Sandy Plains Psychiatry
Adolescent and Adult Psychiatry
3225 Shallowford Rd. Bldg 1300
Marietta, GA 30062
Ph: (678) 575-7754

Please complete the attached paperwork and return with a copy of your insurance card (front and back). Return to: vincentho3225@gmail.com or FAX to: (678) 560-7185.
We will call you upon receipt of all required documents to schedule an appointment.

****Please note there may be a $30 charge for forms and letters completed by the providers****

Thank you,
Sandy Plains Psychiatry

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PATIENT & FAMILY INFORMATION:

Name: _____ Date of Birth: _____ M _____ F_____

Race *(please circle) White, Black, Asian, American Indian, Other* Ethnic Group: _____

Home# _____ Cell# _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

School or Employer: _____

Parent/Guardian Name (if Patient is a minor) _____

Pharmacy: (Phone # and Address) _____

INSURANCE INFORMATION:

Insurance Company: _____ Subscriber/Member ID: _____

Mental Health Coverage:

Did you confirm your mental health coverage with your insurance? ____ Y ____ N

Do you need Prior Authorization for visits? ____ Y ____ N

Is Mental Health covered under the same insurance company? ____ Y ____ N

If NO, please provide the company name. _____

Primary on Insurance: _____ DOB: _____

Relationship to Patient: _____ Employer: _____

Please Sign Both Disclosures

Authorization for Disclosure of Information

By signing below, I hereby consent for the Practice to use or disclose information about myself (or the person whom I have authority to sign for) that is protected under federal law, for the sole purposes of treatment, payment, and healthcare operation.

Patient Signature X _____ Date: _____

Or Parent/Guardian

Authorization for Guarantee of Payment

I authorize payment of medical benefits to Sandy Plains Psychiatry. I will be responsible for the FULL amount of the charges except those under Sandy Plains Psychiatry contractual arrangements with certain insurers.

Patient Signature X _____ Date: _____

Or Parent/Guardian

Patient Name: _____ Date: _____

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, and if so, you will be notified at your next visit to update your signature/date signed.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, insurance purposes, and routine healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, insurance purposes, or healthcare operations (consultations with specialists or hospitalists).
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text message to you to confirm appointments? YES NO

May we leave a message on your voicemail/answering machine? YES NO

May we discuss our condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

_____

PRINT NAME: _____

Circle one: PARENT LEGAL GUARDIAN PATIENT

SIGNATURE: _____ **DATE:** _____

Sandy Plains Psychiatry
Waiver for Mental Health Visits

I _____, agree and consent to participate in the behavioral care services offered and provided by Sandy Plains Psychiatry. I agree to accept full responsibility and payment for any visits with Vincent Ho MD, Sara Moore PMHNP, and Allison Gilley PMHNP-BC in the event that my insurance company does not cover the date of service, or the services rendered are not covered. If the patient is under 18 years of age or unable to consent to treatment, I attest that I have legal custody of the stated named patient below and authorize consent for treatment and services.

It is the policy of Sandy Plains Psychiatry that payment is due at the time of service. <u>We require all patients to pay their copay or self-pay amount before each visit or your appointment will be rescheduled.</u>

Patient's Name

_____

Responsible Party's Name

_____

Relationship to Patient

_____

Responsible Party's Signature

_____ Date _____

Verification of eligibility and benefits does not guarantee that the visit will be covered.

Mental Health Intake Form

Please complete all information on this form and include it with your new patient paperwork. It may seem long, but most of the questions require only a checkmark, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name _____ **Date** _____
Date of Birth _____ **Primary Care Physician** _____
Do you give permission for ongoing regular updates to be provided to your primary care physician? _____
Current Therapist/Counselor _____ Therapist's Phone _____

What are the problem(s) for which you are seeking help?
1. _____
2. _____
3. _____

What are your treatment goals?
_____
_____
_____

Current Symptoms Checklist: (Check once for any symptoms present, twice for major symptoms)

