SHRINK SAVANNAH

PATIENT PROFILE

PLEASE PRINT ALL INFORMATION.

LAST NAME _____ FIRST NAME _____ MI _____

DOB (MM/DD/YYYY) _____ SOCIAL SECURITY NUMBER _____

GENDER/SEX
- ☐ MALE
- ☐ FEMALE
- ☐ TRANSGENDER
- ☐ NON BINARY
- ☐ PREFER NOT TO SAY

PREFERRED PHONE NUMBER _____ ALTERNATE PHONE NUMBER _____

MAILING ADDRESS _____

CITY _____ ST _____ POSTAL CODE _____

RECEIVE APPOINTMENT REMINDERS?
- ☐ TEXT
- ☐ EMAIL
- ☐ PHONE
- ☐ NONE

EMAIL ADDRESS _____

RECEIVE EMAIL FROM SHRINK SAVANNAH?
- ☐ YES
- ☐ NO

EMPLOYER OR SCHOOL _____ PROFESSION/FIELD OF STUDY _____

PRIMARY PHYSICIAN _____ PHONE _____

PRIMARY INSURANCE _____ ID POLICY NUMBER _____

SECONDARY INSURANCE _____ POLICY NUMBER _____

PARENT/GUARDIAN IF UNDER 18 _____ PHONE _____

EMERGENCY CONTACT _____ PHONE _____

CURRENT MEDICATION _____ DOSAGE _____

CURRENT MEDICATION _____ DOSAGE _____

CURRENT MEDICATION _____ DOSAGE _____

KNOWN ALLERGIES

_____

_____

_____

PATIENT HISTORY AND SYMPTOMS

REASON(S) FOR SEEKING TREATMENT

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITIONS? PLEASE EXPLAIN:

PAST MEDICAL PROBLEMS, NON-PSYCHIATRIC HOSPITALIZATION, OR SURGERIES:

IS THERE ADDITIONAL INFORMATION THAT WOULD BE HELPFUL FOR YOUR PROVIDER TO KNOW?

CHECK ALL THAT APPLY

SOCIAL HISTORY:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Dating
- ☐ In a relationship
- ☐ Domestic Partnership
- ☐ LGBTQ

ANXIETY SYMPTOMS:
- ☐ Worry
- ☐ Panic
- ☐ Intrusive thoughts
- ☐ Obsessive Thoughts
- ☐ Social Anxiety
- ☐ Re-experiencing Past Trauma
- ☐ Other _____

MOOD SYMPTOMS:
- ☐ Depression
- ☐ Elevated Mood
- ☐ Irritability
- ☐ Sleep Disturbances
- ☐ Suicidal Thoughts
- ☐ Other _____

THOUGHT DISORDER SYMPTOMS:
- ☐ Auditory Hallucinations
- ☐ Visual Hallucinations
- ☐ Paranoia

COGNITIVE SYMPTOMS:
- ☐ Trouble Concentrating
- ☐ Memory Problems
- ☐ Word Finding Problems
- ☐ Trouble with Navigation

PSYCHIATRIC HISTORY:
- ☐ Outpatient
- ☐ Inpatient
- ☐ Suicide attempt

HAS A MEMBER OF YOUR FAMILY BEEN TREATED FOR:
- ☐ ADD
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Substance Abuse _____
- ☐ Suicidal behavior or committed suicide
- ☐ Other _____

HAS A MEMBER OF YOUR FAMILY BEEN TREATED FOR:
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Epilepsy
- ☐ Seizures
- ☐ Cancer
- ☐ Heart Attack
- ☐ Thyroid
- ☐ Stroke
- ☐ Asthma
- ☐ Dizzy
- ☐ Spells/Fainting
- ☐ Movement disorders
- ☐ Tics (motor or verbal
- ☐ Other Neurological Disorders

CHECK IF YOU HAVE EVER TRIED THE FOLLOWING:
- ☐ Methamphetamine
- ☐ Cocaine
- ☐ Stimulants (pills)
- ☐ Heroin
- ☐ LSD or Hallucinogens
- ☐ Marijuana
- ☐ Pain killers (not as prescribed)
- ☐ Methadone
- ☐ Tranquilizer/sleeping pills
- ☐ Alcohol
- ☐ Ecstasy
- ☐ Other _____

PATIENT HISTORY AND SYMPTOMS CONTINUED

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink / used drugs first thing in the morning to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, what kind and for how long? _____

_____

How many caffeinated beverages do you consume per day:

Coffee _____ Sodas _____ Tea _____ Energy Drinks _____ Other _____

How you ever smoked cigarettes? ( ) Yes ( ) No

Currently smoke? ( ) Yes ( ) No

For how many years have you smoked cigarettes? _____

How many packs per day on average? _____

When did you quit smoking, if you no longer smoke? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No

