

Welcome to Atlanta Psychiatric Specialists

Our new patient paperwork follows and includes the following forms:

- Demographics & insurance information
- Health History
- Treatment agreement
- Privacy practices
- Authorization for release of health information for coordination of care
- Patient Health questionnaire (PHQ-9)
- Attention deficit disorder questionnaire
- Self-rated symptom measure

Please complete these forms and bring them with you to your visit.

Please bring the following:

- Photo ID (Any Government issued ID – we use this to keep a picture of you in your file)
- Insurance card (if applicable)
- Recent lab results, medical reports (if available)
- All medications that you are currently taking (must have a pharmacy label)
- Discharge summaries, medical reports, diagnoses (if available)

If you have any questions about these forms or our office, please call our staff at (404) 685-9414.

Thank you and we look forward to seeing you.

Sincerely,

Ross F. Grumet
Atlanta Psychiatric Specialists, PC
404-685-9666
reception@psychiatryatlanta.com

PATIENT DEMOGRAPHIC & INSURANCE INFORMATION

PATIENT INFORMATION					
Patient's Last Name		First	Middle	Preferred Name:	Maiden Name (if applicable)
Date of Birth	Gender	Social Security Number		Marital Status	
/ /				<input type="checkbox"/> Single <input type="checkbox"/> Married/ Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Preferred Phone No. ()		Alternate Phone No. ()		Email Address	
Street address				Apt or Unit #	
City		State		ZIP Code	
Occupation			How did you find our office? Were you referred?		
INSURANCE INFORMATION					
Are you covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Carrier:	
Are you self-pay?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Group or Account #	
Member ID or Policy #					
ASSIGNMENT OF BENEFITS (IF WE ARE FILING AN INSURANCE CLAIM FOR YOU):					
<p>I authorize my insurance carrier to assign all medical benefits, if applicable, to Ross F. Grumet, MD and/or Atlanta Psychiatric Specialists, PC. I also authorize release of medical information necessary to process all medical insurance claim(s).</p> <p>Signature: _____</p>					
IN CASE OF EMERGENCY					
Emergency Contact Name		Relationship		Phone No.	

APPOINTMENT REMINDERS:

APS provides a courtesy reminder of upcoming appointments via automated phone call, text or email. Please select how you would like to receive appointment reminders:

Automated Telephone Call Phone Number: _____
 Email Email: _____

We can also send you a text message to remind you the day before your appointment. Would you like to receive a text message in addition to a phone call or email?

Yes
 No

It is important that you keep all of your contact information current. Please inform our staff of any information changes immediately.

PATIENT HEALTH HISTORY

This form is for you to provide information about yourself, your health, and your health habits. Please complete it as completely as possible; if you do not know the answer to a question, please note that in the space provided for the question.

NAME:		DATE OF BIRTH:	
Please list any medical conditions that you have been diagnosed with (include mental health diagnoses):			
Please list any hospitalizations or surgeries in the past ten years:			
Year	Reason	Hospital	
List any medications and supplements you take, including, prescriptions, over-the-counter medications, vitamins and supplements			
Name of medication, vitamin or supplement	Strength	How often do you take this medication, vitamin or supplement?	
Are you allergic, or have you had a bad reaction to any medications? (If yes, please list below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Medication Name	Reaction		

