SAVANNAH PSYCHIATRY

EST. 1973

## Welcome to Savannah Psychiatry

We would like to welcome you to our office and help familiarize you with our office policies and procedures. If you have any questions, our office staff is available to assist. You can also find helpful information on our website **www.savannahpsychiatry.com**

### Office Hours

Our normal office hours are 8:00am- 5:00pm Monday through Friday. An answering service is available after hours and will notify the psychiatrist on call for any emergency situations.

### Missed Appointments

We kindly ask that you contact our office at least 24 hours in advance, during normal business hours, to cancel or change your appointment. Appointments not canceled with the appropriate notice will be assessed a missed appointment fee. Insurance providers do not cover missed appointments.

Please understand the importance of keeping your appointments. Unlike other offices our providers do not overbook appointments. You are expected to be on time for your scheduled appointment, and this time is specifically reserved for you.

### Insurance Information

We will file your primary insurance as a courtesy to you. Please be familiar with your mental health benefits. It is your responsibility to inform us of any changes to your insurance policy.

### Prescription Refill Policy

In general, all refill requests should be made **during** appointment times. Remember all refill requests require a minimum 48-hour (not including weekends) turn-around time. At the time of your appointment, you will be supplied with enough refills to last until your next appointment. Refill requests outside of visits are **only** for unusual/extenuating circumstances.

If you are being prescribed medications, you will be scheduled for regular follow up appointments in order to monitor your treatment progress and also to assess any medication safety issues. It is your responsibility to be compliant with your treatment plan and keep your appointments.

### Prescription Refills for Non-Controlled Medications

If a refill is needed for a non-controlled medication outside of an appointment, you may call our

office and will be prompted to leave a voicemail for your provider. Please allow 48 hours for this request at a minimum. Remember, you must have an appointment already scheduled on your providers calendar to request a refill.

**Prescription Refills for Controlled Medications**

The state of Georgia has recently passed new legislation on controlled medications. There are a variety of controlled medications that will now be regulated by this new legislation. These include stimulant medications, short-term anxiety medications, and medications that help with insomnia. Patients who are prescribed these controlled medications must be seen in our office at least every 90 days. The state of Georgia also now requires each patient, who is prescribed a controlled medication, to be monitored by the (PMPD) Prescription Drug Monitoring Program. The (PMPD) is a database that allows your physician to see which medications you are being prescribed by other providers. As with non-controlled medications, in general, all refill requests should be made **during** appointment times. Exceptions will be made only for changes to your medication between appointments or the unforeseen need for refills/rescheduling issues beyond your control. Please realize that if you are outside the 90-day window the office will be unable to fill controlled mediations, and you will be required to see a provider in our office in order to receive a prescription.

If you are prescribed one of these medications, it is critical that you follow the controlled medication policy. This is outlined below.

**Controlled Medication Policy**

- Patients must be seen in the office at least every 90 days and monitored by the PMDP
- Prescriptions will be issued at a regularly scheduled appointment.
- Patients are expected to keep regular appointments and when necessary give **24 hours** of notice if canceling.
- No early refills will be permitted unless discussed and authorized by your psychiatrist. Early refills will only be filled under extenuating circumstances.
- Lost prescriptions will only be replaced for extenuating circumstances and must be authorized by the psychiatrist.
- Stolen prescriptions will only be replaced if the patient brings a copy of a police report.
- A Savannah Psychiatry psychiatrist will provide controlled medications as medically appropriate.
- Patients may be required to provide a urine drug screen prior to the first prescription being written.
- Patients may be required to complete an annual urine drug test with more frequent testing if indicated and requested by a psychiatrist from Savannah Psychiatry
- Patients who test positive for marijuana, or other illicit substances or test negative for the controlled substance will be counseled and a decision made about continued prescription of the medication
- The final determination about whether to prescribe a controlled medication rests with the prescribing psychiatrist.

Violating the controlled medication policy is grounds for termination from the practice.

*To make a refill request for controlled medications, please leave a voicemail with your exact medication request. The provider will leave your prescription in the designated controlled area in the office within **48** hours during **regular business days**. Again, you must have an appointment scheduled with your provider in order to request a refill.

**Emergencies**

There is an afterhours answering service that is available for emergency issues. Please use this for any urgent concerns defined as but not limited to:

Suicidal thoughts or thoughts of harming others,
Unexpected medication reaction with serious symptoms, or
Any unusual behavior that you fear may lead to physical harm.

Our providers will make every effort to respond to you as soon as possible. **If you cannot await a response, please call 911 or go to your nearest emergency room.**

You may reach the National Suicide Prevention Lifeline 800-273-8255.
The Georgia Crisis line is also available 800-715-4225.

Patient's name: _____Phone: _____
Patient's address: _____City: _____
State: _____ Zip code: _____ Social Security number: _____
Insurance company: _____
Address for submitting claims: _____
Policy number: _____ Group number: _____
Employer: _____
Insured's name_____ Relationship to Patient: _____
Insured's Social Security Number: _____ Insured's Date of Birth: _____

**Financial Responsibility:**

The Patient (or patient's guardian, if a minor) is ultimately responsible for the payment of his/her treatment and care. We are pleased to assist you by billing for our contracted insurers however, the patients is required to provide us with the most current and updated information about their insurance and the patient will be responsible for and charges incurred if the information provided is not correct or updated.

