**
Date of Birth:

Instructions: For each item, please check the column which best describes this child **IF APPLICABLE**:

	Not At All	Just A Little	Quite A Bit	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks	○	○	○	○
2. Often has difficulty sustaining attention in tasks or play activities	○	○	○	○
3. Often does not seem to listen when spoken to directly	○	○	○	○
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties	○	○	○	○
5. Often has difficulty organizing tasks and activities	○	○	○	○
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort	○	○	○	○
7. Often loses things necessary for activities (eg., toys, school assignments, pencils, or books)	○	○	○	○
8. Often is distracted by extraneous stimuli	○	○	○	○
9. Often is forgetful in daily activities	○	○	○	○
10. Often has difficulty maintaining alertness, orienting to requests, or executing directions	○	○	○	○
11. Often fidgets with hands or feet or squirms in seat	○	○	○	○
12. Often leaves seat in classroom or in other situations in which remaining seated is expected	○	○	○	○
13. Often runs about or climbs excessively in situations in which it is inappropriate	○	○	○	○
14. Often has difficulty playing or engaging in leisure activities quietly	○	○	○	○
15. Often is "on the go" or often acts as if "driven by a motor"	○	○	○	○
16. Often talks excessively	○	○	○	○
17. Often blurts out answers before questions have been completed	○	○	○	○
18. Often has difficulty awaiting turn	○	○	○	○
19. Often interrupts or intrudes on others (eg., butts into conversations/games)	○	○	○	○
20. Often has difficulty sitting still, being quiet, or inhibiting impulses in the classroom or at home	○	○	○	○
21. Often loses temper	○	○	○	○
22. Often argues with adults	○	○	○	○
23. Often actively defies or refuses adult requests or rules	○	○	○	○
24. Often deliberately does things that annoy other people	○	○	○	○
25. Often blames others for his or her mistakes or misbehavior	○	○	○	○
26. Often touchy or easily annoyed by others	○	○	○	○
27. Often is angry and resentful	○	○	○	○
28. Often is spiteful or vindictive	○	○	○	○

	Not At All	Just A Little	Quite A Bit	Very Much
29. Often is quarrelsome	◉	○	◉	◉
30. Often is negative, defiant, disobedient, or hostile toward authority figures	◉	○	◉	◉
31. Often makes noises (eg., humming or odd sounds)	○	○	○	○
32. Often is excitable, impulsive	○	○	○	○
33. Often cries easily	○	○	○	○
34. Often is uncooperative	○	○	○	○
35. Often acts "smart"	◉	◉	◉	○
36. Often is restless or overactive	○	○	○	○
37. Often disturbs other children	○	○	○	○
38. Often changes mood quickly and drastically	○	○	○	○
39. Often easily frustrated if demands are not met immediately	○	○	○	○
40. Often teases other children and interferes with their activities	○	○	○	○
41. Often is aggressive to other children (eg., picks fights or bullies)	○	○	○	○
42. Often is destructive with property of others (eg., vandalism)	◉	◉	◉	◉
43. Often is deceitful (eg., steals, lies, forges, copies the work of others, or "cons" others)	○	○	○	○
44. Often and seriously violates rules (eg., is truant, runs away, or completely ignores class rules)	○	○	○	○
45. Has persistent pattern of violating the basic rights of others or major societal norms	○	○	○	○
46. Has episodes of failure to resist aggressive impulses (to assault others or to destroy property)	◉	◉	○	◉
47. Has motor or verbal tics (sudden, rapid, recurrent, nonrhythmic motor or verbal activity)	◉	○	◉	◉
48. Has repetitive motor behavior (eg., hand waving, body rocking, or picking at skin)	◉	○	◉	◉
49. Has obsessions (persistent and intrusive inappropriate ideas, thoughts, or impulses)	◉	○	◉	◉
50. Has compulsions (repetitive behaviors or mental acts to reduce anxiety or distress)	◉	○	◉	◉
51. Often is restless or seems keyed up or on edge	○	○	○	○
52. Often is easily fatigued	○	○	○	○
53. Often has difficulty concentrating (mind goes blank)	○	○	○	○
54. Often is irritable	○	○	○	○
55. Often has muscle tension	○	○	○	○
56. Often has excessive anxiety and worry (eg., apprehensive expectation)	○	○	○	○
57. Often has daytime sleepiness (unintended sleeping in inappropriate situations)	○	○	○	○
58. Often has excessive emotionality and attention-seeking behavior	○	○	○	○
59. Often has need for undue admiration, grandiose behavior, or lack of empathy	○	○	○	○
60. Often has instability in relationships with others, reactive mood, and impulsivity	○	○	○	○
61. Sometimes for at least a week has inflated self esteem or grandiosity	○	○	○	○
62. Sometimes for at least a week is more talkative than usual or seems pressured to keep talking	○	○	○	○
63. Sometimes for at least a week has flight of ideas or says that thoughts are racing	○	○	○	○
64. Sometimes for at least a week has elevated, expansive or euphoric mood	○	○	○	○
65. Sometimes for at least a week is excessively involved in pleasurable but risky activities	○	○	○	○
66. Sometimes for at least 2 weeks has depressed mood (sad, hopeless, discouraged)	○	○	○	○
67. Sometimes for at least 2 weeks has irritable or cranky mood (not just when frustrated)	◉	◉	◉	◉

	Not At All	Just A Little	Quite A Bit	Very Much
68. Sometimes for at least 2 weeks has markedly diminished interest or pleasure in most activities	○	○	○	○
69. Sometimes for at least 2 weeks has psychomotor agitation (even more active than usual)	○	○	○	○
70. Sometimes for at least 2 weeks has psychomotor retardation (slowed down in most activities)	○	○	○	○
71. Sometimes for at least 2 weeks is fatigued or has loss of energy	○	○	○	○
72. Sometimes for at least 2 weeks has feelings of worthlessness or excessive, inappropriate guilt	○	○	○	○
73. Sometimes for at least 2 weeks has diminished ability to think or concentrate	○	○	○	○
74. Chronic low self-esteem most of the time for at least a year	○	○	○	○
75. Chronic poor concentration or difficulty making decisions most of the time for at least a year	○	○	○	○
76. Chronic feelings of hopelessness most of the time for at least a year	○	○	○	○
77. Currently is hypervigilant (overly watchful or alert) or has exaggerated startle response	○	○	○	○
78. Currently is irritable, has anger outbursts, or has difficulty concentrating	○	○	○	○
79. Currently has an emotional (eg., nervous, worried, hopeless, tearful) response to stress	○	○	○	○
80. Currently has a behavioral (eg., fighting, vandalism, truancy) response to stress	○	○	○	○

James M. Swanson, Ph.D., University of California, Irvine, CA 92715

What are the current concerns? Please list in order of importance

1. _____

2. _____

3. _____

Previous counseling/mental health/psychiatric services? List providers, dates and reasons:

_____

_____

_____

_____

What does this child/adolescent like to do?

