Dunwoody Psychiatry & Psychotherapy Center (DPPC)

New Patient Form

Patient Information (Please Print):

First Name: _____ Middle Initial: ___ Last Name: _____

Date of Birth: _____

Cell Phone Number: _____

Home Phone Number: _____

*Social SS #: _____-_____-_____

Billing Address: _____

_____

Emergency Contact: _____

Relationship: _____

Phone Number: _____

Email Address: _____

Reason for your visit today: _____

_____

Employment Information:

Employment Status (circle): Employed Unemployed Other: _____

Occupation:_____

Employer Name: _____

Work Phone Number: _____

Employer Address: _____

Insurance Information:

Primary Insurance: _____

Member ID/Policy # _____ Group # _____

Patient is Subscriber/Policy Holder please circle **Yes or No**

Secondary Insurance: _____

Patient is Subscriber/Policy Holder please circle **Yes or No**

Insured Information (If Other Than Patient):

Policy Holder: _____ Relationship to patient: _____ Phone #: _____

Dunwoody Psychiatry & Psychotherapy Center

2150 Peachford Road Suite V

Atlanta, GA 30338

Office Phone #: 770-674-1540 Fax #: 770-674-1765

Informed Consent for Treatment

I voluntarily agree to receive treatment by Dr. Michael Vaughn and/or Dr. Sanaz Rezaei-Vaughn for mental health services. This may include the use of telecommunications to provide mental and behavioral health services. I understand and agree that I will participate in my treatment plan, and that I may discontinue treatment and/or withdraw my consent for treatment and any time.

Printed Name: _____

Signature: _____

Date: _____

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Date: _____ Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

http://www.med.navy.mil/sites/NMCP2/PatientServices/SleepClinicLab/Documents/Beck_Depression_Inventory.pdf

Assignment of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Dunwoody Psychiatry & Psychotherapy Center for medical services or items rendered to me or my dependent by Dunwoody Psychiatry & Psychotherapy Center. Should my insurance carrier deny Dunwoody Psychiatry & Psychotherapy Center payment, I understand hat I am financially responsible for the charges. I authorize Dunwoody Psychiatry & Psychotherapy Center to release any and all of my records to my insurer, or any other third party legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance, and health information.

Signature: _____ **Date:** _____

Cancellation Policy

If you need to cancel your appointment with us, we ask that you give **at least 24 hours'** notice. For appointments that are cancelled within less than 24 hours or for "no show" appointments, you will be charged a **$75.00** or greater cancellation fee. This will be payable prior to your next visit.

Insurance/Office Payment

Our practice participates in many insurance plans. Since each plan has different requirements and coverage limitations and exclusions, it is the responsibility of the patient to understand and meet the requirements of their individual plan. Most patients will have a "co-pay" (a portion of their charges which is not covered by insurance) or a "co-insurance" (a percent of the charge covered by insurance). Those covered by Medicare and some other insurance plans may have "deductibles" as well. Co-pays, co-insurances, deductibles, and non-covered charges are payable **at the time services are rendered**. Our billing staff is available to assist you with questions you may have about your bill. We accept payment by cash, personal check, Visa and MasterCard.

All outstanding balances will be billed a $25 monthly fee until balance is paid in full.

Prescription Renewals

Dr. Vaughn routinely prescribes enough medication to last to your next appointment, so there should be minimal need for refill request. Please try to anticipate your need for prescriptions refills by notifying the office at least 48 hours in advance (not including weekends or holidays) or by advising your physicians of your need during regularly scheduled office visits. If you have not been seen in this practice within the past six months, it is our policy that you make an appointment to renew your medication.

Requests for refills on prescriptions after a missed appointment will be subject to a **$25 fee** and will be filled within a 48-hour period. Prescriptions will not be filled after hours or weekends.

Telephone Calls

Telephone calls requested by you from your doctor or therapist outside of your scheduled appointment time may be subject to a fee which is payable at the time of the phone session or the next scheduled appointment.

Requests for phone calls to the insurance provider or pharmacy for prior authorization will be subject to a 24-72-hour period.

Medication Prior Authorizations

Due to the time it takes to complete medication authorizations, **there will be a $40.00 fee** charged for this service. The fee must be paid before the prior authorization process is started and does not guarantee approval of the medication.

Returned Check Policy

There is a fee of **$25** for any check returned by the bank.

Reports /Letters

Special typed reports requested from various entities may be subject to an administrative fee determined by the amount of physician time required to provide the report. Disability forms may be subject to a **$50 fee.**

Lab Testing

Dr. Vaughn and/or Dr. Rezaei-Vaughn may order lab testing at any time while under their care. Please note that there may be an additional charge to your insurance for any lab service.

$10 is charged at the time of service for urine drug screen cups or oral fluid mouth swabs.

Transferring of Records

You will need to request in writing or contact the front desk if you want to have copies of your records, sent to another doctor or organization. You will need to include the specific dates of service, medical information requested and the reason for this request.

Copies of medical records are subject to a minimum copy **fee of $25.00**.

Updating Your Information

Patients are responsible for providing accurate, up-to-date information. As you may have several physicians, this information can change without the treating doctor being aware of these changes.

Please **notify the office of any insurance changes at least 48 hours in advance**. If insurance is not updated to the correct policy/plan prior to your appointment day, you will be required to pay the out of pocket (self-pay) rate for that day.

I have read and understand the policies listed above and acknowledge my responsibility to abide by the requirements and expectations set forth.

Client's Signature: _____

Date: _____

Signature of Guardian or Personal Representative: _____

Dunwoody Psychiatry & Psychotherapy Center

2150 Peachford Road Ste. V

Atlanta, GA 30338

T: 770-674-1540 F: 770-674-1765

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE : ☐ Michael R. Vaughn, M.D. ☐ Sanaz Rezaei, Ph.D.

TO: _____

Name of Healthcare Provider/ Physician

RE: Patient Name: _____

Date of Birth: _____

The Following Information:

☐ Psychiatric Evaluation ☐ Psychological Evaluation ☐ Consultation
☐ Treatment Plan ☐ Progress Notes ☐ Laboratory Reports
☐ Other (Specify): _____

I, _____, AUTHORIZE THE ABOVE NAMED PERSON/ ORGANZATION/ MEMBERS OF THEIR STAFF TO FURNISH INFORMATION, INCLUDING PHOSTATIC COPIES OF MY MEDICAL RECORDS, CONCERNING MY TREATMENT, TO THE ABOVE ORGANIZATION OR ITS AGENTS, AND I FUTHER AGREE TO INDEMNIFY AND HOLD HARMLESS ITS STAFF FROM ALL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION HEREIN REQUESTED. ANY INFROMATION OBTAINED FROM THIS AUTHORIZE REALEASE SHOULD NO BE RELASED TO ANY OTHER PERSON(S) UNLESS I SPECIFICALLY AUTHORIZE.

I UNDERSTAND THAT THE RECORDS RELEASED MAY CONTAIN ALCOHOL AND DRUG TREATMENT INFORMATION, AIDS/HIV OR PSYCHIATRIC/PSYCHOLOGICAL INFORMATION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN ELIANCE THEREON, AND THAT THIS AUTHORIZATION IS VALID FOR A PERIOD OF 180 DAYS FROM THE DATE OF MY SIGNATURE.

_____

DATE PATIENT SIGNATURE

_____

WITNESS PARENT/ LEGAL GUARDIAN