VALDOSTA PSYCHIATRIC ASSOCIATES, LLC
3541 North Crossing Circle Valdosta, GA 31602 229-244-4200

Required Paperwork:

***Extremely Important - One week prior to your appointment, please return the following*:**

- The enclosed forms – completed and signed
- A copy of your insurance card and/or authorization for your appointment
- Doctor notes or old mental health records (last three appointments only)

Office hours:

Monday - Wednesday: 8:00 a.m. to 6:00 p.m. Thursday: 8:00 a.m. to 8:00 p.m.
Friday: 8:00 a.m. to Noon.

Phone hours:

Monday – Thursday: 9:00 a.m. to 5:00 p.m. Friday: 9:00 a.m. to Noon.
Emergencies: Call our office first during normal office hours. If the office is closed or you get the answering machine, call 911.

Payment for services

Please inform us immediately if your care involves a legal matter, or if the Department of Family and Children Services is involved.

Insurance

- We file with all insurance plans. If your insurance company will not give us the necessary information, we will ask you to pay the bill and we will file your insurance for you.
- You are required to pay any copayment and/or deductible at the time of service.
- You have the obligation to check with your insurance and notify us if you require authorization prior to treatment.
- Counseling and treatment can be filed on your insurance.

Personal Payments

- You may pay by personal check (a $30.00 service charge will be added to your account for all returned checks), money orders, cash, debit card, or major credit card.
- We will bill you $50.00 in advance for each form and letter you ask us to draft.

Office / Appointment Etiquette:

- Do not bring anyone with you unless he/she will be seeing your provider or he/she is your driver.
- Do not bring children who are not coming as patients.
- You will be billed for any appointments made for which you failed to show or cancel at least 24 hours beforehand.

Medications:

- It is important for you to notify us if you change pharmacies. You will not be given another prescription without seeing the doctor again. We do not fax or mail prescriptions.
- Take your medication as directed. Keep up with your quantity. Be certain you have enough to last until your next appointment.
- At times our office may call to reschedule an appointment because your doctor has an emergency. If we should call you, check your medications to be sure you have enough to last until the date you return. It may take up to 24 hours to get your prescription refilled (longer on Fridays).
- We do not participate with discount drug programs.
- If you are in a situation that you cannot afford your medication, do not stop taking your medication. Look and ask until you find assistance, for example, (i) check with your local mental health office, (ii) check with your pharmacist to see what programs they may have available, and (iii) call your local Department of Family and Children Services

Minors:

Must be accompanied by a biological parent. We cannot prescribe medications or initiate treatment without a parent or legal guardian present.

Valdosta Psychiatric Associates, LLC

Sex assigned at birth: _____ Male _____ Female _____ Decline to answer
Gender identity now: _____ Male _____ Female _____ Female-to-male (transgender male)
_____ Male-to-female (transgender female) _____ Other: _____
Preferred gender pronouns: ____ He/him ____ She/her ____ They/them ____ Other:_____

Patient Name:_____
First Middle Last
Date of Birth_____ **Social Security Number**_____ **Marital Status**_____

Street Address_____
City State Zip Code
Home Phone_____ **Cell Phone** _____

Employer_____ **Work Phone** _____

Email Address _____

COMPLETE FOR MINOR PATIENTS ONLY:

Do you have legal custody? ____ Yes ____ No. Has either parent had parental rights terminated? _____ Yes _____ No

Legal Guardian's Name_____ Relationship to Patient_____

Legal Guardian's Social Security Number_____ Legal Guardian's Date of Birth_____

Is Patient a Full-Time Student? Yes ☐ No ☐ School_____

Emergency Contact_____ **Phone**_____

Emergency Contact Address_____

Relationship to Patient _____

Insurance Company_____ **Policyholder Name:**_____
(Name as it appears on the insurance card)
Insurance Co. Address_____ **Phone**_____

Policy/Subscriber Number_____ **Group Number:**_____

Policyholder SSN: **Policyholder Date of Birth:**

I request that payment and benefits be made on my behalf to Valdosta Psychiatric Associates, 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 company or its assignees. I request and authorize treatment at Valdosta Psychiatric Associates, LLC. I understand I am responsible for any deductible, co-payment or any amount not covered by my insurance. I understand that Valdosta Psychiatric Associates LLC turns delinquent accounts over to a third party collector, and I will be responsible for the physician fees, plus a $50.00 collection fee. Monthly finance charges may be added to all accounts over 60 days old.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Legal Guardian (if patient under 18) (Relationship) Date

PATIENT BILL OF RIGHTS

Patient Rights

1. The right to efficient and effective care individualized to his/her needs, and the right to refuse treatment or discontinue treatment.