What kind? _____

How often per day on average? _____ How many years? _____

SHRINK SAVANNAH

1601 ABERCORN STREET • SAVANNAH, GA 31401
PH: 912.712.2550 • FAX: 912.480.0518
INFO@SHRINKSAVANNAH.COM • SHRINKSAVANNAH.COM

PATIENT CONSENT AGREEMENT

FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my healthcare, Shrink Savannah originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Additionally:

- I understand and have been provided with a Notice of Privacy Practices for Protected Health Information that provides a more complete description of information uses and disclosures.
- I understand that I have the right to review the notice prior to signing this consent.
- I understand that Shrink Savannah reserves the right to object to the use of my health information at your request.
- I understand that I have the right to object to the use of my health information for directory purposes.
- I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, co-payment, or healthcare operations and that Shrink Savannah is not required to agree to the restrictions requests.
- I understand that I may revoke this consent in writing, except to the extent that the office of Shrink Savannah has already taken action in reliance thereon.

I _____ FULLY UNDERSTAND AND I HEARBY

☐ ACCEPT
☐ DECLINE

THE TERMS OF THIS CONSENT

_____ _____

SIGNATURE DATE

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION

RIGHT TO NOTICE

As a patient, you have the right to adequately notice of the uses and disclosures of your protected health information. Under the Health Portability and Accountability Act (HIPAA), Shrink Savannah, can use your protected health information for treatment, payment and health care operations.

MARKETING

We will not use your health information for marketing communications without your authorization.

REQUIRED BY LAW

We may also use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of any other crime. We may disclose your health information to the extent necessary to avert a serious threat to your or other individual's health or safety.

APPOINTMENT REMINDERS

We may use or disclose your health information to provide you with appointment reminder via phone, e-mail, letter or mobile text message.

YOUR RIGHTS AS A PATIENT

You have the right to

- restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.
- receive confidential communications regarding your protected health information.
- inspect and discuss your protected health information.
- amend your protected health information. Shrink Savannah has the right to refuse your amendment.
- receive an account of disclosures of your protected health information.

FRIENDS AND FAMILY MEMBERS

Please list any friends or family members that you are granting us permission to discuss your health care information with, including but not limited to, schedule appointments, billing, diagnosis and treatment information.

LEGAL REQUIREMENTS

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by the law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our privacy practices the new practices will be provided to you at your next scheduled appointment.

COMPLAINTS

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. Confidential complaints in writing should be emailed to abrock@shrinksavannah.com.

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Shrink Savannah is dedicated to protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another healthcare provider or a hospital if it is necessary to refer you for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of our services.
- We may need to use your health information within our practice for quality control or other operational purposes such as recall notices, reminder calls and treatment news.
- We are required by law to disclose your information in the event that you become suicidal and/or homicidal.

All health and patient information disclosed to Shrink Savannah and its employees or staff shall remain confidential and we will ensure that we are in compliance with all federal and state laws pertaining to the confidentiality of patient health information, including HIPAA.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions regarding use or disclosure of your health information, please inform Shrink Savannah in writing. We are not required to agree to your restrictions, however we are bound to the restrictions you set if we are in agreement with them.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke any of your authorizations at any time; however your revocation must be in writing. We will not be able to honor a revocation request if we have already released your health information before we receive your written request to revoke your authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I HEARBY AUTHORIZE THE FOLLOWING PEOPLE TO OBTAIN AND DISCUSS MY MEDICAL INFORMATION:

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

SIGNATURE _____ DATE _____

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OFFICE POLICIES AND FINANCIAL RESPONSIBILITY

All new and existing patients are encouraged to review our office policies and procedures carefully. Our administrative team is always able to assist you with any questions or concerns.

OFFICE HOURS

Shrink Savannah is open Monday - Thursday from 8:30 a.m. - 4 p.m. and Friday from 8 a.m. to 3 p.m. The office is closed daily from 12:00 - 1:00 p.m. A provider is available after-hours via an answering service.

MISSED APPOINTMENTS

We reserve your appointment time specifically for you and you alone. For this reason, our office charges for cancellations without 24 hours notice. A credit or debit card is required to be on file for all patients. In the event of a missed appointment, your card on file will be charged the full amount for your missed appointment. Your insurance company will not pay for missed appointment charges. Notifications for missed appointments are accepted via voicemail, website form and email but must be received within 24 hours of the scheduled appointment.

LATE ARRIVALS

If you arrive late for your appointment and your provider determines that there is enough time remaining, he or she will be able to see you only for the allotted time left of your scheduled appointment. At such times, it may be necessary to schedule an additional appointment to allow you and the provider sufficient time to address your treatment concerns.

FORMS AND DOCUMENTS

All medical forms (such as disability forms, school forms, letters) are completed by your provider while he or she meets with you in your session. Please notify your provider at the beginning of each session if you have forms to be filled out. Please be advised there may be additional fees for these documents determined by your provider.

