Atlanta Psychiatric Medicine, Inc.

Dr. Rukhsana Rizvi M.D.

Registration Form

PATIENT INFORMATION			
Last Name (legal)		First Name (legal)	
Maiden Name		Middle Name	
Marital Status	Age	DOB	Sex
Home Address			
Social Security #	Mobile Phone #	Home Phone #	Other Phone # (specify)
Occupation	Employer/School	Therapist	Therapist Phone #
Primary Care Physician (PCP)		PCP Phone #	PCP Fax #

Other family members patients in this office:

INSURANCE INFORMATION		
Primary Insurance	**Secondary Insurance**	**Tertiary Insurance**
Plan	Plan	Plan
Policy # / Member ID	Policy # / Member ID	Policy # / Member ID

EMERGENCY CONTACTS			
Name	Relationship to Patient	Mobile Phone #	Home Phone #
Name	Relationship to Patient	Mobile Phone #	Home Phone #

The above information is true to the best of my knowledge

X_____ _____

Patient or Guardian Signature Date

1902 Macy Drive, Roswell, GA 30076
Phone: (770) 837-9666 Fax: (770) 837-9710
Email: info@thepsychiatristmd.com Website: thepsychiatristmd.com

Atlanta Psychiatric Medicine Inc.

Name: _____Age: _____

A. Place an X next to the problems that you are having.

Sleep changes (Increase, decrease) _____Stress _____ Violence/ Assaultive _____ Tics

_____Hopeless _____ Paranoia _____Anxiety _____ Hyperactive _____ Behavior Problems

_____ Eating Disorders _____ Work /School Problems _____Appetite Changes _____ Mania

_____ Memory Problem _____ Substance Abuse _____Parenting Issues _____ Abuse Issues

_____Delusions _____ Poor Concentration/Attention Problems _____ Depression

_____Relationship Problems _____ Mood Swing _____Panic Attack _____ Marital Issues

_____Decrease/Increase Energy _____Dissociative Behaviors _____ Impulse control issues

_____ Agitated _____Paranoia _____ Anger _____ Helpless _____ Crying spells

_____ Not wanting to live

Concerns: _____

_____

B. Place an X next to the following (if you have used them in the past 30 days)

_____Tobacco _____Alcohol _____Marijuana _____Sleeping/pain killers _____Heroin

_____Cocaine _____ Methadone

Other_____

C. List all medical problems (heart disease, diabetes, seizures, etc.)

_____

_____

_____

D. List all current medications and dosage.

_____

_____

_____

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Atlanta Psychiatric Medicine, Inc.

Agreement

I hereby authorize Atlanta Psychiatric Medicine Inc., to provide me_____
Your Name

And or my following dependent _____
Your dependent or child's Name

Psycho-diagnosis, psychiatry, psychotherapy and such other psychological services as required. I understand that I may withdraw my consent for any specific treatment at any time. I understand that there is no assurance that I will feel better and that in the course of assessment and/or therapy material may be discussed which could be upsetting and thus may be necessary to help me resolve my concerns.

Confidentiality

I further understand that information about my treatment may not be disclose except for the following reasons:

A. If I sign a waiver requesting release of information
B. If a court orders that a release of my records
C. If I raise my mental status or competency in a legal proceeding
D. If there is reason to believe that there is a high risk to harm myself or other
E. If there is suspicion of child or elder abuse

Fees

I understand that fees are payable at the time of each treatment session. I authorize the release of any payment, my signature below acts as one on file for billing purposes. I authorize that the release of any payment, medical, psychiatric, and counseling information necessary to process mine or my family member's claims. I hereby authorize Atlanta Psychiatric Medicine Inc., (Rukhsana Rizvi , MD). I understand that I am financially reasonable to Atlanta Psychiatric Medicine Inc., for all charges not covered by the assignment.

Release of Information

I hereby release my information to Atlanta Psychiatric Medicine Inc and/or Other professionals who might have service to me. I understand that the nature of this communication is solely for the purpose of my continuity of my care.

Responsible Party_____Date_____

Treatment provider/witness _____ Date _____

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Coordination of Care Between Providers

Communication between Atlanta Psychiatric Medicine Inc. and Your Primary care Physician, and other behavioral health providers and/or facilities, is important to ensure you receive compressive and quality health care. This form will allow Atlanta Psychiatric Medicine Inc. to share protected health information with your other provider. This information will not be released without your signed authorization.

