Stepping Stones Psychiatric Care LLC

Carrollton Office: 318 Newnan Road Carrollton, GA 30117
Newnan Office: 3025 Sharpsburg McCullum Road Building B, Suite 103 Newnan, GA 30265Phone #: (678) 890-1121 -or- (678) 673-6202 Fax #: (678) 890-1143

PATIENT REGISTRATION FORM

Patient Demographics

Patient Name: _____ DOB: _____ Gender: _____

Street Address:_____City:_____State:_____Zip:_____

Cell Phone: _____ Email: _____

Referred By: _____

Insurance

Primary Insurance: _____

Member ID: _____ Group #: _____

Relationship to Patient: _____

Emergency Contact

Name:_____Relationship to Patient:_____Phone: _____

Release information to the following:

Name:	Phone #:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have anyone in your household with the same birthday? If yes, please list and include relationship.

Name: _____

Relationship: _____

Pharmacy

Pharmacy Name:_____ Phone:_____

Address:_____ City:_____ State: _____

Signature

Patient Signature:_____ Date:_____

Assignment of Benefits

Consent for Treatment, Payment and Health Care Operations

By signing below, I understand that I hereby authorize the practice to disclose my medical information so that the practice may treat, seek payment from third parties for such treatment, and generally carry on the practice's health care operations. I understand that I am responsible for payments in full of all charges. I request that payment of authorized insurance benefits be paid directly to Stepping Stones Psychiatric Care. I also authorize Stepping Stones Psychiatric Care to release all information necessary for the processing of insurance claims to determine the benefits payable for related services.

Patient Signature:_____ Date: _____

Insurance Waiver

This office will make every effort to submit bills for services rendered your insurance company. Charges, and payment thereof, will then become the responsibility of the patient.

I understand that, should my insurance not pay for my office visit or procedure, I will be responsible forpayment of services. It is the patient responsibility to keep insurance company, name, address, and contact number current with the office.

Patient Signature:_____ Date: _____

Consent for Office Policies and Procedures

Stepping Stones Psychiatric Care, LLC is dedicated to providing excellent mental health services and treating patients with dignity and respect. Below are our office policies and conditions of care:

Please initial below where indicated as acknowledgement and consent of all office policies and procedures:

____**Emergency Calls**: For after hour emergencies, please call 911 or go to the nearest emergency room. Patients can call 678-890-1121 and leave a message for non-emergencies only. All messages will be addressed as soon as they are received and processed by our office staff within 24 hours. If you need to speak with the provider, calls will be returned based on clinical issues that need to be discussed, and the provider's availability. Please refrain from calling multiple times as this will only delay our staff returning your call in a timely manner.

____**Billing Policy**: SSPC will bill your insurance on your behalf; provided we are contracted with your insurance company and you are not a private pay patient. The responsible party agrees to provide all insurance information at or prior to the appointment. The responsible party also agrees to notify SSPC of any changes in insurance coverage within 10 days and is responsible for all charges not covered or not paid by the insurance for any reason.

____Co-payments, deductible & any fees not paid by the insurance are due at the time of service.

____Any returned check from the bank is subject to a $35.00 processing fee.

____Written court reports, copying of records and legal work may be subject to an additional charge.

- A $7 charge for the first 10 pages and $0.35 per page, thereafter, will apply for all copies of medical records.
- A charge of $25 will apply for **ALL** completed forms (FMLA, disability, medical leave, etc.), 2 pages or less and $50 for forms greater than 2 pages. **We do not complete nay social security disability paperwork of any type.**

____**Appointment Cancellation:** There is a 48-hour cancellation policy for all appointments. A $90 fee will be applied to the patient's account for any late cancellations/no-shows. The patient or parent/guardian will be responsible in paying this fee as insurance does not cover these fees/charges. **As a courtesy, we will make 3 attempts to confirm all appointments. If not confirmed after 3 attempts, your appointment will be cancelled.**

____**Medication Refills**: Medication refills will only be given at each scheduled appointment. If for any reason, you cancel or reschedule your appointment, it is your responsibility to reschedule the appointment prior to running out of medication. NO REFILLS WILL BE GIVEN UNLESS SEEN BY PROVIDER IN THE OFFICE OR VIRTAULLY.