PRESCRIPTIONS

Regular attendance at appointments is a critical part of your care. If you need a refill before your next scheduled appointment please call one week prior to running out of your medication or use the online form. Although regularly scheduled visits with your doctor may at times feel burdensome, this commitment ensures that you will receive the highest level of care. Should you run out of your medication due to a missed or rescheduled appointment you may be given enough medication to last until your next scheduled appointment.

PHONE CALLS AND DIRECT CORRESPONDENCE WITH YOUR PROVIDER

Phone conversations with your provider may incur fees. Scheduled phone appointments are charged the full amount of a regular office visit and are not billed with insurance. Quick updates and questions may be provided/answered through the office administrative team. Providers may receive email via info@shrinksavannah.com or by using the form on our website, ShrinkSavannah.com and selecting your provider from the dropdown menu. If a phone call with your provider lasts more than 10 minutes, the provider may charge you up to the full rate of an office visit.

INSURANCE INFORMATION

Your insurance is filed as a courtesy to you. It is your responsibility to be familiar with and to verify your mental health benefits and eligibility. It is the patient's responsibility to inform Shrink Savannah if your insurance company changes or has special requirements such as pre-certification, specific labs or designated hospitals.

FORMS OF PAYMENT

Shrink Savannah accepts payment in cash or major credit cards: Visa, Mastercard, American Express and Discover. Personal checks and money orders are not accepted.

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OFFICE POLICIES AND FINANCIAL RESPONSIBILITY

RESPONSIBLE PARTY

_____ _____ _____
LAST NAME FIRST NAME MI

_____ _____ - _____ - _____
DOB (MM/DD/YYYY) SOCIAL SECURITY NUMBER

_____
ADDRESS

_____ _____ _____
CITY STATE POSTAL CODE

_____ _____
MOBILE PHONE NUMBER ALTERNATE PHONE NUMBER

CREDIT CARD AUTHORIZATION

_____ _____ _____
CREDIT CARD NUMBER EXPIRATION DATE 3 or 4 DIGIT CID

FINANCIAL RESPONSIBILITY

Payment is expected at the time of service. I understand that I am financially responsible to Shrink Savannah for all charges not covered by my insurance including (but not limited to) co-payments and deductibles, which are due at the time of my visit.

_____ _____
Signature of Patient or Insured Individual Date (MM/DD/YY)

INITIAL EACH LINE BELOW

_____ I authorize the release of any information necessary to process my insurance claims.

_____ I understand that I will be charged for any missed appointment.

_____ I understand that a delinquent account may be turned over to a collection agency and an additional 35% fee will be assessed if unpaid within 30 days of statement date.

_____ I understand that if any legal issues arise during my treatment at Shrink Savannah and any providers or staff are required to attend court or participate on my behalf, I will be charged a minimum of $300 per hour for services.

_____ I acknowledge receipt of a copy of Shrink Savannah's privacy practices.

_____ I have read and understand all office policies and financial responsibilities.

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PATIENT TELEHEALTH CONSENT AGREEMENT

I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

I agree to use the video-conferencing platform selected for our virtual sessions via a webcam or smartphone, and the provider or office Administrative team will explain how to use it.

I understand t is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.

I understand it is important to use a secure internet connection rather than public/free Wi-Fi.

I understand I need to be on time and if I need to cancel or change my telehealth appointment, I must notify Shrink Savannah at least 24 hours in advance by phone or through the website form at ShrinkSavannah.com.

I will provide an alternate phone number where I can be reached to re-start the session in the event of technical problems.

I understand the need for a safety plan that includes at least one emergency contact and the closest emergency room to my location, in the event of a crisis situation.

Emergency Contact: _____ Relationship: _____ Phone: _____

Closest Emergency Room: _____ Location: _____

I understand it is my responsibility to confirm with my insurance company whether the telehealth sessions will be reimbursed; if they are not reimbursed, I am responsible for full payment on the day of my appointment.

I _____ FULLY UNDERSTAND AND I HEARBY
☐ ACCEPT
☐ DECLINE
THE TERMS OF THIS CONSENT

_____ _____
PATIENT DIGITAL SIGNATURE DATE

Please select your provider(s). If unknown, leave blank.

☐ Chad Brock, MD
☐ Paige Marnell, MD
☐ Kristy Triplett, PA-C
☐ Lydia Stearns, PA-C
☐ Andrea Yates, PA-C
☐ Calysta Tilley, PA-C
☐ Anna Hilliard, PA-C
☐ Heather Mell, NP-C
☐ Margaret Wheble, LCSW
☐ Mary Hubbard, LPC
☐ Gab Paderewski, LMSW
☐ Chene Walz, LPC, CCMHC