2. The right to be seen at or near the scheduled appointment time. If the treatment provider is late, he/she will extend our session or we will make other arrangements by mutual agreement.

3. The right to privacy and confidentiality. All records and communications will be treated confidentially in compliance with applicable state and federal laws. These laws may obligate the treatment provider to report suspected abuse, neglect, or domestic violence and those who pose a danger to themselves or others.

4. The right to access my medical records within a reasonable timeframe, and to examine and receive and explanation of the bill regardless of the source of payment.

5. The right to be treated with dignity and respect at all times, to have access to the practice's grievance process; to communicate any care problems; to voice grievances regarding treatment or care that is, or fails to be, furnished, and receive written notice of the practice's decision.

6. The right to file a grievance with the Georgia Composite Medical Board, concerning the physician, staff, office and treatment received. The patient should send a written complaint to the board. The patient should be able to provide the physician or practice name, the address and the specific nature of the complaint. Complaints or grievances may be reported to the Board at the following address or telephone number:

   Georgia Composite Medical Board
   Attn. Complaints Unit
   No. 2 Peachtree Street, N.W. 36th Floor
   Atlanta, GA 30303
   (404) 656-3913
   www.medicalboard.georgia.gov

Patient Responsibilities

1. Keeping, and being on-time, for all appointments, or notifying the office staff otherwise. Failing to show for an appointment, and failing to cancel it at least 24 hours beforehand, will result in a missed appointment fee.

2. Providing accurate and complete information concerning present complaints, past illnesses, hospitalizations or any other health related issue.

3. Being responsible for the patient's own health, including following the providers prescribed treatment plan; contacting the treatment provider for any serious situation that arises, even if after normal office hours; working with the provider to achieve treatment goals and advising the provider of any changes in the patient's condition.

4. Being respectful of the rights of others in the facility.

5. Informing the practice of any living will, medical power of attorney, or other healthcare directive.

6. Informing the practice of any change in address, mobile/cell phone, or preferred communication method.

7. Being responsible for all financial obligations related to the patient's care.

8. Addressing any comments or complaints, of if you believe your rights have been violated, through:

   Valdosta Psychiatric Associates
   Attn: Debra Morgan
   P.O. Box 3229
   Valdosta, Georgia 31604

   Department of Health and Human Services
   Office for Civil Rights
   61 Forsyth Street, SW, Suite 16T70
   Atlanta, Georgia 30303-8909
   (800) 368-1019

NAME: _____ **DATE:** _____

ADDRESS: _____

PHONE: _____ □ **Cell** □ **Home** □ **Work**

DOB: _____ **Age:** _____

What Pharmacy do you Use? _____ **Street/City** _____

Who is your Primary Care Physician? _____

Are you involved in an investigation or legal case currently? □ Yes □ No

Type of Suit:

□ Divorce □ Worker's Comp □ Child Custody □ Professional Board

□ Department of Family/Children Services □ Motor Vehicle □ Other _____

Name of Attorney: _____ **Phone:** _____

CONSENT FOR COMMUNICATIONS

You have the right to request that we restrict how protected health information about you is used or disclosed. 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 medications.) Please list any restrictions to the information you have regarding how we can communicate with those you have listed below. (Example: Appointments only, financial matters only; Medications Only, etc. If there are no restrictions, please list "NONE" beside their name

Please list below any persons you will allow us to talk with about you. ***(If you prefer we do not speak with anyone, please write "NO ONE" across this section.***

Name	Relationship to you	Phone Number	Restrictions (See instructions below)

How would you like us to communicate with you?