Patient Rights

- You may end this authorization anytime (permission to use or disclose information) by contracting Atlanta Psychiatric Medicine Inc. and filling out another Coordination of Care form.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or service will be not affected.

Patient Authorization

I hereby authorize that Atlanta Psychiatric Medicine Inc., can release verbally or in writing information regarding any mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state law governing the confidentiality of mental health and understand that I may revoke this consent at any time and must do so in writing by filling out a new form. A request to revoke this authorization will not affect any actions taken if the provider receives the request. This consent expires in six months from the date of signature below unless otherwise stated herein.
Atlanta Psychiatric Medicine Inc. is authorization to release protected health information related to the evaluation and

treatment of _____ _____/_____/_____
Patient Name Date of birth - mm/dd/yyyy

_____ _____
Primary Care Physician Name Primary Care Physician Number

_____ _____ _____
Primary Care Address City
State

_____ _____
Behavioral Health Name Behavioral Health Number

_____ _____ _____
Behavioral Health Address City
State

Disclosure may include following verbal or written information: (check all that apply)
_____ Face sheet _____ History and physical _____Laboratory/test results _____School Information
_____Discharge summary _____Medical Records _____Behavioral health _____Psychological evaluation
_____ER Record report _____ Psychiatric Evaluation _____Summary abuse treatment
_____Summary of treatment records and contact dates
_____ I here refuse to give authorization for any release of information.

_____
Signature of patient, parent, guardian or authorized representative

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Office Policy

Emergencies- In the event of an emergency (a situation which requires immediate attention to oneself or one's family as there is a concern about imminent danger) please call 911 or go immediately to the nearest emergency room Georgia Crisis and Access Line (GCAL) at 1-800-715-4225.

Letters and Forms-The minimum turnaround time for letters is one week, so please make sure you request letters 1-2 weeks in advance. Any medical information needs signature consent. There is a fee that is not covered by insurance.

Disability Claim-Our goal is to help you recover, for your recovery and well-being we fill out FMLA/STD paperwork. If you are requesting assistance in completion of a disability claim, please make note of the following:

- Comprehensive Psychiatric Care does not "give" disability. We can only report symptoms and response to treatment to the company that handles your disability insurance.
- If regularly scheduled appointments are not kept, we will notify your disability carrier.
- Disability paperwork requests can take up to 10 business days to complete.
- There is a fee involved since time taken to fill out this paperwork is not covered by the insurance.
- It is not a guarantee for continuation of your benefits or salary because the decision is made by your employer/third party.
- The FMLA/STD can't be back dated when you were not our patient. We fill out paperwork for two (2) or four (4) weeks at a time and re-evaluate the need for an extension.

Prescription Refill - The patient/guardian is solely responsible for making sure that you do not run out of medication. It is also important that you take your medications according to the doctor's Instructions. Please consider this fact when submitting your request prior to contacting the office. If you have not been seen in this practice within the past 3 months, it is our policy that you make an appointment to renew your medication. We do not give refills on controlled medications without an appointment.

Fees and Insurances-We participate in most insurance plans, including Medicare and Medicaid. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. 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 "copay" (a portion of their charges which is not covered by insurance). Others will be responsible to pay an allowed amount towards deductibles. Please update your insurance information immediately if there's a change. Bills are sent each month and are due upon receipt. If you are unable to make a payment in full, please call our office for a payment plan.
Our billing services are available to assist you with any questions you may have about your bills at 347-732-1357.

Fee Structure-Following charges are not covered by your insurance and payment in full is required prior or at the time services are rendered.

Services	**Fee**
Copay	Variable
CPT test	$150.00
No show or cancellation without 24 hours prior notice	$30.00
FMLA/STD	$75.00
Paperwork/Letters	$25.00 to $100.00
Returned checks	$25.00
Homebound	$30.00
Urine Drug Screening	$25.00
Medical records	$50.00

We appreciate your continued association with Atlanta Psychiatric Medicine Inc.

My signature below indicates that I have read, understood and agree to comply with Atlanta Psychiatric Medicine Inc.'s policies mentioned in this document.

Patient/Guardian: _____DOB:_____Date:_____