Do you have any symptoms in the following areas (including diagnosed and undiagnosed conditions)?			
<input type="checkbox"/> Skin	<input type="checkbox"/> Respiratory system (e.g. breathing difficulty, asthma)	<input type="checkbox"/> Recent weight loss/gain	
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Cardiac system	<input type="checkbox"/> Recent change in energy level	
<input type="checkbox"/> Ears	<input type="checkbox"/> Back, joint or other bone-related problems	<input type="checkbox"/> Problems with sleep	
<input type="checkbox"/> Eyes	<input type="checkbox"/> Genital or urinary system	<input type="checkbox"/> Other:	
<input type="checkbox"/> Throat, Nose, or Sinus	<input type="checkbox"/> Endocrine system (e.g. diabetes, problems with hormones)		
<input type="checkbox"/> Brain (e.g., history of seizures, brain injury)	<input type="checkbox"/> Circulatory system (e.g., high blood pressure, high cholesterol)		
Do you feel like you are under constant stress?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have memory problems?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been bullied, suffered a traumatic event, or suffered abuse (including physical and mental abuse)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever received inpatient care for a mental health condition (including alcohol or substance abuse detox or rehabilitation)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please provide name of facility and date(s) of treatment (if available):			
Are you currently, or have you previously been under the care of a psychiatrist?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please provide physician's name:			
Have you seen a counselor or psychologist?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please provide the counselor or psychologist's name:			
What is your usual activity level?			
<input type="checkbox"/> No regular exercise <input type="checkbox"/> Occasional exercise <input type="checkbox"/> Regular exercise or physical activity			
How many hours of sleep do you get most nights?			
Do you feel rested when you awaken?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Are you currently dieting?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
What type of diet?				
Do you consume caffeinated beverages (coffee, tea, soda) or foods (chocolate)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you drink alcoholic beverages?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If yes, how many drinks per week?				
Have you ever tried or been advised to reduce the amount of alcohol you consume?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you use tobacco (cigarettes, cigars, chew)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Would you like to discuss smoking cessation with Dr. Grumet?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you currently use recreational or street drugs?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever given yourself street drugs with a needle?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you sexually active?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If yes, are you pregnant or are you (or your partner) trying to become pregnant?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you live alone?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have vision or hearing loss?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have an Advance Directive or Living Will?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Questions in this section are used to assess the health history of your family. If you do not know the answer to a question, please note that in the provided spaces.

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Mother		
Sibling(s)	<input type="checkbox"/> B <input type="checkbox"/> S		Children	<input type="checkbox"/> S <input type="checkbox"/> D	
	<input type="checkbox"/> B <input type="checkbox"/> S			<input type="checkbox"/> S <input type="checkbox"/> D	
	<input type="checkbox"/> B <input type="checkbox"/> S			<input type="checkbox"/> S <input type="checkbox"/> D	
	<input type="checkbox"/> B			<input type="checkbox"/> S	

Ross F. Grumet, MD
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**New Patient
Paperwork**

	<input type="checkbox"/> S			<input type="checkbox"/> D		
Grandfather (Paternal)			Grandfather (Maternal)			
Grandmother (Paternal)			Grandmother (Maternal)			

Updated: 02/13

TREATMENT AGREEMENT

Please read the following policies that constitute the treatment agreement between you, Atlanta Psychiatric Specialists, PC and Ross F. Grumet, MD. Your initial and signature indicates that you have read and agree to these policies. If you have any questions, please speak with a member of our staff before signing this form.

Office Hours: Our office hours are Monday through Friday 9:00 am to 6:00 pm and some Saturdays by appointment. An automated voicemail system is available 24 hours a day, 7 days a week at (404) 685-9414. **Messages left on our voicemail system will be returned within one business day. If we have not returned your call after 24 hours, please call again so we are sure that we have received your message.** In the event of an emergency, please call 911 or your local emergency services provider. _____ (Initial)

Appointments: We see patients on an appointment-only basis, Monday through Friday and some Saturdays. These days are subject to change. We do not offer walk-in appointments; however, we will try to accommodate your scheduling needs wherever possible. Please call our office during business hours to schedule an appointment. We use an automated system to make reminder calls the day before scheduled appointments. These calls are a courtesy and we are not responsible for appointments missed due to incorrect contact information or non-receipt of a voicemail message. **It is your responsibility to keep your scheduled appointments and to keep your contact information current. If your contact information has changed, please let a member of our staff know.** _____ (Initial)

Cancellations and No-Shows: We require a 24-hour notice to cancel or reschedule an appointment. **Missed appointments and same-day cancellations will be charged an administrative fee of \$95.00. This fee is NOT covered by insurance and must be paid before your next appointment is scheduled. We will attempt to collect this fee twice before sending your account to collections. If our office cancels your appointment due to unforeseen circumstances, you will not be charged a missed appointment.** _____ (Initial)