Hobbies:_____

BIOLOGICAL MOTHER: Age_____

Education_____

Work_____

Health_____

Criminal History_____

Times married_____

Times divorced_____

BIOLOGICAL FATHER: Age_____

Education_____

Work_____

Health_____

Criminal History_____

Times married_____

Times divorced_____

CHILD RAISED BY: ( ) BOTH PARENTS ( ) MOTHER ( ) FATHER ( ) GRAND PARENTS ( ) FOSTER CARE ( ) ADOPTIVE PARENTS

( ) OTHER_____

WHO HAS LEGAL CUSTODY:_____

IF ADOPTED WHAT AGE:_____**KIND OF ADOPTION:**_____

DEVELOPMENTAL HISTORY

PREGNANCY AND BIRTH HISTORY

PREGNANCY WAS ☐ PLANNED ☐ UNPLANNED

PREGNANCY COMPLICATIONS: ☐ NO ☐ YES_____

If yes, please specify:_____

DELIVERY WAS: ☐ VAGINAL ☐ CESAREAN ☐ OTHER_____

BABY WAS ☐ FULL-TERM ☐ PREMATURE IF PREMATURE, BY HOW MANY WEEKS? _____

COMPLICATIONS MOTHER/CHILD HAD DURING/IMMEDIATELY AFTER BIRTH: ☐ NONE ☐ YES

If yes, please specify:_____

WHAT SUBSTANCES, IF ANY, DID THE MOTHER USE DURING THE COURSE OF PREGNANCY ?

ALCOHOL: ☐ NO ☐ YES_____

PLEASE LIST STREET DRUGS (IF APPLICABLE): ☐ NO ☐ YES _____

WHAT MEDICATIONS, IF ANY, DID THE MOTHER USE DURING THE COURSE OF PREGNANCY?

_____

POSTNATAL PERIOD AND INFANCY

WERE THERE ANY FEEDING PROBLEMS DURING INFANCY?

❒ Yes ❒ No If yes, specify: _____

WAS THIS CHILD/ADOLESCENT COLICKY AS AN INFANT? ❒ Yes ❒ No

WERE THERE EARLY INFANCY SLEEP PATTERN DIFFICULTIES?

❒ Yes ❒ No If yes, specify: _____

WERE THERE PROBLEMS WITH THE INFANT'S RESPONSIVENESS/ALERTNESS?

❒ Yes ❒ No If yes, specify: _____

HOW "EASY" WAS THIS CHILD/ADOLESCENT AS AN INFANT?

❒ Very easy ❒ Easy ❒ Average ❒ Difficult ❒ Very

DID THIS CHILD/ADOLESCENT EXPERIENCE ANY HEALTH PROBLEMS DURING INFANCY OR TODDLER YEARS?

❒ Yes ❒ No If yes, specify: _____

AS AN INFANT/TODDLER, HOW DID THIS CHILD/ADOLESCENT BEHAVE WITH OTHER PEOPLE?

❒ Avoided social contact ❒More shy than average ❒ Average sociability ❒ More sociable than average

AS AN INFANT/TODDLER, HOW INSISTENT WAS THIS CHILD/ADOLESCENT WHEN THEY WANTED SOMETHING?

❒Not insistent Average ❒Somewhat insistent ❒ Very insistent

HOW WOULD YOU RATE THE ACTIVITY LEVEL OF THIS CHILD/ADOLESCENT AS AN INFANT/TODDLER?

❒ Not active ❒ Less active ❒ Average ❒ More active Very active

WOULD YOU DESCRIBE THE INFANT/TODDLER'S TYPICAL PLAY?

❒ Played alone
❒ Interested in playing with others
❒ Repetitive
❒ Imaginative/make-believe
❒ Rigid, concrete
❒ Quiet
❒ Loud

DEVELOPMENTAL MILESTONES

HAVE YOU OR ANYONE ELSE EVER HAD CONCERNS ABOUT THIS CHILD/ADOLESCENT'S DEVELOPMENT?

❒ Yes ❒ No If yes, specify: _____

WAS YOUR CHILD SLOW TO DEVELOP MOTOR SKILLS OR AWKWARD COMPARED TO PEERS? (e.g., running, skipping, climbing, biking, playing ball

❒ Yes ❒ No If yes, specify: _____

AT WHAT AGE DID (S)HE: **SIT UP**: _____ **CRAWL**: _____ **WALK**: _____

(S)HE SPEAK FIRST WORD? _____ **PUT 2-3 WORDS TOGETHER?** _____

AT WHAT AGE WAS (S)HE **TOILET TRAINED**? _____

ANY PROBLEMS WITH **BEDWETTING, ACCIDENTS OR SOILING**? _____

WAS PHYSICAL THERAPY EVER NECESSARY? _____

WAS OCCUPATIONAL THERAPY EVER NECESSARY? _____

WAS SPEECH/LANGUAGE THERAPY EVER NECESSARY? _____

ANY ORAL MOTOR PROBLEMS? (e.g., late drooling, poor sucking, poor chewing) _____

WAS CHILD SLOW TO: ❒ LEARN THE ALPHABET _____ ❒ NAME COLORS _____ ❒ COUNT _____

ANY SPEECH DELAYS OR PROBLEMS? (e.g., stuttering, difficult to understand) _____

DOES YOUR CHILD HAVE **UNUSUAL LANGUAGE? (DESCRIBE)** _____

SOCIAL BEHAVIOR

DOES YOUR CHILD:			
	GET ALONG WITH OTHER CHILDREN?----------	❒ Yes	❒ No
	ENGAGE IN IMAGINATIVE PLAY ACTIVITIES? -----	❒ Yes	❒ No
	GET ALONG WITH ADULTS? ----------	❒ Yes	❒ No
	HAVE FRIENDS? ----------	❒ Yes	❒ No
	KEEP FRIENDS?----------	❒ Yes	❒ No
	UNDERSTAND GESTURES? ----------	❒ Yes	❒ No
	HAVE A GOOD SENSE OF HUMOR? ----------	❒ Yes	❒ No
	UNDERSTAND SOCIAL CUES SUCH AS WHEN OTHERS ARE ANGRY? FEEL UNCOMFORTABLE, NEED SUPPORT? ----------	❒ Yes	❒ No
	HAVE PROBLEMS WITH PEER PRESSURE? (e.g., alcohol/drug use) ----------	❒ Yes	❒ No

EDUCATIONAL HISTORY

PLEASE SUMMARIZE YOUR CHILD/ADOLESCENT'S ACADEMIC, BEHAVIORAL AND EMOTIONAL PROGRESS WITHIN EACH OF THESE GRADE LEVELS. INCLUDE ANY TEACHER COMMENTS OR OBSERVATIONS:

PRESCHOOL/DAYCARE:_____

_____

ELEMENTARY: _____

_____

JUNIOR HIGH: _____

_____

HIGH SCHOOL: _____

_____

HAS THE CHILD/ADOLESCENT REPEATED ANY GRADES?

