Registration Sheet

Date:_____

Patient Name: _____
Last First M.I.

Date of Birth: _____-_____-_____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone :(____) _____-_____ can a message be left at this number? ___yes ___no

Work Phone :(____) _____-_____ can a message be left at this number? ___yes ___no

Ext.: _____

Mobile Phone :(____)_____-_____ can a message be left at this number? ___yes ___no

Pager :(____) _____-_____ E-mail Address_____

How do you prefer to be contacted? _____

Referred by:_____

<u>In Case of Emergency, Contact:</u>

Name:_____ Relationship:_____

Phone:_____

CHS Psychiatric Associates Medical History Self Report

Patient's Name: _____ **Date of Birth:** _____

Allergies to Food, Medication, Other:_____

Current Family Physician: _____**Date of Last Physical Exam:** _____

Are there currently or have there previously been problems with any of the following?

	Yes	No		Yes	No
Skin problems	☐	☐	Eating	☐	☐
Wounds not healing/easy bruising	☐	☐	Alcohol	☐	☐
Glaucoma/Vision	☐	☐	Street drugs	☐	☐
Hearing	☐	☐	High blood pressure	☐	☐
Headaches	☐	☐	Heart disease/Chest pain	☐	☐
Head injuries	☐	☐	Heartbeat irregularities	☐	☐
Black outs/Fainting	☐	☐	Rheumatic fever	☐	☐
Numbness/Tingling	☐	☐	Nausea/Vomiting	☐	☐
Thyroid problems	☐	☐	Ulcers	☐	☐
Blood sugar	☐	☐	Liver disease or jaundice	☐	☐
Sickle cell	☐	☐	Kidney/Bladder problems	☐	☐
HIV/AIDS	☐	☐	Pregnancy (If pregnant, due date _____)	☐	☐
Fatigue	☐	☐	Sexual function		
Anemia/Low blood count	☐	☐	Pain	☐	☐
Breathing/Shortness of breath	☐	☐	Daytime sleepiness	☐	☐
Fever	☐	☐	Sleeping too little	☐	☐
Cancer	☐	☐	Lead/Chemical exposure	☐	☐
Excessive movement during sleep	☐	☐	Seizures	☐	☐
Snoring	☐	☐	Change in Weight	☐	☐

Please describe:_____

_____

Have any family members had any of the following?

	Yes	No	Who
Depression	☐	☐	_____
Bipolar Disorder	☐	☐	_____
Suicide	☐	☐	_____
Schizophrenia	☐	☐	_____
Eating Disorder	☐	☐	_____
Anxiety Disorder	☐	☐	_____
Alcohol/Drug Problems	☐	☐	_____
ADHD	☐	☐	_____
Thyroid problems	☐	☐	_____
Asthma	☐	☐	_____
Diabetes	☐	☐	_____
Stroke	☐	☐	_____
Dementia/Senility	☐	☐	_____
Stomach Problems	☐	☐	_____
Seizures (what kind	☐	☐	_____
Heart Problems	☐	☐	_____
Cancer (what kind)	☐	☐	_____
High blood pressure	☐	☐	_____
Abnormal heart rhythm	☐	☐	_____
Sudden cardiac death	☐	☐	_____
Tics	☐	☐	_____

Have there been hospitalizations for any medical reasons such as illness, accidents, operations, or tests?

Reason for Hospitalization	Date	How Long?

Current Medications (including any over the counter or herbal preparations):

Name of Medication	Dosage	For what reason?	How Long?	Side effects (if any)

Other Psychiatric medications which have been taken in the past:

Name of Medication	Dosage	For what reason?	How Long?	Side effects (if any)

Psychiatric care in the past? (Such as psychiatrist, psychologist, social worker, nurse, counselor, or psychological testing)

For what reason?	When?	By Whom?	Type of Treatment	Were you hospitalized?

Currently using caffeine? ☐ **Yes** ☐ **No** **If yes, how much, how often** _____
Currently using cigarettes? ☐ **Yes** ☐ **No** **If yes, how much, how often** _____
Currently using alcohol? ☐ **Yes** ☐ **No** **If yes, how much, how often** _____

_____
Signature **Date**

CONFIDENTIALITY STATEMENT

Some important issues regarding confidentiality need to be understood as we begin our work together. Please review this material carefully so that we may discuss any questions or concerns.

In general, law protects the confidentiality of all communications between a patient and treatment provider. I can only release information about our work to others with your written permission. There are a few exceptions, however.

In most judicial proceedings you have the right to prevent me from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require my testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, I may have to reveal part or all of your treatment or evaluation records.

If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. My testimony may also be ordered in other cases including legal proceedings relating to psychiatric hospitalization, malpractice and disciplinary proceedings, court-ordered psychological evaluations, and certain legal cases following the death of a client.