Telephone Consults: In some cases Dr. Grumet may be able to discuss your care with you over the phone in lieu of an office visit. **Phone consults are not covered by insurance** and are handled on a case by case basis. _____ (Initial)

Insurance: If we are in-network with your insurance plan, we will file a claim on your behalf. Coverage varies widely from plan to plan and we cannot guarantee that your plan will cover your charges. If we are not in-network with your plan, you will be responsible for all charges incurred. We will provide you with an itemized receipt if you wish to file a claim with your carrier directly. You will receive a statement if there is a balance due. **As a courtesy, we allow 30 days for insurance payment to be processed and received. If your insurance carrier fails to pay its portion of your charges within those 30 days or there is a remaining balance after the insurance payment then that amount becomes your responsibility.** The estimated patient responsibility must be paid at the time of service. _____ (Initial)

Collections: Any account with an unpaid balance **60 days or older** will be turned over to our collections agency. **If your account is turned over to our collections agency, a charge of 35% of the outstanding balance will be assessed to your account to cover the cost of the collection fees.** _____ (Initial)

Forms and Letters: Completion of narrative reports, medical leave forms, or other forms or letters are subject to fees based on the complexity of the form and the amount of time required to complete it ranging from \$15.00 to \$100.00 or more. These fees will be determined at the time the form is delivered to the office. Please note that there is no charge for Jury Duty forms. _____ (Initial)

Prescription Refills: **All prescription refills must be handled during scheduled office appointments.** Sufficient medication is prescribed to last until your next visit. It is your responsibility to inform Dr. Grumet about what medications you need during your visit. Please pay attention to your medications and schedule appointments accordingly. **If you do run out, you will be required to schedule an appointment. We will make our best effort to work you in. If an appointment is rescheduled or missed and we are unable to work you in, we will charge a \$35 fee to refill your medication. Please allow 48 hours for these requests.** _____ (Initial)

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New Patient Paperwork

Prior Authorizations: Some insurance plans require “advance approval” for certain medications. If your plan requires a prior authorization, you have two options. One option is that you can contact your insurance company and initiate the process yourself (you will likely need medical information from us; if so, please ask the insurance company to send us a fax requesting the necessary information). Your other option is to incur a fee of \$50.00 for our office to complete the entire process for you. **Please allow a minimum of 24 hours for your request to be processed by our office.** The insurance processing time for prior authorizations varies; in some cases it may take up to 72 hours for approval. If you have any questions about your pharmacy benefits please contact your insurance carrier directly. _____ (Initial)

Please sign below to acknowledge that this information has been made available to you.

Printed Name: _____ Date of Birth: _____
Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Your health information is important to us and we have adopted strict policies to ensure that it remains confidential. In most cases, we must have written consent from you to release health information to an outside individual or agency. **Protected Health Information** is information about you, your health status and your medical care that is maintained by this office. This may include demographic information, treatment records, evaluation reports and medical records received from other sources. This notice explains how **Atlanta Psychiatric Specialists PC** and its employees may use and disclose information we maintain about you. It also explains your rights regarding this information.

By consenting to receive treatment from this office, you allow us to use your health information in the following specific ways unless you request in writing for us to limit these disclosures:

- **For Payment:** We may use and disclose health information about you, such as your diagnosis and treatment plan, to secure payment for your treatment received at this office. This includes payment made by a worker's compensation plan.
- **For Treatment.** We may use your health information to provide you with medical care or to recommend treatment alternatives. Office personnel may also disclose limited health information to an outside source in order to directly coordinate your care (such as securing authorizations through an insurance company or coordinating a referral to another medical provider)
- **Within a Treatment Setting:** We may also disclose certain information in a treatment setting if we receive verbal authorization. For example, we may disclose personal health information to your spouse if you bring your spouse with you into the treatment room.