□ Cell Phone #_____ Okay to leave voicemail? □ Yes □ No

□ Home Phone #_____ Okay to leave message on answering machine? □ Yes □ No

□ Mail (Address _____)

□ Email _____@_____

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 manner listed above and authorize Valdosta Psychiatric Associates 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 and/or Psychotherapy Information.

_____ Date_____ _____

Signature of Patient/Legal Guardian (Minors 12-17 must sign) Witness:

Notice of Privacy Practices Receipt

Our Notice of Privacy Practice (NPP) provides information on how our practice may use and/or disclose protected health information about you for treatment, payment, and health care operations. A copy of our NPP can be found at http://www.vpavaldosta.com/forms (under "Our Privacy Notice") and upon request.

I acknowledge that I have received a copy of Valdosta Psychiatric Associates, LLC's Notice of Privacy Practices.

Patient Name: _____

Patient's Legal Representative (*if patient is under 18*)**:** _____

Patient's / Legal Representative Signature's: _____

Today's Date: _____

Patient's Date of Birth: _____

Name:_____ DOB: _____

INTAKE QUESTIONNAIRE

Who referred you to our office?_____

Have you ever had treatment for a mental or nervous condition before? Yes □ No □

Where were you treated before?_____

Has anyone in your family ever been treated for a mental or nervous condition before? Yes □ No □

Mother □ Father □ Brother/Sister □ Children □ Grandparents □ Other □

Are you allergic to any medications or ever had an adverse reaction to any medications? Yes □ No □

Please list drug allergies _____

Do you smoke? Yes □ No □ (How many cigarettes per day?_____ Packs per day _____)

Do you drink alcohol? Yes □ No □ (How many alcoholic drinks do you consume per week?_____)

Are you, or have you been, investigated by the Department of Family/Children Services? Yes □ No □

Are you involved in any legal actions or lawsuits? Yes □ No □

Your attorney's Name:_____ Type of Suit_____
(Divorce, Disability, Motor Vehicle Accident, Workers Comp, Other)

Are you involved in a worker's compensation claim? Yes □ No □

What Pharmacy do you use? _____

Street/City_____

Who is your Primary Care Physician? _____

What is your main complaint? / Why are you here today? _____
_____

How long and/or how often has this been occurring?_____

List any Medical Condition you are being treated for _____
_____

Medical History

□ Allergies/Seasonal	□ Anemia	□ Arthritis
□ Asthma	□ Back Pain (Chronic)	□ BPH
□ Cancer (type)_____	□ COPD/Emphysema	□ Diabetes □ Type I □ Type II
□ Disc Disease □ Lumbar □ Cervical	□ Fibromyalgia	□ GERD / Gastritis
□ Gout	□ Hearing Loss	□ Heart Disease
□ Hepatitis	□ Hernia	□ High Cholesterol
□ HIV	□ Hypertension	□ Hypotension
□ Hyperthyroidism	□ Hypothyroidism	□ Irritable Bowel Syndrome
□ Kidney Disease	□ Kidney Stones	□ Liver Disease
□ Lupus	□ Migraine Headaches	□ Obesity
□ Parkinson's Disease	□ Seizure Disorder	□ Sleep Apnea
□ Sexually Transmitted Disease	□ Stroke/TIA (History of)	□ Testosterone (Low)
□ Traumatic Brain Injury	□	□ No Medical Problems

Other Illnesses not listed above:_____

Surgical History

□ Appendectomy	□ Back □Lumbar □ Cervical	□ Bariatric Surgery	□ Brain
□ Cardiac Value	□ Cardiac Bypass	□ Ear/Nose/Throat	□ Gall Bladder
□ Gastric Bypass	□ Hernia Repair	□ Hip Replacement	□ Hysterectomy (Partial)
□ Hysterectomy (Total)	□ Kidney Stones Removed	□ Kidney Removed	□ Knee Replacement
□ Prostate	□ Rotator Cuff	□ Shoulder	□ Tubal Ligation
□ Wrist			

Other Surgeries not listed above: _____

Medications

Please list all medications you take daily, including all prescriptions, over-the-counter, herbals, and vitamin/mineral/dietary (nutritional) supplements, along with the dosages and frequency:

Medication	Dosage	How often?