❒ Yes ❒ No If yes, what grade(s) and why? _____

HAS THE CHILD/ADOLESCENT EVER BEEN IN ANY TYPE OF SPECIAL EDUCATION PROGRAM, AND IF SO, DURING WHICH GRADE(S)?

Program	Grade(s)
❒ Learning disabilities (LD)	_____
❒ Resource room	_____
❒ Emotional/behavioral disorders (EBD)	_____
❒ Speech/language therapy	_____
❒ Occupational therapy	_____
❒ Adaptive physical education	_____
❒ Autism services	_____
❒ Other: _____	_____

HAS THE CHILD/ADOLESCENT EVER BEEN IN ANY TYPE OF SUPPLEMENTARY PROGRAM, AND IF SO, DURING WHICH GRADE(S)?

Program	Grade(s)
❒ Chapter 1 help in reading/math	_____
❒ 504 plan	_____
❒ Gifted programs	_____
❒ Social skills group	_____
❒ Other: _____	_____

CHILD/ADOLESCENT'S TYPE OF PLACEMENT IN SCHOOL:

❒ Regular ❒ Learning Disability ❒ Behavior Disorder ❒ Resource Room ❒ Intellectual Delays ❒ Other

CHILD/ADOLESCENT'S STRENGTHS IN SCHOOL SUBJECTS: _____

CHILD/ADOLESCENT'S WEAKNESSES IN SCHOOL SUBJECTS: _____

DISCIPLINE

WHO ORDINARILY DISCIPLINES YOUR CHILD? _____

DO THE ADULTS CARING FOR THIS CHILD AGREE ON DISCIPLINE? _____

HOW IS YOUR CHILD DISCIPLINED:

❒ SPANK ❒ TAKE AWAY PRIVILEGES ❒ YELL ❒ SEND TO ROOM ❒ TALK TO OR REASON WITH ❒ TIME OUT

❒ ASSIGN EXTRA CHORES ❒ OTHER: _____

DO YOU REWARD YOUR CHILD FOR OBEYING OR BEHAVING WELL?	❒ Often	❒ Sometimes	❒ Never
DO YOU IGNORE YOUR CHILD WHEN HE/SHE IS MISBEHAVING?	❒ Often	❒ Sometimes	❒ Never
DO YOU ASK YOUR CHILD WHAT HIS/HER PLANS ARE FOR THE DAY?	❒ Often	❒ Sometimes	❒ Never
DOES YOUR CHILD TALK YOU OUT OF BEING PUNISHED ? (e.g., lifting restrictions earlier than you originally said)	❒ Often	❒ Sometimes	❒ Never

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MEDICAL HISTORY

HOW WOULD YOU DESCRIBE YOUR CHILD'S HEALTH?

❒ Very Good ❒ Good ❒ Fair ❒ Poor ❒ Very Poor

HOW IS HIS/HER: Specify any problems:

HEARING: ---------- ❒ Good ❒ Fair ❒ Poor _____

SPEECH/LANGUAGE: ---------- ❒ Good ❒ Fair ❒ Poor _____

GROSS MOTOR COORDINATION: -- ❒ Good ❒ Fair ❒ Poor _____

FINE MOTOR COORDINATION: ---- ❒ Good ❒ Fair ❒ Poor _____

VISION: ---------- ❒ Good ❒ Fair ❒ Poor _____

DOES YOUR CHILD WEAR GLASSES? _____

ARE IMMUNIZATIONS UP TO DATE? _____**ANY MEDICINAL ALLERGIES?**_____

WHICH OF THE FOLLOWING ILLNESSES HAS THE CHILD HAD? (check all that apply)

❒ Stomach aches ❒ High fevers ❒ Asthma ❒ Food allergies
❒ Constipation ❒ Chronic ❒ Urinary tract infection ❒ Chronic pain
❒ Lead poisoning diarrhea ❒ RSV ❒ Chicken pox ❒ Chronic ear infections
❒ Croup ❒ Pneumonia ❒ Encephalitis ❒ Chronic headaches
❒ Seizures ❒ Other (specify): _____

IS THERE A HISTORY OF (check all that apply):

❒ Headaches ❒ Depression ❒ High Anxiety ❒ Abdominal pains/vomiting
❒ Febrile seizures ❒ Epilepsy/seizures ❒ Loss of consciousness ❒ Sleep difficulties (including nightmares)
❒ Impulsivity ❒ Hyperactivity ❒ Clumsiness ❒ Self-injurious behavior
❒ Frequent ear infections ❒ Asthma or allergies ❒ Temper tantrums ❒ Nail biting
❒ Head banging ❒ Failure to thrive ❒ Thyroid disorder ❒ Breath holding
❒ Abuse toward animals ❒ Physical/sexual abuse ❒ Diabetes ❒ Drug or alcohol use
❒ Tics/twitching ❒ Kidney disease ❒ Blood disorder ❒ Lead poisoning/toxic ingestion
❒ GI disease ❒ Lung disease ❒ Heart disease ❒ Obsessive-compulsive behavior
❒ Repetitive movements (e.g., hand flapping)

HAS YOUR CHILD/ADOLESCENT HAD ANY OTHER MEDICAL PROBLEMS ASIDE FROM USUAL CHILDHOOD ILLNESSES?