We may use or disclose information about you **without your consent** for the following purposes, subject to applicable state and federal laws. **Where appropriate, we will make every effort to notify you prior to releasing information in these contexts:**

- To avert a serious threat to your health or safety, or to avert a serious public health risk.
- To a coroner, medical examiner, or funeral director to assist in identifying a deceased person or identifying the cause of death
- To health oversight agencies for audits, investigations, inspections, or licensing purposes
- To law enforcement or other legal entities in response to a court order, subpoena or similar process
- To military, national security and intelligence agencies (if you were part of one of these agencies) when we are legally required to do so.
- To organ and tissue donation agencies (if you are an organ or tissue donor) to facilitate organ or tissue transplants.
- To public health agencies in order to prevent or control disease or injury or to report certain medical events such as birth defects or adverse reactions to medications.

We may also disclose limited health information to a relative or friend if we can infer, based on our professional judgment, that failure to do so may result in serious harm to you.

Health information that does not identify you: We may use or disclose health information about you in a way that does not personally identify you. For example, this information may be used to evaluate our services or to comply with certain government regulations that monitor the healthcare system. In some cases, this information may be provided to another agency.

Use of health information for research: We may use and disclose health information about you, with your consent, for research projects that are subject to a special approval process.

Your rights: You have the following rights regarding the use of your health information:

- Right to inspect and copy certain portions of your records
- Right to amend information that you think is incomplete or inaccurate
- Right to an accounting of disclosures of your healthcare information
- Right to file a complaint if you feel your privacy rights have been violated
- Right to request restriction on disclosure
- Right to request confidential communications
- Right to revoke consent to release information at any time

Please note: Federal law has placed restrictions on access (including patient access) to mental health, substance abuse records and records relating to diagnosis and treatment of HIV/AIDS and we will comply with regulations applicable to your records. If we decline to release your health information, you may ask that the denial be reviewed by an independent agent and we will comply with that agent's decision.

Limitations on Disclosure: If you wish to limit disclosure of your health information, you must make this request in writing. We will comply with all reasonable requests unless the information is needed to provide you emergency treatment.

Other Uses and Disclosure of Health Information: We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization.

Please sign below to acknowledge that this information has been made available to you. If you have questions regarding this form, please speak with a member of the staff before signing this form.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

You may revoke this consent at any time by giving us written notice. Any revocation will apply only to future uses of your health information, and is not applicable to any information that has already been released.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR COORDINATION OF CARE

In order to ensure that you receive the best treatment, we would like to communicate with your primary care physician and therapist (if applicable). This communication will allow us to exchange pertinent medical information, such as lab results and medication records. Allowing us to coordinate care can be beneficial to addressing other health issues and reduce the risk of side effects and interactions between medications you are prescribed. ***This form is optional, and your information will always be maintained in accordance with all privacy regulations.***

1. Patient Information:

Name: _____ Date of Birth _____

Address: _____

City: _____ State: _____ Zip: _____

2. Physician, Therapist or Facility Information:

(Please complete a separate form if you would like us to coordinate care with more than one physician, therapist or facility.)

PRIMARY CARE PHYSICIAN OTHER PHYSICIAN THERAPIST

NAME: _____

Address _____ Suite: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

3. Release of Medical Information:

To authorize Atlanta Psychiatric Specialists, PC and/or Ross F. Grumet, MD to communicate with the physician, therapist or facility named above for the purpose of **coordination of care**, please sign below:

(Signature of Patient or Authorized Representative) (Date)

4. Additional Disclosures:

To protect your privacy, state and Federal regulations have placed additional restrictions on the release of records relating to the diagnosis and treatment of mental health conditions, substance use conditions, and HIV/AIDS. We may need to release limited information from these portions of your record (where applicable) to coordinate care. If you agree to this disclosure, please sign below:

(Signature of Patient or Authorized Representative) (Date)

You may revoke or restrict this form at any time. It will automatically expire twelve months from the date signed. If you have questions about what information we transmit or would like to request a restriction related to this form, please speak with a member of our staff.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the past two weeks, have you experienced any of the following symptoms? If so, how often?

	NO I HAVE NOT EXPERIENCED THIS	YES SEVERAL DAYS	YES MORE THAN HALF THE DAYS	YES NEARLY EVERY DAY
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				

If you checked off <i>any</i> problems, how <i>difficult</i> 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	

ATTENTION DEFICIT QUESTIONNAIRE

Over the past two weeks, have you experienced any of the following symptoms? If so, how often?

