

THE POTTERS BEHAVIORAL CLINIC
307 OLD STONE ROAD
VILLA RICA, GA 30180

CLIENT INFORMATION FORM

DATE: _____ SSN# _____

NAME: _____

(LAST) (FIRST) (M.I.) (MAIDEN)

AGE: _____ DATE OF BIRTH: ___/___/___ SEX: M ___ F ___ RACE: _____ MARTIAL STATUS: _____

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

ADDRESS: _____ LANGUAGE SPOKEN: _____

TELEPHONE: (H) _____

(C) _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ TELEPHONE: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATION: _____ PHONE: _____

ADDRESS: _____

MAY WE LEAVE A MESSAGE? YES _____ NO _____ IF SO, WITH WHO? _____

INSURANCE

INSURANCE CO: _____ ID #: _____ GROUP#: _____

DO YOU HAVE SECONDARY INSURANCE? YES _____ NO _____

SECONDARY INSURANCE CO: _____ ID#: _____ GROUP #: _____

POLICY HOLDER: _____ PHONE: _____ DOB: _____

RELATIONSHIP: _____ ADDRESS: _____ SSN#: _____

REASON FOR VISIT

I AM PRIMARILY INTERESTED IN.....

FINDING A NEW PSYCHIATRIST _____ SECOND OPINION _____ CHANGING MEDICATION _____

THERAPY FOR MY RELATIONSHIP _____ TALK THERAPY, BUT I AM NOT SURE OF THE PROBLEM _____

PROFESSIONAL SUPPORT DURING A DIFFICULT TIME _____ IN NEED OF MEDICATION _____

MEDICATION FOR: _____ OTHER: _____

PATIENTS SIGNATURE: _____ DATE: _____

REPRESENTATIVE: _____ DATE: _____

FOR OFFICE USE ONLY DIAGNOSIS #1 _____ #2 _____ #3 _____

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Dr. Oyebanjo, M.D. and other clinicians for the purpose of diagnosing or providing treatment to me, or obtaining payment for my healthcare bills. I understand that diagnosis or treatment of me by Dr. Oyebanjo and other clinicians may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Oyebanjo and other clinicians are not required to agree to the restrictions that I may request. If Dr. Oyebanjo and other clinicians agree to a restriction that I request, the restriction is binding on Dr. Oyebanjo and other clinicians.

I have the right to revoke this consent in writing, at anytime, unless Dr. Oyebanjo or other clinicians have taken action in reliance on this consent. My "protected health information" means health information collected from me and created or obtained by Dr. Oyebanjo and other clinicians, this includes my demographic information as well as information from another provider, my health plan, or clearinghouse. I understand that I have a right to review Dr. Oyebanjo's and other clinicians "Notice of Privacy Practice" prior to signing this document, and have received a copy of HIPPA. Dr. Oyebanjo and other clinicians reserve the right to change the privacy practices that are described in the Notice of Privacy Practice.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges generated by this patient regardless of insurance coverage. Office policy requires payment at the time of service. If Dr. Oyebanjo or other clinicians are a provider for my insurance plan, I will pay the co-payment/deductible/co-insurance at the time of service and Dr. Oyebanjo and other clinicians will bill my insurance company for the balance. I authorize my insurance benefits be paid directly to Dr. Oyebanjo. If Dr. Oyebanjo or other clinicians render a service that is not covered by my insurance company, I understand that I am responsible for the full payment and will pay within 30 days of notification. I understand that unpaid balances **30 days past due will incur a late fee of 5% of the outstanding balance**. Examples of uncovered services are telephone sessions, missed appointments, psychological testing, and legal evaluations, such as document review. My signature below confirms agreement with above statements. All services not reimbursed by my insurance company within 90 days of submission shall be billed to me.

Signature

Date

PATIENT POLICIES

Payment Policy:

Patients are responsible for their charges. Payments are requested at the time of each visit unless other arrangements have been approved. **There will be a 5% late fee (charged monthly) assessed for any balances not paid within 30 days.** If you have insurance, and opt to see Dr. Oyebanjo or other clinicians as an out of network provider, our office will provide you with the necessary information to submit to your insurance company.

Appointment Changes/Cancellations/No Shows:

Patients will be charged a fee of **\$100 for appointments not cancelled within 24 business hours prior to appointment time or for missed appointments. Please note that in order to schedule another appointment, you must pay \$100 before any staff member can do so. Please also note that NO prescriptions will be called in or written, therefore you must be seen by the physician in order to have your medications.** It is your responsibility to remember appointments, even though we call to confirm your appointment. If you are a Medicaid/Medicare client and miss 2 appointments, you may be terminated from The Potters Behavioral Medicine Clinic.

Miscellaneous Charges:

There will be a nominal charge for record requests. The charge covers the cost to duplicate the records and postage.