❒ Yes ❒ No If yes, specify: _____

LIST SERIOUS ILLNESSES/INJURIES/SURGERIES/HOSPITALIZATIONS (INCLUDE PSYCHIATRIC HOSPITALS):

Age of child	Incident (please explain)
_____	_____
_____	_____
_____	_____

HAS YOUR CHILD/ADOLESCENT HAD ANY ACCIDENTS RESULTING IN THE FOLLOWING? (check all that apply)

❒ Broken bones ❒ Loss of consciousness ❒ Severe lacerations ❒ Head injury
❒ Severe bruises ❒ Eye injury ❒ Sutures ❒ Loss of teeth

If yes, please explain: _____

DOES YOUR CHILD/ADOLESCENT HAVE BLADDER CONTROL PROBLEMS? ❒ Yes ❒ No

DOES YOUR CHILD/ADOLESCENT HAVE BOWEL CONTROL PROBLEMS? ❒ Yes ❒ No

DESCRIBE THIS CHILD/ADOLESCENT'S SLEEP PATTERNS/HABITS:

❒ Sleeps all night without disturbance
❒ Awakens during the night/restless
❒ Severe snoring
❒ Sleepwalking
❒ TV in bedroom
❒ Watches TV/plays video games up to bedtime
❒ Gets up after bedtime to watch TV/play games
❒ Difficulty falling asleep
❒ Early morning awakening
❒ Sleeps outside of bedroom

DESCRIBE THIS CHILD/ADOLESCENT'S APPETITE:

❒ Overeat ❒ Average ❒ Under eat ❒ Binge

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD/ADOLESCENT'S EATING HABITS?

❒ Yes ❒ No If yes, please explain: _____

HAS YOUR CHILD EVER RECEIVED MEDICATIONS IN THE PAST FOR EMOTIONAL OR BEHAVIORAL PROBLEMS?

❒Yes ❒No If yes, please give the following details:

	DOSE	RESPONSE	SIDE EFFECTS
1. Ritalin			
2. Adderall			
3. Adderall XR			
4. Concerta			
5. Vyvanse			
6. Intuniv (Tenex)			
7. Clonidine (Kapvay)			

8. OTHERS: FOCALIN_____FOCALIN XR_____METADATE CD_____STRATTERA _____DAYTRANA_____

9. ANY OTHER MEDS:_____

IS YOUR CHILD/ADOLESCENT PRESENTLY TAKING ANY MEDICATION? If yes then please provide details ( ) No

1._____
2._____
3._____
4._____
5._____

OTHER MEDICATIONS AND DOSES (INCLUDE OVER THE COUNTER MEDICINES):

_____

_____

FAMILY HISTORY OF MENTAL HEALTH AND CHEMICAL DEPENDENCY

Check & list – i.e. Mother (M), Father (F), Bother (B), Sister (S), Aunt (A), Grandmother (GM), Grandfather (GF) etc.)

	Biological Mother/ Her Family	Biological Father/ His Family	Siblings/Other Caretaker(s) _____	_____
Problems with attention, hyperactivity or impulse control				
Problems with aggressive, defiant and oppositional behavior as a child				
Arrests / antisocial behavior				
Learning Disabilities				
Mental Retardation				
Autism				
Depression for longer than two weeks				
Suicidal thoughts or attempts				
Bipolar Disorder				
Anxiety Disorder (worry, nervousness, panic)				
Obsessive-Compulsive Behavior				
Eating Disorder				
Psychosis or Schizophrenia				
Alcohol abuse or dependence				
Drug abuse or dependence				
Victim of physical abuse				
Victim of sexual abuse				
Other (specify): _____				

SEXUAL ABUSE HISTORY

	Yes	No	Don't Know
Has your child/adolescent ever been exposed to inappropriate pornographic material?	○	○	○
Has anyone ever exposed him/herself to your child/adolescent?	○	○	○
Has anyone had sexual activity with your child/adolescent against their will?	○	○	○
Has your adolescent been sexually involved with someone at least four years older than him/her?	○	○	○
Have any of the above incidents been reported to social services?	○	○	○

LIFE CHANGES OR STRESSFUL EVENTS

WHICH OF THE FOLLOWING MAJOR LIFE EVENTS HAVE TAKEN PLACE IN YOUR CHILD'S LIFE? PLEASE CHECK ALL THAT APPLY:

	Experienced event within last 12 months	Experienced event more than one year ago
Change in living conditions	☐	☐
Change in schools	☐	☐
Change in family member's health	☐	☐
Death/loss of family member	☐	☐
Death/loss of friend	☐	☐
Illness or injury to child	☐	☐
Illness or injury to family	☐	☐
Divorce of parents	☐	☐
Marital separation of parents	☐	☐
Job change or parent	☐	☐
Change in family financial status	☐	☐
Pregnancy of mother	☐	☐
Jail term for parent	☐	☐
Family violence	☐	☐
Arrests/imprisonments	☐	☐
Foster care/other placement outside of	☐	☐
home Verbal/emotional abuse	☐	☐
Physical abuse	☐	☐
Sexual abuse	☐	☐

IX. RISK ASSESSMENT

A. Are there any firearms in any homes where your child resides? ☐ Yes ☐ N

B. Is there any history of domestic violence in the home? ☐ Yes ☐ No

If yes, has the family ever been referred to CPS or DFCS? ☐ Yes ☐ No

C. Does your child have a history of homicidal (harm to others) thoughts or behaviors? ☐ Yes ☐ No

D. Does your child have current homicidal (harm to others) thoughts or behaviors? ☐ Yes ☐ No

F. Does your child have history of suicidal thoughts or behaviors? ☐ Yes ☐ No

G. Does your child have current suicidal thoughts or behaviors? ☐ Yes ☐ No

H. Do you have other safety concerns at this time? ☐ Yes ☐ No

Today's Date:

AR Psychiatric And Counseling Center

Date_____

CHECKLIST: Review of Systems

General-
□ Weight loss
□ Weight Gain
□ Fever or chills
□ Fatigue
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts
□ Last eye exam

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores **Neck-**
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Breasts-
□ Lumps
□ Pain
□ Discharge
□ Self-exams
□ Breast-feeding

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary-
□Frequency
□Urgency
□Burning or pain
□Blood in urine
□Incontinence
□Change in urinary strength

Vascular-
□Calf pain with walking
□Leg cramping

Musculoskeletal-
□Muscle or joint pain
□Stiffness
□Back pain
□Redness of joints
□Swelling of joints
□Trauma

Neurologic-
□Dizziness
□Fainting
□Seizures
□Weakness
□Numbness
□Tingling
□Tremor

Hematologic-
□Ease of bruising
□Ease of bleeding

Endocrine-
□Head intolerance
□Cold intolerance
□Sweating
□Frequent urination
□Thirst
□Increase in appetite

AR PSYCHIATRIC AND COUNSELING CENTER
General Information

Welcome to the AR Psychiatric and Counseling Center. We are a private mental health facility located at Lowndes County on North Oak Street, extension. We also have a satellite office in Tift County. Our staff consists of psychiatrists, advanced practice registered nurse (APRN), licensed clinical social workers, and licensed professional clinical counselors. We treat all age groups and provide:

- Psychiatric evaluation and management.
- Individual, family, and couple therapy for children, adolescents, and adults.
- Substance abuse /addiction assessment and treatment.
- In addition, we are the first provider in South Georgia to offer **Transcranial Magnetic Stimulation Therapy and Spravato Nasal treatment for depression**

We recognize that psychiatric disorders are painful conditions that involve many aspects of a person's life. Understanding these various aspects and addressing unique individual needs is crucial for recovery. At ARPCC, we use a comprehensive approach for evaluation, and every patient has an individual treatment plan to address these various aspects of care. We are glad you took the first step in seeking care for painful emotional issues. Now, you can expect the best professional efforts, respect, and quality of care from our team of service providers. An essential aspect of treatment is that you fully understand the risks and benefits of your care. We encourage you and your family to take an active part in your treatment process and let us know if you don't understand any part. Please review the following information and initial after each section. One of the ARPCC staff or your provider will review it with you once completed.