	NOT AT ALL	JUST A LITTLE	SOMEWHAT	MODERATE	QUITE A LOT	VERY MUCH
I find my mind wandering from tasks that are uninteresting or difficult.						
I find it difficult to read written material unless it is very interesting or very easy.						
Especially in groups, I find it hard to stay focused on what is being said in conversations.						
I have a quick temper...a short fuse.						
I am irritable, and get upset by minor annoyances.						
I say things without thinking, and later regret having said them.						
I make quick decisions without thinking enough about their possible results.						
My relationships with people are made difficult by my tendency to talk first and think later.						
My moods have highs and lows.						
I have trouble planning in what order to do a series of tasks or activities.						
I easily become upset.						
I seem to be thin skinned and many things upset me.						
I almost always am on the go.						
I am more comfortable when moving than when sitting still.						
In conversations, I start to answer questions before the questions have been fully asked.						
I usually work on more than one project at a time, and fail to finish many of them.						
There is a lot of "static" or "chatter" in my head.						
Even when sitting quietly, I am usually moving my hands or feet.						
In group activities it is hard for me to wait my turn.						
My mind gets so cluttered that it is hard for it to function.						
My thoughts bounce around as if my mind is a pinball machine.						
My brain feels as if it is a television set with all the channels going at once.						
I am unable to stop daydreaming.						
I am distressed by the disorganized way my brain works.						

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New Patient Paperwork

SELF-RATED SYMPTOM MEASURE

The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem over the past **TWO WEEKS**.

	None	One or two days	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3	4
Feeling down, depressed, or hopeless?	0	1	2	3	4
Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4
Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
Feeling panic or being frightened?	0	1	2	3	4
Avoiding situations that make you anxious?	0	1	2	3	4
Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)	0	1	2	3	4
Feelings that your illnesses are not being taken seriously enough?	0	1	2	3	4
Thoughts of actually hurting yourself?	0	1	2	3	4
Hearing things other people couldn't hear, such as voices when no one else was around?	0	1	2	3	4
Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
Problems with sleep that affected your sleeping quality over all?	0	1	2	3	4
Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)	0	1	2	3	4
Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
Not knowing who you really are or what you want out of life?	0	1	2	3	4
Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4
Drink at least four drinks of any kind of alcohol in a single day?	0	1	2	3	4
Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco?	0	1	2	3	4
Using prescription medications or drugs on your own (without a doctor's prescription) or in greater amounts than prescribed?	0	1	2	3	4

Adapted from "DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure-Adult" © 2013 American Psychiatric Association.

Atlanta Psychiatric Specialists, P.C.

"Time Efficient Psychiatry"

Name: _____ Date of Birth: _____

Why I Am Here Today

Please CIRCLE Yes or No on all questions and complete any details if applicable.

Yes
No

1.) I am generally satisfied with my current treatment but I would like another Psychiatrist to continue the same general treatment and medication.

Details: _____

Yes
No

2.) I am having a significant problem with (circle the problem) depression, mood changes, suicide or hopeless thoughts, severe sleep issues, panic, anxiety, nervousness, or physical health.

Details: _____

Yes
No

3.) I am having a problem with (circle the problem) compulsive or repetitive behavior (such as smoking tobacco, alcohol, opioid dugs, other medicines or drugs), overeating, physical health, risky or dangerous actions, embarrassing moments, etc.

Details: _____

Yes
No

4.) I am having problems with attention, focus, distraction, procrastination, which affects my life and may be related to ADD or ADHD.

Details: _____

Yes 5.) I am here because someone else recommends me to be here. Or, I was referred
No here by someone. Or, I am here because my job or school or someone else thinks it
would be a good idea.

Details: _____

(see next page)

Yes 6.) I need a report completed, a form filled out, or some kind of paperwork is necessary.
No If so, please provide the details below:

Details: _____

Yes 7.) I am here for an expert psychiatric opinion about something or for a problem
No not covered above.

If so, please provide the details below:
Details: _____

Thank you for completing the above information to help us be more efficient.