____**Termination of Treatment:** Treatment can be terminated if treatment for any reason; failure to follow the recommended treatment plan; delinquent payments; failure to keep scheduled appointments, failure to adhere to the controlled substance contract or any other office policy in the packet, or rude/abusive treatment of staff.

____**Privacy Policy Notice:** I acknowledge that I have reviewed a copy of the Notice of Privacy Practices (All documents are available for review at front desk.).

I hereby authorize SSPC to conduct evaluation and treat myself and/or my dependents with regard to psychiatric or behavioral problems. I have read and understand the above office policies and agree with these policies.

Signature: _____ Date: _____

Patient's Name: _____

Informed Consent for Tele-psychological Services

- There are potential benefits and risks of video conferencing (e.g., limits to patients' confidentiality) that differ from in-person sessions.
- A webcam or smart phone during the session is needed.
- It is important to use a secure Internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your appointment, you must notify the office in advance by phone or email.
- In the event of a crisis, please provide at least one emergency contact and the closest emergency department to your location.
- You should confirm with your insurance company that video sessions are covered under your insurance plan. If they are not reimbursed, you are responsible for full payment.
- As your psychiatric provider, I may determine that due to certain circumstances, tele psychological services are no longer appropriate and that we would resume our sessions in person.

Patient Signature: _____ Date: _____

Consent to Disclose Protective Health Information

(1) _____
(Name) (Date of Birth)

_____
(Street Address) (City, State, Zip Code)

I authorized the use and /or release of my protected health information as described in Section 4 below. I understand this authorization is voluntary and is made to confirm my instruction.

(2) Authorization To Release From:

_____
Name

_____
Street Address

_____
City, State, Zip

Fax #: _____

(3) Release Protected Health Information To:

_____
Name

_____
Street Address

_____
City, State, Zip

Fax #: _____

Include:
___ All Medical Records ___ Billing Records ___ Treatment Plan ___ Evaluation Reports

___ Lab Reports/Radiology Reports ___ Medication List / Diagnostic Material ___ Progress Notes

I understand authorizing the use or disclosure of the health information identified above is voluntary and I need not sign this authorization form to ensure healthcare treatment.

I understand that any disclosure of private health information carries the potential for unauthorized re-disclosure and may no longer be protected by federal privacy laws or regulations. I further agree to indemnify and hold harmless Stepping Stones Psychiatric Care's staff from all liability that may arise from the release of the information herein requested.

I understand that I have the right to inspect or obtain a copy of health information to be disclosed. Medical records frequently contain information that may be privileged and or confidential remarks furnished by the patient, patient's family, and staff. If, in the judgment of medical staff, disclosure of the privilege/confidential information will be harmful to the patient release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, patient photographs, AIDS/HIV or psychiatric/psychological/other mental health privileged or confidential information. Certain communications are privileged and not subject to release without your consent under state and/or federal law.

After giving due consideration to the above statement, I authorize the office and/or member members of its staff to furnish information, including electric, photostatic or fax copies of my medical records including matters privileged under the law of the state of Georgia, and the applicable federal laws and regulations including but not limited to HIPPA, to the above organization/individual, or its agents.

I understand that I have the right to revoke this authorization at any time and that revocation request may be submitted in writing. I understand that revocation will not apply to information that has been previously released in response to this authorization I understand that revocation will not apply to my insurance company when the law provides my ensure with the right consent and claim under my policy. Unless otherwise revoke this authorization is only valid only valid found for a period of one year from the date of my signature.

_____ _____
Patient Signature or Legal Guardian *Date*

_____ _____
Witness ***Date***

Stepping Stones Psychiatric Care
318 Newnan Road Carrollton, GA 30117
Office: 678-890-1121 Fax: 678-890-1143

New Patient History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your personal medical record.

LIST ANY PSYCHIATRIC CONCERNS/ PROBLEMS

CURRENT MEDICAL PROBLEMS (I.E. HYPERTENSION, DIABETES, HEART DISEASE, LUNG PROBLEMS, GI ISSES, ETC.)