Initial Evaluation & Follow-up Medication

Visits On your **First Visit:**

- A clinician will obtain a detailed medical and psychiatric history; taking up to 45-60 minutes. A few cases, when the diagnosis is not clear from history, he may need additional testing before making treatment recommendations.

- The clinician then explains the diagnosis, makes treatment recommendations, and answers any questions you may have.
- The clinician will also direct you to check out to schedule a follow-up appointment. It is wise to schedule that appointment while in the office, if possible.

For follow-up **Medication Management Visits:**

- Patients routinely are scheduled with the clinician for follow-up medication management visits to assess your treatment response and monitor for side effects. In addition, the clinician will meet with you to obtain information regarding your response to the treatment plan.
- For your safety, medication changes are generally not made over the phone. However, if you feel you have an adverse reaction, please call your primary contact person immediately.
- You will typically see the clinician for return visits.

- If you need **Psychotherapy:**
  The clinician will refer you to a therapist in our office, if possible, on your insurance plan. **All the therapists working at ARPCC are independent contractors and not ARPCC employees. Independent contractors are responsible for their actions, and the ARPCC shall not be liable for the acts or omissions of any such independent contractors**.

_____I have read the above policy and understand it.
Initials

Patient Name: _____Date: _____

Dr. Anil K. Gupta, M. D.
Dr. Bhavesh A. Patel, M. D.

PLEASE REVIEW AND INITIAL THE FOLLOWING POLICIES FOR TREATMENT:

___ ITEM 1 - FEMALE PATIENTS
Initial If taking medication, I agree to notify my psychiatrist, in the event that I am planning to become pregnant, or I become pregnant so that I may discuss the risks/benefits of medication.

___ ITEM 2 - ALCOHOL/DRUGS/HERBAL SUPPLEMENTS
Initial It is recommended not to use alcohol/drugs or herbal supplements in combination with prescription psychiatric medication and I agree to notify my psychiatrist if this is a concern.

___ ITEM 3 - MEDICATION REFILLS
Initial Medication is prescribed to last until your next appointment. You will need to make an appointment when medication refills are required.

___ ITEM 4 - LETTERS AND/OR FORMS
Initial There will be a charge for any forms and/or letters that must be completed in this office by any practitioner or office staff.

___ ITEM 5 - THERAPY SESSIONS
Initial Therapy sessions are scheduled for 45 or 60 minutes. In order that you receive your entire session, please be prompt for your appointment.

___ ITEM 6 - CONFIDENTIALITY
Initial All information is guarded by strict confidentiality. We require your written consent in order to release/obtain information.

___ ITEM 7 - CONSENT FOR TREATMENT MUST BE SIGNED PRIOR TO THE START OF
Initial **YOUR APPOINTMENT**

I hereby give consent for myself or the above-named patient to be treat/tested by my psychiatrist. If the above-named patient is a minor who is/has been involved in any court proceedings, I have provided proof by the attached court documents, that I have the legal right to request treatment for the above-named minor. If you are **18 years of age**, you must sign yourself and are allowed to choose whether you wish anyone/parents to be present during your evaluation and treatment. Both parties must sign consent for treatment if seen for marital or co-joint therapy. A parent/guardian may not come in for an appointment without the patient. **The patient must be present every visit. Patients under 18 years of age will only be seen with a parent or guardian present.**

___ ITEM 8 - TERMINATION OF TREATMENT
Initial Assault or verbally threatening behavior towards staff, other patients, or physical property of AR Psychiatric & Counseling Center will be cause to terminate treatment and be held responsible for damages. Firearms and other weapons are prohibited, with exception for an officer of the law.

___ ITEM 9 - CANCELLATIONS
Initial **Cancellations must be made 24 HOURS before your session.** Your session time is reserved for you and you will be charged a **$50.00 no-show fee** for late cancellations or missed appointments. **Our office policy allows three no-show fees before terminating services.**

Patient Name: _____Date: _____

___ ITEM 10 - OUTSIDE LAB OR OTHER DIAGNOSTIC TESTS

Initial We do not get authorization from your insurance for any ordered tests that are performed outside our office. We suggest you contact your insurance carrier to insure that you will be reimbursed for the charges and are aware of your benefit coverage.

___ ITEM 11 - MANAGED CARE PLANS

Initial This practice has contracted with several managed care plans and will be handled according to our agreement with them. All co-payments must be paid at time of service. It is your responsibility to be aware of coverage variables, such as preventive health care, deductibles, etc., and to pay for services not covered by your insurance company. Following notification for the insurance company, any denied amounts would be due immediately, upon being notified by our office.

___ ITEM 12 - FINANCIAL POLICY

Initial I acknowledge that I have read and understand the financial policies of this office.

___ ITEM 13 - TELEHEALTH POLICY

Initial I acknowledge that I have read and understand the telehealth policies of this office.

___ ITEM 14 – SOCIAL MEDIA POLICY

Initial I acknowledge that I have read and understand the social media policies of this office.

___ ITEM 13 - EMERGENCY SERVICES

Initial I agree to contact my psychiatrist or 911 in the event that I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

___ ITEM 14 - NOTICE OF PRIVACY PRACTICES

Initial I acknowledge that I have received a copy of the Notice of Privacy Practices of this office.

_____ _____ _____

Patient Signature Initials Date

_____ _____ _____

Parent/Guardian Signature Initials Date

Items 1-15, initialed by me, indicate my understanding of legal Terms and Conditions in connection with the treatment of patients.

AR PSYCHIATRIC AND COUNSELING CENTER
FINANCIAL POLICY

We are committed to providing our patients with the best possible care and are pleased to discuss our professional services with you anytime. Your clear understanding of our Office Procedures and Financial Policies is very important. All patients must complete our "Patient Information Form" before seeing the Professional.