Allergies

Please list any drug or non-drug allergies you have:

Please check all stressors you are currently experiencing

□ Economic/Financial	□ Education/School	□ Family Conflict	□ Grief/Loss
□ Legal Problems	□ Medical Illness	□ Work (stressors)	□ Living Situation
□ Social Environment	□ Substance Abuse	□ Marital Conflict	□ Family Disruption due to divorce or separation
□ Personal Injury	□ Relationship	□ Physical health	

Please check any symptoms you are currently experiencing

□ Anxiety / worry	□ Decreased energy	□ General Stress	□ Unexplained or chronic pain
□ Anger	□ Decreased pleasure and interest in things	□ Grief/Loss	□ Thoughts of hurting someone else
□ Appetite disturbance	□ Depressed Mood	□ Uncontrolled Fear or Phobia	□ Hallucinations (hearing voices, seeing things)
□ Decreased concentration	□ Feelings of hopelessness,	□ Falling Asleep during	□ Insomnia (trouble falling asleep or

	helplessness or worthlessness	the daytime	staying asleep)
□ Nervousness	□ Decreased energy	□ General Stress	□ Irritability
□ Anger	□ Decreased pleasure and interest in things	□ Impulsiveness	□ Isolating (staying away from others)
□ Mania (unusually hyperactive, talkative)	□ Nightmares	□ Panic Attacks	□ Rapid weight loss or weight gain
□ Memory Impairment	□ Sexual Dysfunction	□ Thoughts of hurting myself	

Please list any other symptoms not listed above: _____
_____

Past Psychiatric History

Have you ever been treated by a psychiatrist or counselor in the past? □ Yes □ No

Outpatient Treatment

Provider:	Dates of Treatment:
Provider:	Dates of Treatment:
Provider:	Dates of Treatment:

What were you being treated for?_____

Inpatient Treatment

Facility Name:	Type of Admission	Date/Year
□	□ Voluntary □ Involuntary	
□	□ Voluntary □ Involuntary	
□	□ Voluntary □ Involuntary	

□ Reason for Admission:

□ Depression	□ Drug/Alcohol	□ Manic Episode	□ Psychotic Episode
□ Severe Anxiety	□ Suicidal Ideations	□ Suicide Attempt	□ Violence/Assaultive Behaviors

Family History

Has anyone in your family ever been treated for psychiatric condition or Substance Abuse? □ Yes □ No □ Unknown

Family Member	Type of problem

Father: □ Living □ Deceased (Age _____) / Mother: □ Living □ Deceased (Age _____)

Brief Description of your Father and Mother: _____
_____

Siblings:□ # Living _____ □ # Deceased ___

If you were not raised by your biological parents, please explain:
_____
_____

What is your cultural background: (Hispanic, Italian, German, Irish, etc.) _____

Substance Abuse History

Do you have a history of Substance Abuse? □ Yes □ No □ Maybe: _____

Type of substance Used	Quantity Used	Frequency of Use

Have you experienced any of the following as a result of your drug or alcohol use?

□ Arrests	□ Consuming more than intended	□ Blackouts	□ DUI
□ Employment Issues	□ Family/Marital Conflict	□ Feeling guilty	□ Financial problems
□ Fighting	□ Health Problems	□ Increased Tolerance	□ Increased tolerance
□ Unintentional Overdose	□ Physical Health Problems	□ Seizures	□ Withdrawal Symptoms

List any other consequences not listed above: _____

Education History

Highest grade level obtained:	□ Some college	□ Master's Degree
□ Less than a high school education	□ Technical degree	□ Doctorate Degree
□ Graduated from high school or GED	□ College degree	□ Other: _____

Employment Status

□ Full-time □ Part-time (Employer Name _____ Months/Yrs. at job _____)
□ Unemployed □ Retired □ Disabled □ Homemaker
Occupation: _____

Military Service History:

□ Never been in the military	□ Active Duty Military	□ Parent is active duty military
□ Spouse is Active Duty military	□ Retired from the military	□ Honorably discharged from military
□ Veteran	□ Medically discharged from military	□ Dishonorable discharge

Branch of military: _____

Marital Status:

□ Single/Never married	□ Married	□ Divorced
□ Separated	□ Widowed	□ Partnership/Serious Relationship

Current level of satisfaction in the relationship is: ___ N/A _____ Very satisfied _____ Somewhat satisfied _____ Dissatisfied

Number of Marriages _____ Number of Children: _____ List the Names and Ages of Children: _____
_____

Residential Status:

□ Own A home	□ Rent	□ Live w/parents	□ Foster Care
□ Homeless	□ Nursing Home Facility	□ Live w/roommate(s)	

Housing Conditions are: _____ Excellent _____ Good _____ Fair _____ Poor

List the members of your current household (name and relationship to you): _____
_____
_____

Social Supportive Network:

□ Supportive Family	□ Friends	□ Religious Congregation	□ Co-workers
□ Internet-based	□ Social Services	□ Sponsor	□

Cultural:

□ Caucasian	□ African-American	□ Hispanic	□ Asian
□ Native American	□ Bi-Racial	□ Indian	

Sexual Orientation:

□ Heterosexual	□ Homosexual	□ Bi-Sexual	□ Transgendered	□ Don't know

Religion

□ Denomination:	□ Participate in religious activities	□ Do not participate in religious activities

CONTROLLED SUBSTANCE POLICY

As part of your treatment, your physician may order medications for you. Many of these medications can have serious side effects if they are not managed properly. You will be made aware of any side effects from medications that we have prescribed for you. Please read the following agreement **CAREFULLY** and ask your doctor/nurse if you have any questions:

1. I agree to follow exact dosing instructions prescribed by my physician.
2. I agree to keep all appointments required by my physician. If I miss an appointment, I understand that a follow up must be made before any prescriptions will be refilled or changed.
3. I agree to maintain all prescriptions at the same pharmacy, unless reasonable circumstances occur.
4. Refill requests are to be made during office hours only. Mon-Thurs 9:00 am to 4:00pm. Fridays 9:00 a.m. to 11:00 a.m.
5. Refill requests must be made in **ADVANCE** (7 days). If my physician is out of the office, I understand that my prescription **will not** be filled until they return.
6. **NO CONTROLLED SUBSTANCES WILL BE FILLED DURING EVENINGS, WEEKENDS OR HOLIDAYS!**
7. In most cases if a **Controlled Substance** prescription is lost, it will **NOT BE REFILLED.** It is your responsibility to keep track of your medications.
8. I understand that any misuse of my medications will be reported to the appropriate authorities and I can be terminated from the practice.

I agree that I have read and fully understand this controlled substance contract. I will ask my physician if I have any questions regarding the potential risk of dependency, addiction and side effects of the medications given to me. I do understand that a breach of this contract will result in my termination from Valdosta Psychiatric Associates, LLC

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Patient Signature Date

_____

Physician

SOCIAL MEDIA POLICY – VALDOSTA PSYCHIATRIC ASSOCIATES, LLC

3541 North Crossing Circle, Valdosta, GA 31602
(229) 244-4200

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 anything in this policy, please bring it up at 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 fully with the use of 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 Dr. Morgan or your therapist 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; pop-up messages on your cell phone may be viewed by others, 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 administers of the internet service provider. Valdosta Psychiatric Associates does not use encryption in our email system, therefore, should you choose to contact us via email, and 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 do so by faxing us at 229-244-4995. 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. It could compromise your confidentiality to use Wall posts, replies, or others means of engaging in conversations on these sites. 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 the 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.

_____

Initial Above that you have and understand items contained on this page

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 surmise you are in treatment at Valdosta Psychiatric Associates. Please ask your service provider if you are unware of how to disable this setting.

WEBSITE

Our website www.vpavaldosta.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 feel 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 of these sites include forums in which users rate their provider 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 Valdosta Psychiatric Associates 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 it is 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, there is a good possibility it will never been seen. If you choose to write something on a business review site, keep in mind 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 (both 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: _____