In addition, there are some circumstances when I am required to breach confidentiality without a patient's permission. This occurs if I suspect the neglect or abuse of a minor, in which case I must file a report with the appropriate State agency. If, in my professional judgment, I believe that a patient is threatening serious harm to another, I am required to take protective action, which may include notifying the police, warning the intended victim, or seeking the client's hospitalization. If a client threatens to harm himself or herself, I may be required to seek hospitalization.

The clear intent of these requirements is that a treatment provider has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgment indicates that such danger exists. Fortunately, these situations rarely arise in my practice.

There are several other matters concerning confidentiality:

1. I may occasionally find it helpful or necessary to consult about a case with another professional. In these consultations I make every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to maintain confidentiality. If I feel that it would be helpful to refer you to another professional for consultation then, of course, with your authorization, I will discuss your case with her or him.

2. I am required to maintain complete treatment records. Patients are entitled to receive a copy of these records, unless I believe the information would be emotionally damaging and, in such cases, the records must be made available to the patient's appropriate designee.

3. If you use third party reimbursement, I am required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary. If you request it, I will provide you with a copy of any report to submit.

4. If you are under eighteen years of age, please be aware that while the specific content of our communications is confidential, your parents have a right to receive general information on the progress of the treatment. Your parents may also request a copy of your record from me.

5. Under current South Carolina law, in group and family therapy and in marital therapy all participants are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege or release of the record is court ordered.

6. At times, I will be using a cellular phone to contact you or return your calls. Please be aware that I will not notify you when I am using such a device so if the information you are discussing requires a more secure level of confidentiality, please let me know so I can arrange to contact you in another way.

7. I routinely use a fax machine in communication with other agencies. I will only release information that you have authorized me to release and do send these with a cover sheet that includes a confidentiality statement but this does not insure that the fax is received in the proper place or handled in a confidential matter once it is received. You may pick up and hand carry documents to agencies if you wish. I will also mail documents on special request.

8. I will reply to email messages sent to me and I will make effort to limit the type of information discussed in these messages but again it is important to stress that email is not a confidential mode of communication and should not be utilized if you require a higher degree of security.

While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, you should be aware that the laws governing these issues are often complex. I encourage our active discussion of these issues. However, if you need more specific advice, formal legal consultation may be desirable.

I have read the above; fully understand the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached.

_____ _____

Signature Date

Consent for Treatment Services

CHS Psychiatric Associates, LLC

Name of Patient: _____

I, _____ consent to the following psychological/psychiatric services:

Check and Initial All That Apply

[ ] Clinical Interview/Evaluation
[ ] Counseling/Psychotherapy
[ ] Medication
Other_____

[ ] Psychological Testing
[ ] Psychiatric Evaluation
[ ]

_____ _____
Signature of Person Giving Consent Date

_____ _____
Signature of Witness Date

Fee Schedule/Payment Agreement 2009 for CHS Psychiatric Associates, LLC

- **Child Initial Evaluation:** This includes an in-depth evaluation, interviewing both child and parent(s) and/or legal guardians. This also includes any necessary review of records, report preparation, correspondence with referring physicians, schools or other agencies as requested, and administrative time.

Fee**: $300**

- **Adult Initial Evaluation**: This includes an in-depth evaluation, also including any necessary review of records, report preparation, correspondence with referring physicians, schools or other agencies as requested, and administrative time.

Fee: **$300**

- **Individual Psychotherapy**
  20 minute session: **$150**
  45 minute session: **$200**

- **Medication Management**
  20 minute session: **$150**

- **Family Therapy**
  45 minute session: **$200**
  80 minute session: **$300**

- **Phone Consultation**
  First 10 minutes per month: no charge
  Every 15 minutes thereafter: **$50**

- **Generation of specially requested report**
  Per hour of effort: **$175**

- **Prescription refills if appointment is missed/not made**
  $50

- **Second Opinion/Consultation**: Includes same services as initial evaluation with a more extended initial session and report/discussion

Fee: **$500**

****Late Payment Fee:** Accounts not settled within 30 days of service will be charged a monthly service charge of 10%

Fee Schedule/Payment Agreement 2009 for CHS Psychiatric Associates, LLC

- **I understand that fees are due as stated and are payable at each session**

- I agree to accept financial responsibility for any missed appointments or any appointments cancelled with less than 24 hours notice. The missed appointment fee is the full fee of the missed appointment and is not billable to my insurance

- I understand my name and contact information will be turned over to a collections agency should I hold a balance more than 120 days.

- I have carefully read all the terms of the above guidelines, fee schedules, and have had an opportunity to discuss any questions

_____

_____ _____

Signature of Responsible Party Date