JYDES FAMILY CLINIC
BEHAVIORAL HEALTH SERVICES

Patient Name: _____
(First, Middle, Last)

Sex: □ Male □ Female **Date of Birth:** _____ **Age:** _____

Marital Status: □ Single □ Married □ Other _____

Race: _____ **Ethnicity**: _____

Preferred Language: _____ **Religion**: _____

Parent/Guardian Names: (If patient is under 18 years): _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ **Mobile Phone:** _____

Can a message be left at the above numbers? Yes/No

Work Phone: _____

Email: _____ **@** _____

Emergency Contact: (*Person to notify in case of emergency.)*

Name: _____ **Relationship:** _____

Contact Phone Number: _____

Primary Care Physician:

Name: _____ **Phone Number:** _____

Pharmacy:

Name: _____ **Phone Number:** _____

Insurance Information

Policy Holder: _____
(Name) (DOB)

Primary Insurance Name:
Member ID:
Group Number: Phone Number:

Policy Holder: _____
(Name) (DOB)

Primary Insurance Name:
Member ID:
Group Number: Phone Number:

Insured Address (*If different from above*)**:** _____
If patient is under 18yrs old parent/guardian information

Occupation: _____ Employer: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

- **I understand I am responsible for payments/copays/coinsurance in full prior to appointments, unless a payment plan has been arranged.**
- **I authorize payments for medical benefits to be paid to Jydes Family Clinic from my insurance carrier.**
- **I understand I am responsible for payment of services if my insurance carrier denies payment.**
- **I will inform Jydes Family Clinic of any insurance changes, 24 hours prior to my next appointment or I will pay the Jydes Family Clinic contracted rate with my insurance carrier until insurance can be verified.**
- **I have been offered Jydes Family Clinic Notice of Privacy Practices.**
- **I have read and understand Jydes Family Clinic policies.**
- **I give permission for Jydes Family Clinic to use an automated appointment reminder system via my contact phone number.**

_____ _____
Signature of Patient or Parent/Guardian **Date**

Name of medication, vitamin, or supplement: (Prescriptions, over-the-counter, vitamins)	**Dosage**	**Frequency of use**	**Reason given**

Are you allergic or have had a bad reaction to any medications?	□ **Yes** □ **No** If yes, please list below	
Medication Name:	**Reason Given:**	**Side Effect:**

Check any of the following problems that you are currently experiencing:

□ Lack of appetite	□ Difficulty trusting
□ Excessive drinking	□ Low self-esteem
□ Anger Management	□ Relationship problems
□ Drug use problems	□ Difficulty concentrating
□ Nervousness	□ Feelings of unreality [Zone-out]
□ Fatigue	□ Flashbacks
□ Panic attacks	□ Depression
□ Anxiety	□ Bowel problems
□ Loneliness	□ Bladder control problems
□ Nightmares	□ Difficulty relaxing
□ Intrusive thoughts	□ Fears/phobia
□ Sleep disturbance	□ Obsessive thoughts
□ Headaches	□ Compulsive behavior
□ Sexual problems	□ Martial/family problems
□ Stomach problems	□ Poor impulse control
□ Pain: _____	□ Confusion
□ Destruction of property	□ Easily distracted
□ Fighting	□ Unable to complete task
□ Disruptive	□ Isolative

Patient Name: _____

Please list **ALL** prior behavioral health treatment: (Psychiatrists, Therapist, and Psychologist).

Providers:	Month/Year:

Have you ever received inpatient mental health treatment: □ **No** □ **Yes** If yes, please list ALL prior inpatient hospitalizations for behavioral health?

Hospital:	Date:	Reason for Hospitalization:

Please list ALL prior surgical procedures: (Surgeries that required anesthesia)

Operation:	Date:

Medical History

(Check the boxes that apply to you and give details if needed)

[ ]Diabetes: □ Type 1 □ Type 2	**[ ] Gynecological:**
	[ ] Lung Disease:
[ ] Hypoglycemia: Other Blood Sugar: _____	□ Asthma □ Other:_____
[ ] Obesity:	**[ ] Sleep Apnea**
Current Weight: _____ □ Weight gain past 6 weeks □ Weight loss past 6 weeks	**[ ] Cancer:** Type: _____

[ ] GI Tract:

□ Reflux
□ Ulcer
□ Irritable Bowels
□ Crohn's Disease
□ Other:_____

[ ] Kidney Disease

[ ] Thyroid Problems

Status: _____

[ ] Neurological Disorder:

□ Migraines
□ Frequent Headaches
□ Seizure Disorders
□ Other:_____

[ ] Autoimmune Disorder:

□ AIDS/HIV
□ Lupus
□ Autoimmune Disease
□ Other:_____

[ ] Orthopedic:

□ Osteoarthritis
□ Rheumatoid Arthritis
□ Fibromyalgia
□ Other:_____

[ ] Heart Problems:

□ Hypertension
□ Heart Disease
□ Heart Attack
□ Other:_____
□ Cardiac Workup
□ Stroke

[ ] Dermatological

[ ] Female Only

When was your last menstrual period? _____
Are you pregnant or suspect that you are? Y/N

[ ] Other : _____

INFORMATION, AUTHORIZATION & CONSENT TO TREATMENT

Welcome to ***Jydes Family Clinic***. We are very pleased that you selected our practice for your outpatient treatment, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect regarding policies, confidentiality, emergencies, and several other details regarding your treatment here at ***Jydes Family Clinic***. Information regarding our provider's educational background and experience may be found on our website under his or her name. Please feel free to view that information at ***www.jydesfamilyclinic.com.***

Appointments

Here at ***Jydes Family Clinic,*** we are available to you during regular business hours by appointment only. We ask that you arrive on time to your appointment and understand that if you are more than 10 minutes late, you will be asked to reschedule your appointment. We strongly encourage you to schedule your next appointment at the time of check out, as our providers schedules tend to book up weeks in advance. Due to the high volume of patients that we serve, we are unable to keep an appointment cancellation list. As a courtesy, ***Jydes Family Clinic*** provides reminder calls for appointments; however, it remains the patient's responsibility to arrive to scheduled appointments, even if a reminder call was not received.