( ) Depressed Mood	**( ) Racing thoughts**	**( ) Excessive worry**
( ) Unable to enjoy activities	**( ) Impulsivity**	**( ) Anxiety Attacks**
( ) Sleep pattern disturbance	**( ) Increased risky behavior**	**( ) Avoidance**
( ) Loss of interest	**( ) Increased libido**	**( ) Hallucinations**
( ) Concentration/forgetfulness	**( ) Decreased need for sleep**	**( ) Suspiciousness**
( ) Change in appetite	**( ) Excessive energy**	**( ) _____**
( ) Excessive guilt	**( ) Increased irritability**	**( ) _____**
( ) Fatigue	**( ) Crying Spells**	**( ) _____**
( ) Decreased Libido		

Suicide Risk Assesment
Have you ever had feelings or thoughts that you didn't want to live? **( ) Yes ( ) No**
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? **( ) Yes ( ) No**
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1-10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Past Medical History

Allergies _____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: **(if none, write none)**

Medication Name	**Total Daily Dosage**	**Estimated Start Date**

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? **( ) Yes ( ) No** If yes, when _____
Was the EKG **( )** normal **( )** abnormal or **( )** unknown

For women only: Date of last menstrual period _____
Are you currently pregnant or do you think you might be pregnant? **( ) Yes ( ) No**
Are you planning to get pregnant in the near future? **( ) Yes ( ) No**
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss? **( ) Yes ( ) No**
Date and place of last physical exam _____

Personal and Family Medical History:

	You	**Family**	**Which family member?**
Thyroid Disease	( )	( )	
Anemia	( )	( )	
Liver Disease	( )	( )	
Chronic Fatigue	( )	( )	
Kidney Disease	( )	( )	
Diabetes	( )	( )	
Asthma/respiratory problems	( )	( )	
Stomach or intestinal problems	( )	( )	
Cancer (Type) _____	( )	( )	
Fibromyalgia	( )	( )	
Heart Disease	( )	( )	
Epilepsy or Seizures	( )	( )	
Chronic Pain	( )	( )	
High Cholesterol	( )	( )	
High Blood Pressure	( )	( )	
Head Trauma	( )	( )	
Liver Problems	( )	( )	
Other _____	( )	( )	

Is there any additional personal or family medical history? **( ) Yes ( ) No**
If yes, please explain: _____

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth? _____

_____

Past Psychiatric History

Outpatient Treatment ( ) Yes ( ) No If yes, please describe when, by whom, and nature of treatment.

Reason **Dates Treated** **By Whom**

_____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, please describe when, by whom, and nature of treatment.

Reason **Dates Treated** **By Whom**

_____

_____

_____

Past Psychiatric Medications: if you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates **Dosage** **Response/Side-Effects**

Antidepressants

Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Luvox (fluvoxamine) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Remeron (mirtazapine) _____
Serzone (nefazodone) _____
Anafranil (clomipramine) _____
Pamelor (nortriptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Other _____

Mood Stabilizers

Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Topamax (topiramate) _____
Other _____

Past Psychiatric medications (Continued)

Dates **Dosage** **Response/Side-Effects**

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine) _____
Zyprexa (olanzapine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____
Other _____

Sedative/Hypnotics

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon) _____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____

ADHD medications

Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____

Anti Anxiety medication

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Other _____
Valium (diazepam) _____

Your Exercise Level:

Do you exercise regularly? **( ) Yes ( ) No**
How many days a week do you get exercise? **( ) Yes ( ) No**
How much time each day do you exercise? **( ) Yes ( ) No**
What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar Disorder	**( ) Yes ( ) No**	Schizophrenia	**( ) Yes ( ) No**
Depression	**( ) Yes ( ) No**	Post-traumatic Stress	**( ) Yes ( ) No**
Anxiety	**( ) Yes ( ) No**	Alcohol abuse	**( ) Yes ( ) No**
Anger	**( ) Yes ( ) No**	Other substance abuse	**( ) Yes ( ) No**
Depression	**( ) Yes ( ) No**	Post-traumatic Stress	**( ) Yes ( ) No**
Suicide	**( ) Yes ( ) No**	Violence	**( ) Yes ( ) No**

