Patient Registration
Georgia Psychiatry & Sleep, LLC
Talk Therapy

Reason for Visit: _____

Patient Name: _____

DOB: _____

Release of medical information: Please list below other individuals (family, spouse, and parents) with whom your provider can discuss your care or release your psychiatric medical records.

Name	Relationship

Patient Information

Home address:

_____

Contact Number: _____

Email Address: _____

Coordination of Care Between Health Care Providers and Release of Information: Please indicate any physician/Therapist you allow to release records and/or health information for regarding your care.

Therapist Name	Therapist phone number	Therapist Fax Number

Financial Policies and Benefit Assignment- Read and Sign

I authorize Georgia Psychiatry & Sleep to furnish information as necessary to my insurance carrier regarding my illness and treatment, and I assign to Georgia Psychiatry & Sleep all insurance payments for medical services rendered. I understand that I am responsible for providing all necessary information to the office or submitting charges to the insurance company for payment. If I fail to provide this information, I accept the financial responsibility of payment for services rendered. This office has a cancellation policy that requires 24 - hour advance notification. I understand that if I cancel with less than 24 hour notice, a charge will be made for the time reserved. This charge is not covered by insurance and is not payable from any insurance company.

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Office policies

Listed below are all office policies. All office policies must be acknowledged and agreed to prior to the initial evaluation. Compliance with office policies are required. Please check each box after reading for acknowledgement.

- New patient no-show fee of $100 will be required before our staff is able to reschedule an initial evaluation ☐
- New patient same-day cancellation fee of $75 will be required before the initial appointment is rescheduled ☐
- Existing patient no-show fee of $50 for medication management & $100 for talk therapy ☐
- Existing patient same-day cancellation fee of $100 for talk therapy, and $25 for medication management ☐
- Patient is responsible for providing our office with up to date and active insurance. ☐
- Patients with 3 or more missed/cancelled appointments may be considered for possible termination from our practice ☐
- Patient responsibility is due at the time of service ☐
- Any medication refill requests will be considered on a case-to-case basis, and if approved by the provider, will be a cost of $25 if refilled without an appointment. ☐
- Insurance, address, phone number and pharmacy changes need to be updated with our office. ☐
- Disability cases must require hospital based program and will be referred out. Disability papwerwork will not be evalutated and completed by this practice ☐

I have received and read the office policies, financial policy and patients' rights and responsibilities. A copy of these forms are available on our website and can be provided by request.

_____ _____

Patient Signature Date

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General Health and Mental Health Information

Have you previously received any type of mental health services (therapy, psychiatric services, etc.)? __No __Yes, If yes, previous therapist/practitioner(s): _____

Are you currently taking any prescription medication? □ Yes □ No Please list:

_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No If yes, Please list and provide dates:

_____

_____

How would you rate your current physical health? (please circle) Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

_____

_____

How would you rate your current sleeping habits? (please circle) Poor Unsatisfactory Satisfactory Good Very good Please list any specific sleep problems you are currently experiencing:

_____

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____ 4.
Please list any difficulties you experience with your appetite or eating patterns:

_____

Are you currently experiencing overwhelming sadness, grief, or depression? __No __Yes If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? __No __Yes If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? __No __Yes If yes, please describe:

_____

Do you drink alcohol more than once a week? __ No __ Yes

How often do you engage recreational drug use? __ Daily __ Weekly __ Monthly __ Infrequently __ Never

Are you currently in a romantic relationship? __No __ Yes If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? And why? _____

_____

What significant life changes or stressful events have you experienced recently: _____

_____

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FAMILY MENTAL HEALTH HISTORY

Identify if there is a family history of any of the following: If so indicate the relationship to you.

Identifier	Yes	No	Family member relationship(dad, mom, grand mom etc)
Alcohol/Substance Abuse			
Depression			
Domestic Violence			
Eating disorders			
Obesity			
Obsessive Compulsive Behavior			
Schizophrenia			
Suicide Attempts			
Other:			

Are you currently employed? __ No __ Yes If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? __ No __ Yes If yes, describe your faith or belief:

_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____ _____
Patient Signature Date

_____ _____
Name of Patient's Parent/Guardian(Print) Relationship to Patient