Telephone and Email Policy:

The office returns call within 24-48 hours. Please ensure that you do not have anonymous call block activated due to the return call may be from a private number. Phone calls returned by the office are for **brief issues** such as medication questions, appointment changes, etc. For more extensive issues, please schedule a phone appointment or an appointment to come into the office. Phone appointments are a charge of **\$50 per 10 minutes and are not covered by insurance. There are NO prescriptions called in, so if an appointment is missed, you must pay the \$100 no show fee in order to reschedule an appointment.** Email correspondence is similar to a phone consult in that it is for brief, administrative issues. The website and email are secure, however it is not foolproof against computer hackers, therefore be cautious as to how much personal information you send via email, especially if your email server is not secure. Dr. Oyebajo and other clinicians strive to provide quality psychiatric care to all patients. My signature indicates I have read and accept the above stated policies.

Signature of Patient/Guardian

Date

Witness (Staff Member)

Date

MENTAL HEALTH HISTORY QUESTIONNAIRE

NAME: _____ DOB: _____ M___ F___

Circle which applies: You are here for.....treatment | consultation | legal problems | work problems

PLEASE CIRCLE ALL THAT APPLY

Sad or Depressed for more than 2 weeks | So much energy that you didn't need to sleep | Made big plans | Bad Decisions | So anxious that you couldn't do anything or even leave the house | Often feel that you need to count, check, or clean things in a special way | Several minutes of extreme anxiety and fear that comes out of the blue | Can't control your thoughts | Feel people can read/control your mind | Thought about someone so much you followed them | Trouble Sleeping | Current use of recreational/street drugs | Given yourself street drugs with a needle | Current use of ANY narcotics | Victim of sexual abuse | Addiction/Substance Abuse

-Have you ever been involved in: Personal injury litigation | Sexual harassment complaints | Workers Compensation | Bankruptcy | Termination/suspension from a professional society or managed care/insurance panel

-List your prescribed medications and over the counter medications (including vitamins), and include the strength and frequency at which you take them. _____

-List any Allergies to medications. _____

-List any family members (this includes grandparents, parents, children, siblings, etc.) who have been diagnosed with any mental disorders and please specify the age of diagnosis. _____

DEVELOPEMENTAL HISTORY

Where were you born? _____ To your knowledge, did you develop normally as a child? Yes No Did you have any discipline/behavioral problems in school? Yes No If yes, what were the problems? _____

Did you have and legal problems as a child? Yes No If yes, what were the problems? _____

	ALCOHOL	BENZO'S	PAIN PILLS	METHADONE
USE: YES or NO				
FIRST USE				
FREQUENCY				
LAST USE				
AMOUNT				
PRESCRIBED: YES or NO				
HISTORY of TREATMENT				
WITHDRAW SYMPTOMS				

	SOMA	COCAINE	AMPHETAMINE	OTHERS
USE: YES or NO				
FIRST USE				
FREQUENCY				
LAST USE				
AMOUNT				
PRESCRIBED: YES or NO				
HISTORY of TREATMENT				
WITHDRAW SYMPTOMS				

Medical History Please circle all that apply: Diabetes | Anemia | Appendicitis | Pneumonia | Jaundice | Arthritis | Bone Disease | Joint Disease | Epilepsy | Hepatitis | Head Injury | Liver Disease | Gall Bladder Disease | Food Poisoning | Chemical Poisoning | Drug Poisoning | Bladder Disease | Tuberculosis | Migraine | Heart Disease | Ear Disease | Ear Injury | Colitis | Other Bowel Disease | Ulcer | Gastritis | Cancer | Hemorrhoids | Eye Disease | Eye Injury | High Blood Pressure | Neuritis | Neuralgia | Hay Fever | Asthma | Sciatica | Hives | Polio | Meningitis | Thyroid Disease | Frequent Infections or Boils | HIV | AIDS | DT's |

Any Other Disease (specify): _____ **Current weight** _____

.Please circle if you now have or have ever had: Visual Change | Hearing Change | Ringing in Ears | Fainting Spells | Light Headedness | Blood in urine | Difficulty in Urination | Indigestion | Gas | Belching | Constipation | Diarrhea | Rectal Bleeding | Black Tarry Stools | Numbness | Tingling | Paralysis | Weakness | Dizziness | Vertigo | Headaches | Enlarged Glands | Abnormal Thirst | Chest Pain | Shortness of Breath | Varicose Veins | Spitting up Blood | Trouble Swallowing | Trouble with Nose | Trouble with Sinuses | Trouble with Mouth | Trouble with Throat | Convulsions | Palpitation | Fluttering Heart | Swelling of Hands | Swelling of Feet | Swelling of Ankles | Fatigue | Night Sweats | Insomnia | Disorientation | Cough | Tiredness | Weakness | Loss of Appetite | Rash | Prostate Trouble | Heart Burn

Date of Last menstrual period _____ **Pregnant Yes or No** _____

Current or Occasional Medicines, over the counter, Vitamins, Herbal, Birth control and dosages _____

Allergies _____

Past surgeries _____

Name Primary care Physician _____

Current suicidal thoughts? Yes No Plans _____

Past suicide attempts? Yes No How many _____ Last episode _____

Means of previous Suicide attempts _____

History of Violence _____

Previous psychiatry treatment Circle the one that applies.

Outpatient, counseling, detox, rehab inpatient psychiatry hospital, therapist, groups, psychiatrist, primary care physician

Last Psychiatrist name? _____

Last Psychiatric hospitalization _____

Past Psychiatric Medication _____

Current psychiatric medication _____