If YES, who had each problem? _____
_____

Has any family member been treated with psychiatric medication? **( ) Yes ( ) No** If YES, who was treated, what medications did they take, and how effective was the treatment? _____
_____

Substance Use:

Have you ever been treated for alcohol or drug use/abuse **( ) Yes ( ) No** If YES, for which substances?
Where were you treated and when? _____

_____

_____

How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drink you have consumed in one day? __
Have you ever felt you ought to cut down on your drinking or drunk use? **( ) Yes ( ) No**
Have people annoyed you by criticizing your drinking or drug use? **( ) Yes ( ) No**
Have you ever felt bad or guilty about your drinking or drug use? **( ) Yes ( ) No**
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? **( ) Yes ( ) No**
Do you think you may have a problem with alcohol or drug use? **( ) Yes ( ) No**
Have you used any street drugs in the past 3 months? **( ) Yes ( ) No**
If YES, which ones? _____
Have you ever abused prescription medication? **( ) Yes ( ) No**
If YES, which ones and for how long? _____

_____

Check if you have ever tried the following:

	Yes	**No**	If YES, how long and when did you last use?
Methamphetamine	**( )**	**( )**	_____
Cocaine	**( )**	**( )**	_____
Stimulants (pills)	**( )**	**( )**	_____
Heroin	**( )**	**( )**	_____
LSD or Hallucinogens	**( )**	**( )**	_____
Marijuana	**( )**	**( )**	_____
Pain Killers (not as prescribed	**( )**	**( )**	_____
Methadone	**( )**	**( )**	_____
Tranquilizers/sleeping pills	**( )**	**( )**	_____
Alcohol	**( )**	**( )**	_____
Ecstasy	**( )**	**( )**	_____
Other	**( )**	**( )**	_____

How many caffeinated beverages do you drink per day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

Have you ever smoked cigarettes? **( ) Yes ( ) No**
Currently? **( ) Yes ( ) No** How many packs per day on average? _____ How many years? ____
In the past? **( ) Yes ( ) No** How many years did you smoke? _____ When did you quit? _____
Currently? **( ) Yes ( ) No** How many packs per day on average? _____ How many years? ____

Pipe, cigars, or chewing tobacco: Currently? **( ) Yes ( ) No** In the past? **( ) Yes ( ) No**
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? **( ) Yes ( ) No** Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents divorce? _____
If your parents are divorced, who did you live with? _____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically, or by neglect? **( ) Yes ( ) No**
Please describe when, where, and by whom: _____
_____

Educational History:

Highest grade completed? _____ Where? _____
Did you attend college? _____ Where? _____ Major? _____
What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: **( )** Working **( )** Student **( )** Unemployed **( )** Disabled **( )** Retired
How long in present position? _____
What is/was our occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge **( ) Yes ( ) No** Other type of discharge _____

Relationship History and Current Family:

Are you currently: **( )** Married **( )** Partnered **( )** Divorced **( )** Single **( )** Widowed
How long? _____
If not married, are you currently in a relationship? **( ) Yes ( ) No** If YES, how long? _____
Are you sexually active? **( ) Yes ( ) No**
How would you identify your sexual orientation?
( ) straight/heteroxexual **( )** lesbian/gay/homosexual **( )** bisexual
( ) unsure/questioning **( )** asexual **( )** other **( )** prefer not to answer
What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other: _____
_____
Have you had any prior marriages? **( ) Yes ( ) No** If so, how many? _____
How long? _____
Do you have children? **( ) Yes ( ) No** If YES, list ages and gender. _____
_____
Describe your relationship with your children: _____
List everyone who currently lives with you: _____
_____

Legal History:

Have you ever been arrested? _____

Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? **( ) Yes ( ) No**

If YES, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? **( )** More helpful **( )** Stressful

Is there anything else that you would like us to know?

_____

_____

_____

_____

_____

_____

_____

_____

Signature _____ Date _____

Guardian Signature (if under 18)_____ Date _____

Emergency Contact _____ Phone # _____

For Office Use Only:

Reviewed by: _____ Date _____

Reviewed by: _____ Date _____