Payment of services is handled prior to your session. Your insurance company mandates you must pay your co-payment at the time of service. If you cannot pay, you may be asked to reschedule.

We accept cash, checks, Visa, and Debit. If a check is returned for insufficient funds, we will not accept another check from the patient. Payment will have to be cash, credit, or debit. There is a **$30 returned check fee**. We do not accept temporary or post-dated checks if you are a new patient.

We charge for missed/canceled appointments unless canceled at least 24 hours in advance. Our policy is to charge $50.00 for missed/canceled appointments. A few of the therapist charge $100.00. Please do not rely on appointment reminder calls, as this is a courtesy. Having three or more no-shows or cancellations of appointments can result in termination of treatment. Please help us serve you better by keeping scheduled appointments.
NOTE: You may be asked to reschedule if you are more than 15 minutes late for your appointment. If you feel you were charged in error, please discuss this matter with our office manager.

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 not billed to your insurance. **The cost for drafting letters and completing forms is $50.00 each.** If you choose, this office will provide you with a completed receipt showing charges and payments, which you may file with your insurance company.

In the event of a Divorce, we must have a copy of the Divorce Decree signed by a judge. The decree must state which parent has **Managing Conservatory Privileges for the minor child.**

REGARDING INSURANCE ASSIGNMENT

We will only file claims with insurance companies we are contracted with. In order to achieve this, we must have all current insurance information on file.

If there are any changes in your insurance coverage, you must notify our office 5 days prior to your next appointment or the visit will be self-pay or rescheduled.

The patient must stay current with the payment of their deductibles and co-payments. All information this office gives in reference to your insurance coverage is based on information obtained from your insurance company, is only descriptive of your benefits, and is not a guarantee of payment by your insurance company. An insurance company may quote benefits and give authorization, but clearly state in their disclaimer this is not a guarantee of payment. Therefore, any amount we collect at the time of service or quote as your responsibility is an estimate only. You are ultimately responsible for any and all balances on your account.

Should you have any problems regarding your account or about the filing of claims, fees, or billing records, please do not hesitate to ask our office Staff.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES OF AR PSYCHIATRIC & COUNSELING CENTER.

_____ _____

Signature **Date**

AR PSYCHIATRIC AND COUNSELING CENTER
SOCIAL MEDIA POLICY

'Social media' refers to online and mobile tools that people use to share opinions, information, experiences, images, and video or audio clips, and includes websites and applications (apps) used for social networking. Common sources of social media include, but are not limited to, social networking sites such as Facebook and LinkedIn, blogs (personal, professional and those published anonymously) and microblogs such as Twitter, content-sharing websites such as YouTube and Instagram, and discussion forums and message boards.

This document outlines our office policy related to the use of Social Media. Please read it carefully to understand how our licensed mental health professionals conduct themselves on the Internet and how you can expect a response to interactions that may occur between you and your doctor, nurse, or therapist using social media or technology. If you have any questions about this policy, please bring them up during your visit. As new technology develops, this policy may be updated to reflect those changes, and you will be notified in writing. You may obtain a copy of this policy upon request. Our primary concern is your privacy and maintaining a professional therapeutic relationship with our patients.

EMAILS, CELL PHONES, FAXES, MOBILE DEVICES

Secure and private communication cannot be guaranteed entirely using non-secure technology such as cell/smart phones, mobile devices, tablets, regular email, or via our website. It is your right to decide whether using this type of non-secure technology may be permitted and under what circumstances. Should you choose to contact your provider using any type of non-secure technology, it will be considered implied consent (with your permission) that we respond and return messages in the same non-secure manner, and you agree to take the risk that such communication may be intercepted. Please be advised that although it is a convenient way to communicate, it is very important that you are aware that computers, email, and cell phones, including text messaging without encryption, can be accessed by unauthorized people. Some risks include: conversations being overheard; emails can be sent to the wrong recipient; others may view pop-up messages on your cell phone, and notification services may alert others of your location. Service providers retain a log of all emails, and though it is unlikely someone will look at these logs, they can be read by system administrators of the internet service provider. AR Psychiatric & Counseling center does not use encryption in our email system; therefore, should you choose to contact us via email, we ask that you limit your communication to administrative issues only, such as changing appointments or billing questions, to protect your privacy. Our fax is secure, and if you need to communicate clinical information, we ask you to do so by faxing us at 229-244-2038. If you communicate confidential or private information via text or email, we assume you have made an informed decision and will view this as an agreement to take the risk and will honor your desire to communicate on such matters. We will not initiate contact via text or email without your consent or as stated above.

NEVER USE EMAIL, TEXT OR FAX FOR EMERGENCIES. Emails or faxes may not be checked daily. Due to computer network problems, emails may not be delivered or there may be a disruption in connection. In the event of emergency, please call 911.

SOCIAL MEDIA NETWORKING SITES

Networking sites such as Facebook, Twitter, or LinkedIn are NOT secure. Using Wall posts, replies, or other means of engaging in conversations on these sites could compromise your confidentiality. In addition, exchanges on social networking sites can become part of your legal medical record. This policy serves to notify you that being linked as friends or contacts on these sites can compromise your confidentiality, privacy, and therapeutic relationship. As in any other public context, you have control over your own description regarding the nature of your acquaintances. If you choose to disclose information regarding your relationship with one of our clinical professionals, you acknowledge that you understand and accept the risk associated with using social networking. We do not accept friend requests from former or current patients to protect your privacy and maintain a professional boundary in the therapeutic relationship.

LOCATION BASED SERVICES

If you use location-based services on your cell mobile device, you may compromise your privacy while attending sessions in the office. We do not list the practice as a check-in location on various sites such as Foursquare; however, it may be found as a Google location, and if you have passive Location Based Services enabled, it may show that you are at the location regularly and others may surprise you are in treatment at AR Psychiatric & Counseling Center. Please ask your service provider if you are unware of how to disable this setting.

WEBSITE

Our website www.arpccenter.com is for general information purposes only and should not be used as a substitute for your mental health care. Although we have a contact us link, please note that the webpage is not a secure means of communicating clinical information and should be limited to non-clinical questions.

SEARCH ENGINES

It is not a regular part of our practice to search for patients on Google, Facebook other search engines. Extremely rare exceptions may be made during times of crisis (in the event the doctor or therapist feels you are a danger to yourself or others), and all other means to contact you have been exhausted, a search engine may be used to ensure your welfare. If this occurs, this will be fully documented in the clinical record and discussed with you at your next visit.