CURRENT MEDICATIONS

NAME OF MEDICATION	STRENGTH	FREQUENCY TAKEN

ALLERGIES

NAME OF DRUG	REACTION YOU HAD	NAME OF ALLERGEN	REACTION YOU HAD

SURGICAL HISTORY

DATE OF SURGERY	TYPE OF SURGERY	HOSPITAL

Have any members of your biological family had mental problems or received mental health or alcohol and drug treatment? _____Yes _____No (If yes, please complete the box below)

FAMILY HISTORY

RELATION/NAME	SYTMPTOMS	WAS TREATMENT HELPFUL (YES/NO)

HOSPITALIZATION HISTORY

DATE OF ADMISSION	REASON	HOSPITAL

Consent for Random Drug Screen Testing

I, _____ give Stepping Stones Psychiatric Care LLC., consent to administer random urine drug screen as needed. Urine drug screening is mandatory for all new patients. This screening may not be covered by insurance and I will be responsible for the $20.00 charge. I understand by refusing to do a drug screen, I could be denied any controlled medications, and/or it is grounds for termination.

_____	_____	_____
Patient's Signature	Date	Patient's Name Printed
_____	_____	_____
Staff Member's Signature	Date	Staff Member's Name Printed

Consent for Random Pregnancy Testing

I, _____ give Stepping Stones Psychiatric Care LLC., consent to administer a random urine pregnancy test as needed. Pregnancy testing is mandatory for all female patients of child-bearing age. This testing may not be covered by insurance and I will be responsible for the $10.00 charge. I understand by refusing to do a urine pregnancy test I could be denied any controlled medications, and/or it is grounds for termination.

_____	_____	_____
Patient's Signature	Date	Patient's Name Printed
_____	_____	_____
Staff Member's Signature	Date	Staff Member's Name Printed

Provider's Initials: _____ Date: _____

SCREENINGS PATIENT NAME:_____DOB: _____

TOBACCO USAGE

Current Tobacco user?	Yes No	If yes -- What Type of Tobacco: _____
How often do you use tobacco?	**Circle One:**	Every day Some days but not every day
How many cigarettes do you smoke/day?	**Circle One:**	5 or less 6 - 10 11 - 20 21 - 30 31+
How soon after waking up?	**Circle One:**	5 min 6 - 30 min 31 - 60 min after 60 min
Are you interested in quitting?	**Circle One:**	Ready to Thinking about Not ready to
Former Smoker?	Yes No	When did you quit?

DEPRESSION SCREENING

Little interest or pleasure in doing things?	Yes No
Feeling down, depressed, or hopeless?	Yes No

IF NO TO BOTH, SKIP TO THE MISCELLANEOUS SECTION

Over the last 2 weeks, how often have you been bothered by any of the following problems?	0 – Not at all 1 – Several Days 2- More than half days 3 – Nearly every day			
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling asleep, staying asleep or sleeping too much?	0	1	2	3
Feeling tired and having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself or that you are a failure, or have let yourself or family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV?	0	1	2	3
Moving or speaking so slowly that other people have noticed – or the opposite – being fidgety or restless?	0	1	2	3
Thoughts that you would be better off dead, or hurting yourself in some way?	0	1	2	3

MISCELLANEOUS

Drink Coffee or Tea (circle one)	Yes No	**How many cups per day?** 1 – 2 2 – 3 3 – 4 4+ **TYPE**: Caffeinated Decaf
Do you Drink Alcohol?	Yes No	Occasional weekends weekly Daily 2x a week 3x a week **TYPE:** Beer Wine Liquor
Do you have a history of substance abuse?	Yes No	Occasional Weekly Daily 2x a week 3x a week
Marital Status:	Yes No	Single Married Separated Divorced Widowed
Do you have any children?	Yes No	**How many?**
Health Literacy / Education:	**CIRCLE ONE:**	Did not finish high school Finished high school Not finished college Finished college Professional schools/Masters/PhD
Employment Status: Occupation:_____	**CIRCLE ONE:**	Employed Retired Unemployed Part-Time Employed Student Disabled
Family History of mental health or substance abuse:	Yes No	**If yes, specify:**
Do you need a refill on a prescription today?	Yes No	Medications needed to be refilled:

Current Height: _____ Current Weight: _____ lbs

Controlled Substance Contract

Patient Name: _____ DOB: _____

As a patient being asked to sign the contract, I know:

