Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

New Patient Paperwork

Welcome to our office. 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*
- Mood disorder questionnaire*

***required**

If possible, please complete these forms and bring them with you to your visit. In addition, please bring the following:

- Photo ID (any ID is fine –we use this to keep a picture of you in your file for our records)
- Insurance card (if applicable)
- Recent lab results or medical reports, if available

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

Or email us at: reception@psychiatryatlanta.com

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

New Patient Paperwork

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
/ /			[ ] Single [ ] Married/ Domestic Partner [ ] Divorced [ ] 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?

INSURANCE INFORMATION

Are you covered by insurance?	❑ Yes ❑ No	Carrier:
Member ID or Policy #		Group or Account #

ASSIGNMENT OF BENEFITS (IF WE ARE FILING AN INSURANCE CLAIM FOR YOU):

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).

Signature: _____

IN CASE OF EMERGENCY

Emergency Contact Name	Relationship	Phone No.

APPOINTMENT REMINDERS:

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

[ ] Automated Telephone Call
[ ] 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

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

New Patient Paperwork

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)	☐ **Yes**	☐ **No**
Medication Name	Reaction	

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

Do you have any symptoms in the following areas (including diagnosed and undiagnosed conditions)?

☐	Skin	☐	Respiratory system (e.g. breathing difficulty, asthma)	☐	Recent weight loss/gain
☐	Head/Neck	☐	Cardiac system	☐	Recent change in energy level
☐	Ears	☐	Back, joint or other bone-related problems	☐	Problems with sleep
☐	Eyes	☐	Genital or urinary system	☐	Other:
☐	Throat, Nose, or Sinus	☐	Endocrine system (e.g. diabetes, problems with hormones)		
☐	Brain (e.g., history of seizures, brain injury)	☐	Circulatory system (e.g., high blood pressure, high cholesterol)		

Do you feel like you are under constant stress?	☐	Yes	☐	No
Do you have memory problems?	☐	Yes	☐	No
Do you feel depressed?	☐	Yes	☐	No
Have you been bullied, suffered a traumatic event, or suffered abuse (including physical and mental abuse)?	☐	Yes	☐	No
Have you ever seriously thought about hurting yourself?	☐	Yes	☐	No
Have you ever attempted suicide?	☐	Yes	☐	No
Have you ever received inpatient care for a mental health condition (including alcohol or substance abuse detox or rehabilitation)?	☐	Yes	☐	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?	☐	Yes	☐	No
If yes, please provide physician's name:				
Have you seen a counselor or psychologist?	☐	Yes	☐	No
If yes, please provide the counselor or psychologist's name:				

What is your usual activity level?

☐ No regular exercise
☐ Occasional exercise
☐ Regular exercise or physical activity

How many hours of sleep do you get most nights?				
Do you feel rested when you awaken?	☐	Yes	☐	No
Are you currently dieting?	☐	Yes	☐	No
Do you consume caffeinated beverages (coffee, tea, soda) or foods (chocolate)	☐	Yes	☐	No
Do you drink alcoholic beverages?	☐	Yes	☐	No
If yes, how many drinks per week?				
Have you ever tried or been advised to reduce the amount of alcohol you consume?	☐	Yes	☐	No
Do you use tobacco (cigarettes, cigars, chew)?	☐	Yes	☐	No
Would you like to discuss smoking cessation with the physician?	☐	Yes	☐	No

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

Do you currently use recreational or street drugs?	☐	Yes	☐	No
Have you ever given yourself street drugs with a needle?	☐	Yes	☐	No
Are you sexually active?	☐	Yes	☐	No
If yes, are you pregnant or are you (or your partner) trying to become pregnant?	☐	Yes	☐	No
Do you live alone?	☐	Yes	☐	No
Do you have vision or hearing loss?	☐	Yes	☐	No
Do you have an Advance Directive or Living Will?	☐	Yes	☐	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)	☐ M ☐ F		**Children**	☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
Grandfather (Paternal)			**Grandfather** (Maternal)		
Grandmother (Paternal)			**Grandmother** (Maternal)		

Updated: 02/13

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

TREATMENT AGREEMENT

Please read the following policies that constitute the treatment agreement between you, Atlanta Psychiatric Specialists, PC and Ross F. Grumet, MD. Your 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. 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. **In the event of an emergency, please call 911 or your local emergency services provider**.

Appointments: We see patients on an appointment-only basis, Monday thru Thursday from 9:20am-5:20pm and on Friday from 9:20am to 4:40pm. These hours 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 our 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**.

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 we are unable to schedule any additional appointments until this fee has been paid.**

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.

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. You are responsible for any charges that are not covered by your insurance carrier. 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. Balances not paid within 30 days are subject to a finance charge of 1.5% (18% annually). We do not extend credit and the estimated patient responsibility must be paid at the time of service.

Completions of Forms: Completion of narrative reports, medical leave forms, or other forms are subject to fees based on the complexity of the form and the amount of time required to complete it. These fees will be determined at the time the form is delivered to the office.

Prescription Refills: As a general rule, our office does not call in prescriptions for patients outside of regular office visits. Dr. Grumet expects to see you to discuss your medications. **If an appointment is rescheduled or missed and medication is required, we charge a $35 fee. Please allow 48 hours for prescription refill requests.**

Prior Authorizations: Some insurance plans require prior authorization for medications. If your plan requires a prior authorization, please ask your pharmacy to fax the information to our office. It is ultimately up to your insurance carrier to determine coverage for medications. The processing time for prior authorizations varies; in some cases it may take up to **72 hours**. If you have any questions about your pharmacy benefits please contact your insurance carrier directly.

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

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

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.

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

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.

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

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.

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

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 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	

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

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.						

Ross F. Grumet, MD
1720 Peachtree St. NW
North Tower, Ste. 333
Atlanta, GA 30309

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