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Cancellation Policy

In the event that you are unable to keep an appointment, you must notify our office at least 24 hours in advance. If such advance notice is not received, you will be charged a **$50.00** same day cancellation or no show fee that will be due prior to being seen at the next appointment. Please note that insurance companies do not reimburse for missed sessions. Please be aware that after three (3) no show or same day cancellations of a scheduled appointment, you will be discharged from ***Jydes Family Clinic***, unless otherwise determined by one of our providers.

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Insurance and Payments

We accept many private insurance plans and participate in several managed care plans. As a courtesy to you, ***Jydes Family Clinic*** will bill your insurance company; however, it is your responsibility to find out your insurance company's terms and conditions of coverage. We ask that you keep ***Jydes Family Clinic*** informed of any changes to your insurance coverage prior to your next scheduled appointment. Please note that any date of service not covered by your insurance company will become your financial responsibility.

All payments are due prior to being seen for your appointment. This includes insurance copayments, deductibles and coinsurance. We accept most major credit cards, bank debit cards and cash payments.

Jydes Family Clinic does **not** accept personal checks.

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Medications and Prior Authorizations for Medications

It is the policy of ***Jydes Family Clinic*** that you must have a scheduled appointment in order to receive all medication prescriptions and/or have medication changes. Our providers do not call in medications or medication refills to the pharmacy.

There are times when insurance companies require certain medications to have a Prior Authorization from the prescribing provider before they will determine coverage. Please be aware that ***Jydes Family Clinic*** completes these Prior Authorizations as a courtesy to you. We ask for up to 30 days in order to complete the insurance requirements for the prior authorization. Upon receiving the authorization, our office will contact you.

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In Case of an Emergency

Jydes Family Clinic is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not schedule same-day appointments or accept walk-in appointments; therefore, if you have a mental health emergency that cannot wait until your next appointment, we encourage you to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Laurelwood Hospital at 770.531.3800
- Call Ridgeview Institute at 770.434.4567
- Call Summit Ridge Hospital at 678.442.5858
- Call Peachford Hospital at 770.454.5589
- Call Lakeview Hospital at 678.713.2600
- Call 911.
- Go to your nearest emergency room.

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Confidentiality, Records & Fees

Your communication with our providers at ***Jydes Family Clinic*** will become part of a clinical record of treatment, referred to as Protected Health Information (PHI). Your PHI will be kept in an electronic file, as well as, a physical file that will be stored to protect your confidentiality to the fullest extent. Both verbal information and written records cannot be shared with another party without a signed "Release of Information" form by the client or the client's legal guardian. Noted exceptions are as follows: (1) you are determined to be a danger to yourself or to others; (2) you report information of being a victim of abuse or about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (3) we are ordered by a judge to disclose information.

Any paperwork needing to be completed by a provider at ***Jydes Family Clinic*** will require you to schedule an appointment prior to completion in order to discuss the paperwork (ie. Disability, Social Security, FMLA, Return to Work, Short Term Disability, etc.). Be aware that you will be charged a fee for the completion of any paperwork and we ask for up to 30 days for full completion.

In the event that you become involved in legal proceedings that require the participation of any ***Jydes Family Clinic*** provider, you will be expected to pay for all professional time, including preparation and transportation costs, even if they are called to testify by another party. There will be a charge of **$200.00** per hour for preparation and attendance at any legal proceedings payable to Jydes Family Clinic.

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Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with any of our staff or providers at ***Jydes Family Clinic*** remains therapeutic and professional. Therefore, if at any time there is communication with us via cell phones, Email or text messaging, please know that it is our policy to utilize these means of communication strictly for brief topics, such as appointment confirmations. Since this is not a secure means of communication and your confidentiality may potentially be compromised, there should not be communication containing therapeutic content.

It is our policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality.

We ask that you silence and refrain from using your cell phones for personal calls at ***Jydes Family Clinic***, both during your appointment and while you are waiting in the lobby.

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Urine Drug Screening (UDS)

I give consent for myself or consent for my child to Jydes Family Clinic to obtain a urine sample at each medication management appointment. I acknowledge that these results will aide in my treatment and that failure to give submit to a UDS may result in the provider refusing to prescribe certain medications.
I understand my insurance will be billed by the lab that processes these results. Per Jydes Family Clinic's agreement with the Lab, Jydes Family Clinic will accept the payment your insurance reimburses for the results.

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Our Agreement to Enter into a Professional and Therapeutic Relationship

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies and you are authorizing our providers to begin treatment with you.

_____

Client Name (Please Print)

_____ _____

Client Signature **Date**

If Applicable:

_____

Parent's or Legal Guardian's Name (Please Print)

_____ _____

Parent's or Legal Guardian's Signature **Date**