FOLLOWING

Our licensed professionals will not follow any client on Twitter, Instagram, blogs, or other apps/websites. If there is content you wish to share from your online life, please bring it into the session, where it can be explored together. If you follow any of our licensed therapist's blogs, be aware that your privacy may be compromised if you use an easily recognizable name.

BUSINESS REVIEW SITES

You may find our psychiatry and psychotherapy services on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some sites include forums where users rate their providers and add reviews or comments. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please be aware that a listing for AR Psychiatric & Counseling Center is NOT a request for a testimonial, rating, or endorsement from you as a patient. You have the right to express yourself on any site, but due to confidentiality, we cannot respond to any review on any of these sites, whether positive or negative. You are urged to take your privacy as seriously as we take our commitment to your confidentiality. You should also be aware that if you use these sites to communicate with one of our professionals, it is possible it will never be seen. If you choose to write something on a business review site, remember that you may be sharing personally revealing information in a public forum.

ACKNOWLEDGEMENT OF REVIEW OF SOCIAL MEDIAL POLICY

By signing below, you are indicating that you have read this document (all pages), understand your rights as a client/patient, and accept the responsibility as stated. You may request a printed copy of the Social Media Policy, and all questions regarding these policies have been answered to your satisfaction.

Printed Name of Patient:_____ Date:_____

Signature of Patient/Legal Representative:_____

AR PSYCHIATRIC AND COUNSELING CENTER

Controlled Substance Policy

I, (name) _____ (DOB) _____, understand that my provider is prescribing a controlled substance medication as part of my treatment plan. I may be treated with medications such as benzodiazepines, stimulants, and or partial opioid agonists (like buprenorphine). These medications may impair my alertness, reflexes, coordination, and judgment. These types of medications are controlled and monitored by local, state, and federal agencies. These medications can be highly effective when taken as directed under medical supervision but have the potential for abuse and misuse.

I understand that psychological dependence and addiction to controlled substances can occur and are a risk of treatment. If this happens, I will follow my physician's guidance and participate in any recommended treatment programs, which may include medical detoxification and psychological counseling on substance misuse.

I AGREE TO ABIDE BY THE FOLLOWING CONDITIONS:

- I will take the medication exactly as prescribed, and I will not change the medication dosage and/or frequency without my physician's approval.
- I agree not to share my medication with anyone.
- I will keep regularly scheduled appointments with my physician. If refills are needed between office visits, I will call the office staff at least **5** days before your medication runs out.
- I understand that **no** early refills of medication will be authorized.
  I understand that I will **not** be given a dosage higher than the FDA guideline's recommended dosage. I am currently on a higher dosage than the FDA's maximum recommended dosage, then my provider may decide to reduce the dosage or change the medication.
- I will not accept or seek controlled substance medication from any other physician or health care provider outside of this practice while being prescribed controlled medication.
- I understand that I must keep my provider informed of all medication that is prescribed to me outside of this practice.
- I understand that office staff is not permitted to refill controlled medications without provider approval.
- I understand that my controlled prescription will only be sent to **one** pharmacy and cannot be transferred or sent to multiple locations
- I understand that lost, stolen, or misplace prescriptions or pills will **not** be replaced.
- I agree that I will not use any illegal drug(s) while receiving care and medication from this practice.
- I agree and understand that my physician may ask a random urine drug testing. If I fail to obtain a drug screen when asked or if the results are inconsistent, I may forfeit the right to continue receiving controlled medication.
- I understand that I should not mix benzodiazepine (anti-anxiety) medications with alcohol and/or opiate (pain)medications. There is a major risk of a decreased respiratory rate that can lead to death when mixing these medications with other substances.

I have read this agreement. I fully understand the consequences or violating this agreement may include cessation of therapy with controlled substances and/or discharge from this practice.

Signature: _____ Date: _____

AR PSYCHIATRIC AND COUNSELING CENTER

Informed Consent for Telemental Health Services

Information About Telemental Health:

Telemental Health involves using two-way videoconferencing to enable you to participate in treatment sessions with your provider (psychiatrist/ therapist) remotely, such as at your home or another private location. Treatment sessions are similar to in-person sessions, in that you and your provider can communicate in real-time while seeing each other over live video.

While telemental health is similar to in-person care, there are differences and some associated limitations. Here are the expected benefits, as well as risks, to consider before proceeding with it.

Expected Benefits:

- Improved access to medical care by enabling you to remain at a remote site, such as your home, while still receiving regular medical care.
- Greater consistency in scheduling.

Possible Risks:

- Reduced ability to perform certain aspects of a physical examination or evaluation.
- Insufficient information (e.g., poor resolution of images or audio) to allow for appropriate medical decision-making by your provider.
- Technical problems or failures interrupting or delaying treatment sessions.
- Failure of security protections resulting in a breach of protected health information

Here is more information regarding how telepsychiatry is conducted in our office:

- **IMPORTANT:** ***You must be in Georgia for Telehealth sessions.***
- Telemental health appointments will be conducted through the HIPAA-compliant, encrypted platform Doxy.me/ Doximity, or via phone if the encrypted platform fails.
- You will need to use a camera-enabled computer, tablet, or smartphone during the session. Please advise your provider of an alternate telephone number or another contact method in the event technical problems interrupt your treatment session.
- It is important for your provider to know where you are physically located during your treatment session in case an emergency arises. Please try to establish a consistent location for you to participate in telemental health sessions.
- In an emergency, your provider may advise you to proceed to an emergency room or other direct care facility for further evaluation and treatment. Please designate at least one emergency contact person and the closest emergency room to your location.
- It is your responsibility to contact the practitioners in your area if an emergency arises and include but are not limited to the following:
  a. 988 Suicide & Crisis Lifeline
  b. GCAL (Georgia Crisis & Access Line) – 800-715-4225
  c. National Suicide Hotline – 800-273-TALK (8255)
  d. Other Local Emergency Number: _____

- At the discretion of your provider, and for controlled substance prescriptions, you may be required to participate in periodic in-person visits to augment telehealth sessions.
- We cannot conduct a session while you are operating a moving vehicle or not in a fixed location to protect your safety and the safety of others.
- For minor patients, we require written consent from a parent or legal guardian for telemental health sessions (see the signature section below).

- It is important for you to be on time for telemental health appointments. If you need to cancel or change your appointment, you must notify your provider in advance by telephone.

Privacy and Confidentiality:

- It is important for you to be in a quiet, private space free of distractions (including cell phones or other devices) during sessions.
- It is important to use a secure internet connection during treatment sessions rather than public or free Wi-Fi.
- Confidentiality still applies for telemental health sessions; treatment sessions will not be recorded without the express permission of all participants, including you and your psychiatrist/therapist.