- My provider has explained all the risks and side effects of the controlled substance medication being prescribed.
- I will only get the prescribed controlled substance medication from the provider listed below.
- I will get any refills of the prescribed controlled substance at the same pharmacy.
- I understand the Georgia Prescription Monitoring Program database will be used to verify my controlled substance history prior to obtaining a prescription, and while being treated to monitor compliance.
- I understand it is my responsibility to ensure I have enough medication to last non-business hours, weekends, and holidays. Medication refills will only be provided at office visits and during normal business hours.
- I agree to submit to random urine drug screens at my expense.
- If my urine drug screen shows positive results for any medication/substance not prescribed by my provider, not documented in my medical history as being prescribed by another physician or does not show positive for the controlled substance medication prescribed by my provider, I may not be given any refills.
- I may not be given my controlled substance medication if my urine drug screen is positive for marijuana, even if it is medical marijuana.
- If I take a benzodiazepine (Xanax, Clonazepam, etc.) and a stimulant (methylphenidate, Adderall, Vyvanse, etc.), my provider with decrease and discontinue either the benzodiazepine or stimulant.
- Controlled substance medications can be addictive. My body may need more and more medication as time goes by, and it may be difficult to stop taking this medication. My provider will evaluate this at each office visit prior to giving any refills or increasing my dose of medication.
- Taking more than the prescribed dose and/or combining it with other medications can cause serious problems, including but not limited to loss of consciousness, difficulty/stopping breathing, and death. I will ensure my provider know all the medications I am currently taking. I will contact my provider to inform them of any new medications prescribed by another physician, and why it was prescribed.
- I will keep my controlled substance medication in a controlled, safe place. If my medication is lost/stolen, my provider may not refill it until the due date. My provider has the final decision on if any medication is refilled early.
- My provider may discontinue a controlled substance medication anytime, at their discretion.
- If I break this contract for any reason, substance medication may be discontinued, and I may be dismissed as a patient from Stepping Stones Psychiatric Care.

My provider and I have discussed my controlled substance medication. I understand that I must follow this agreement. If not, my provider at Stepping Stones Psychiatric Care may not prescribe controlled substance medication for me. If I do not follow this agreement, they may also refuse to provide additional care.

_____	_____	_____
Patient's Signature	DATE	Patient's Name Printed
_____	_____	_____
Guardian/Authorized Representative Signature	DATE	Guardian/Authorized Representative's Relationship
_____	_____	_____
Provider's Signature	DATE	Provider's Name

Credit Card Authorization

I, _____ authorize Stepping Stones Psychiatric Care to keep my credit/debit card information on file and be used for future payments. I will be charged only the amount verbally authorized or as per any agreement signed for recurrent payments. A receipt for each payment will be provided to me by mail, email, or text message. The charge will also appear on my credit card or bank statement.

Billing Information

Billing Address: _____

Phone: _____ Email: _____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

Account/CC Number _____

Expiration Date ____ /____ CVV _____

I understand that this authorization will remain in effect until I notify the office in writing. I will call the office with any changes or new card information within 10 days of any set dates of a payment arrangement. I acknowledge that the origination of credit card transactions to my account must comply with the provisions of U.S. law. I certify that I am the card holder or authorized user of the credit card listed above. I will not dispute any verbally agreed upon charges or any scheduled charges of a payment arrangement, so long as the transactions correspond to the terms indicated in this authorization form or signed payment arrangement agreement.

Signature: _____ Date: _____
(Cardholder's Signature)

Print Name: _____

Patient's Name: _____

HIPAA Authorization Form

_____

Patient's Full Name Patient's Date of Birth

_____

Address City, State Zip Code Telephone Number

____ I have received the Notice of Privacy Practices for Stepping Stones Psychiatric Care.

Stepping Stones Psychiatric Care may share my health information with:
I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

_____

2. The following person (or class of persons) may receive disclosure of protected health information about me:
   Name/Relationship: _____
   Name/Relationship: _____
   Name/Relationship: _____

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying Beckman and Associates in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. **FEES FOR COPIES**: Federal and state laws permit a fee to be charged for the copying of patient records. You will be required to pre-pay for the copies, then your copies will be available for you to pick up or can be mailed.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____ _____ _____
Signature Date Relation to Patient

_____ _____ _____
Witness Date Printed Name