Patients are responsible for the payment, co-pays, co-insurance, deductibles for all procedures or treatments not covered by their insurance plan. Payment is due at the time service is rendered. For your convenience we accept, cash, check and most major credit cards at our office. Any payments received by Savannah Psychiatry may be applied to any unpaid bill(s) for which the patient is liable. Any and all balances assigned as patient responsibility may be subject to collection efforts after 90 days, as well as credit reporting.

Patients may incur, and are responsible for the payment of additional charges. These charges may include (but are not limited to)

*Charge for returned checks
*Charge for missed appointments without 24-hours advance notice.
*Charge for the copying and distribution of patient medical records.
*Any costs associated with collection of patient balances.
*Medication refill as outlined in our refill policy.

By my signature below, I acknowledge and understand that it is ultimately my responsibility and obligation to be aware of my insurance's requirements, coverages, deductibles and payments. **initials: _____**

By my signature below, I thereby authorize Savannah Psychiatry to release medical and other information acquired in the course of my examination to the necessary insurance companies, third party payers, and or other physician or healthcare entitles required to participate in my care. **initials: _____**

By my signature below, I nearby authorize assignment of financial benefits directly to Savannah Psychiatry and any associated healthcare entitles for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment. I understand that account balances not paid by my insurance company within 90 days are the patient's/my responsibility. I also understand that account balances not paid within 90 days from the date of service will be sent to collections. **initials: _____**

By my signature below, I authorize Savannah Psychiatry personnel to communicate by mail, text, answering machine message, voicemail, and/or email according to the information I have provided in my patient registration information. **initials: _____**

By my signature below, I am acknowledging that I have reviewed the Savannah Psychiatry Privacy Policy, Medication Refill Policy and Missed Appointment Policy. A copy of these policies was made available to me at my appointment. **initials: _____**

Print name of Patient or legal guardian: _____

Signature of Patient or legal guardian: _____ Date: _____

# Treatment History

Name: _____ Date: _____

Occupation: _____
Highest level of education or current grade level:_____
Date of birth: _____ Age: _____ Sex:_____ Height: _____Weight:_____
Emergency Contact: _____Relation:_____ Phone # _____
Preferred ways for us to reach you: _____
Who referred you to our office? _____

Describe the problems you are experiencing that led you to make this appointment?

_____
_____
_____
_____

Have you had past psychiatric treatment? If yes, please give list your past treatment and approximate dates?

_____
_____
_____
_____
_____

Have you had any psychiatric hospitalizations in the past? If yes please give approximate dates:

_____
_____
_____
_____

Are you on any current psychiatric medications? If yes, please list your medications and dosing information:

_____
_____
_____
_____

Please list any past psychiatric medications you have been prescribed in the past and list any side effects you had on these medications:

_____
_____
_____

Please list any past or current medical conditions:

_____
_____

Please list all medications or supplements you are currently taking:

_____

_____

Are you allergic to any medications: _____

Please tell us about your family members as listed below and list any medical or psychiatric illnesses. Are they living? Please list the nature of the relationship providing both names and ages.

A) Mother:
_____

B) Father:
_____

C) Siblings:
_____

D) Children:
_____

E) Others:
_____

List all people living in the household, and their relationship to you:

_____

_____

Have you ever served in the military? If so please let dates and describe your service:

_____

Please tell us how much alcohol you consume:

_____

Please tell us about any illegal drugs you currently use or have used in the past:

_____

_____

Do you use tobacco products:

_____

Have you had any panic attacks, hyperventilation, or anxiety symptoms?

_____
_____

Do you have excessive hand washing, repetitive checking, or bothersome thoughts that keep coming back into your mind?
Describe:

_____
_____

Have you been exposed to any traumas as a child or adult?
Describe:

_____
_____

Have you ever considered harming yourself?

_____

Have you attempted suicide? _____
How many times? Please describe and date any prior attempts?

_____

Have you been arrested?

_____
What were the charges? _____

Have you had an eating disorder or forced yourself to throw up?

_____

Please describe any additional stressors or issues that you are currently going through:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Mental Status Checklist

Name: _____ Date:_____
Please indicate if you have had any of the following symptoms. If you answer "yes" to any of the items below, please indicate the severity of the symptom by placing a circle on the scale of 0 to 10 with o being no symptoms and 10 being the most severe symptoms that one can experience. Describe what the specific symptom is and when you are likely to have it.

- ❖ Constant nervousness or anxiety 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Fears or phobias 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Sudden panic attacks 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Thoughts you could not get out of your mind 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Acts or deeds that you feel felt you had to do in spite of yourself

  0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Depression or low mood 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Suicidal thoughts, actions or plans 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Unusually high spirits 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Feelings that part of your mind/body is strangely changed/unreal (not related to drugs) 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Feelings that things around you were strange 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Hearing voices or seeing things that others say are not there

  0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Feelings that your thoughts, actions, or senses were controlled from outside yourself 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Feelings that others could hear your thoughts 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Feelings that others are out to harm you 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

- ❖ Memory Problems 0 1 2 3 4 5 6 7 8 9 10

Describe? _____
When? _____

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:** _____ **DATE:** _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
*(use "✓" to indicate your answer)*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

add columns _____ + _____ + _____

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).*

TOTAL: _____

**10.** If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____



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