In-Person Care:

- You have the right to discontinue telemental health sessions and proceed through in-person care if you feel it would be more beneficial to you.
- Your provider may determine that telemental health is no longer appropriate due to certain circumstances and resume in-person treatment sessions.

Patient Consent for the Use of Telehealth:

By signing this form, I indicate the following:

- I have read and understand all the expected benefits and risks associated with telemental health, and any questions have been answered to my satisfaction.
- I understand that I have the right to withhold or withdraw my consent to the use of telemental health in the course of my care at any time and proceed with in person care without affecting my right to future care or treatment.
- I understand that the laws that protect the privacy and the confidentiality of medical information also apply to telehealth; that appropriate measures will be taken to secure transmitted information and maximize privacy and confidentiality.
- I hereby give my informed consent for the use of telemental health in my medical care.

Patient Name: _____ Date: _____DOB: _____

Patient Signature: _____

Parent/Guardian or Other Responsible Party: _____

Name: _____ Signature: _____Date: _____

Witness Name: _____

Signature: _____ Date: _____

AR PSYCHIATRY AND COUNSELING CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHIATRIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment , Payment and Health Care Operations

AR Psychiatric & Counseling, LLC and its contracted providers may use or disclose your protected health information (henceforth termed PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

A."PHI" refers to information in your health record that could identify you.
B."Treatment, Payment and Health Care Operations" refers to

- Treatment is when AR Psychiatric & Counseling, LLC provides, coordinate or manage your health care and other services related to your healthcare. An example would be when we consult with another health care provider, such as your family physician or your psychologist.
- Payment is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Heath Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.

C."Use" applies only to activities within my (office, clinic, practice group, etc), such as sharing employing, applying, utilizing, examining, and analyzing information that identifies you.
D."Disclosure" applies to activities outside my (office, clinic, practice group, etc.) such as releasing, transferring, or providing access to information about you or other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of your treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your "*Psychiatric Notes*". "Psychiatric Notes" are notes we have made about our conversation during our sessions which we have kept separate from the rest of your medical records. These notes are given a greater degree of protection that PHI.
You may revoke all such authorizations (of PHI or Psychiatric Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) We have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Possible Use or Disclosure of PHI or Psychotherapy Notes without Consent or Authorization

AR Psychiatric & Counseling, LLC and its contracted providers may use or disclose PHI without your consent or authorization in the following circumstances:

- ***Child Abuse*** **:** If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority
- ***Adult and domestic abuse*****:** If we have reasonable cause to believe that a disabled adult or elder person has had physical injury or injuries inflicted on them, other than by accidental means, or has been neglected or exploited we must report that belief to the appropriate authority.
- ***Health Oversight Activities*****:** If we are subject of an inquiry by the Composite State Board of Medical Examiners or the Composite State Board of Professional Counselors, Social Workers and Marriage and Family Therapists, the Department of Community Health or any other Government regulatory agency with appropriate authority, we may be required to disclose your PHI or psychotherapy records.
- ***Judicial and Administrative Proceedings*****:** If you are involved in court proceedings and a request is made about the professional services provided to you, we may provide relevant information regarding the dates and times of service. We may also provide other relevant PHI , however, psychotherapy notes, or any information that is privileged under state law, will not be released without your consent or court order. Please be advised that the privilege does not apply when you undergo an evaluation for a third party or when the valuation is court ordered; in these instances , you will be informed as to whether your records are privileged
- ***Serious Threat to Health and Safety*****:** If we determine, or pursuant to the standards of Psychiatry should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.
- ***Worker's Compensation*****:** We may disclose PHI regarding you or authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

Patient's Rights and Psychiatrist's Duties

Patient's Rights

- ***Right to Request Restrictions***: you have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction request.
- ***Right to receive Confidential Communications by Alternative Means and at Alternative locations***: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are going to Center for Family Psychiatry Inc. and its contracted providers on your request we will send the bill to another location.)
- ***Right to Inspect and Copy*****: You have the right to inspect or obtain a copy (or both)** of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record subject to reasonable fees for copying. We may deny access to your PHI under certain circumstances, but in some cases you may have the decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- ***Right to Amend***: You have the right to request an amendment of PHI as long as PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- ***Right to an Accounting***: You generally have the right to receive an accounting of disclosures of PHI. On your request we will discuss with you the details of the accounting process.
- ***Right to Paper Copy***: You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychiatrist's or Providers Duties

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to change privacy policies and practices with respect to PHI.
- If we revise the policies and procedures we will provide you with a revised notice via our message board at the front desk.

IV. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records or have other concerns about your privacy rights, you may contact *Renu Gupta who is the Privacy Officer for the practice*.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to Attn: Renu Gupta, AR Psychiatric & Counseling, LLC, 3312-D North Oak Street Ext., Valdosta, GA 31605.

You may also send a written complaint to the Secretary of the U.S. Dept of Health and Human Services.
The Privacy Officer listed above can provide you with the appropriate address upon request.
You have specific rights under Privacy Rule. AR Psychiatric &Counseling and its contracted providers will not retaliate against you for exercising your rights to file a complaint.

V. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on 11/01/2011. AR Psychiatric & Counseling, LLC and its contracted providers reserve the right to change the terms of this notice and to make the new notice effective for all PHI that we maintain. Any revised notices will be posted at the front desk.

Please Sign _____Date_____

(Patient or legal Guardian if under 18)

Print "signature" name if different from above_____

AR PSYCHIATRIC AND COUNSELING CENTER

Consent for Communication

Patient Name:_____ Date:_____

Most patients have family members and friends that occasionally become involved in their care. For example, your spouse calls to confirm your appointment time; or your adult child calls with questions about your medication; or a friend, who helps you, calls because they are concerned about you. You have a right to request that we restrict how protected health information about you is used or disclosed.

If you have anyone that you would allow us to communicate with, please list them below. Due to privacy regulations, we cannot speak to anyone but the patient unless we have your written permission.

I give the ARPCC Clinic staff my permission to speak with the following individuals regarding my care.
Note: If you prefer that we not speak with ANYONE, please write "No One" across the lines

Name of Family or Friend	**Relationship**

Restrictions to Communications: _____

_____

I request that all communications (by telephone, mail or otherwise) by ARPCC Clinic staff be handled in the following manner:

* For written communications Address to: _____

_____

_____

* For oral communications Call: _____
(Telephone number)

May we leave a message? ☐ Yes ☐ No

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the following manner and authorize AR Psychiatric & Counseling Center staff to disclose information only to those individuals listed above **and** in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

_____ _____
Signature of Patient/Legal Guardian (minors 12-17 must sign) Date

_____ _____
ARPCC Staff Date