

ARUN A. POL M.D., P.C.

Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.

PLEASE PRESENT A PHOTO ID AND INSURANCE CARD BEFORE SERVICES CAN BE RENDERED. PRINT LEGIBLY

1. PATIENT INFORMATION

Full Name (First, MI, LAST): _____

Gender: _____ Marital Status: _____ Date of Birth: _____

Primary Mobile Phone: _____ Alternate Phone: _____

Social Security Number _____ Email Address _____

Address: _____ City _____ State _____ Zipcode _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

2 RESPONSIBLE PARTY: (Legal Guardian if minor, who is primary on insurance)

Father's Name: _____ Date of Birth: _____

Mobile Phone: _____ Email address: _____

Address: _____ City _____ State _____ Zipcode _____

Mother's Name: _____ Date of Birth: _____

Mobile Phone: _____ Email Address: _____

Address: _____ City _____ State _____ Zipcode _____

3. INSURANCE INFORMATION: We do not file secondary Insurance

Does patient have Insurance: ☐ Yes ☐ No ☐ Self Pay (If not provider for your Insurance)

Primary Insurance: _____ Phone # : _____

ID #: _____ Group Number: _____

Policy Holder Name: _____ Relationship: ☐ self ☐ spouse ☐ child ☐ other

Date of Birth of Insured: _____ Social Security of Insured: _____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical/psychological information necessary to process my Insurance claims. I authorize and request payment of medical benefits to my Psychiatrist, Arun A. Pol, M.D., P.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. I understand and agree to pay for missed appointments not canceled with 48 or more hours of notice.

Signature of Patient (Guardian) _____ Date: _____

ARUN A. POL, M.D., P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for ARUN A. POL, M.D., P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (ARUN A. POL, M.D., P.C. 's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. ARUN A. POL, M.D., P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to ARUN A. POL, M.D., P.C.

With this consent, ARUN A. POL, M.D., P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent ARUN A. POL, M.D., P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that ARUN A. POL, M.D., P.C. restrict how it used or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to ARUN A. POL, M.D., P.C. 's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, ARUN A. POL, M.D., P.C. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian

ARUN A. POL, M.D., P.C.-OFFICE POLICIES/ FINANCIAL POLICY/CONSENT FOR TREATMENT

- Your **co- payment/ deductible is due at the time of service**, before we can file a claim on your behalf with the Insurance company. There cannot be any exceptions to this. Failure to pay may result in your visit being rescheduled.
- **Mental Health benefits differ from your Medical benefits** and may have different co-payments and deductibles. You must **verify your benefits with your Insurance company, obtain authorization** before your initial visit and every time there is a change in your Insurance coverage.
- It is your responsibility to **bring in your Insurance card at each visit** and to **notify us of any change in Insurance coverage** (including any additions or deletions in Insurance plans), **prior to your next visit**. If you submit a new Insurance card at the time of a follow-up visit, your visit may be rescheduled so we can verify your coverage / obtain necessary authorizations from your Insurance company for the visit.
- **If your Insurance has lapsed** or your Insurance information is not correct, you will be responsible for all charges for the visit.
- Please **notify us of any change** in your **Address & / Telephone number** immediately.
- A **10 \$ service fee** may be added to any unpaid balances.
- If the **' amount due' / previous balances remain unpaid**, despite repeated billing then **treatment may be terminated** and you may be referred to another Psychiatrist.
- We will file the claim with your Insurance company for you, if we are a participating provider for your plan.
- You will be responsible for payment for any all services in excess of your Insurance limits, as well as non-covered services.
- Your **check out statement** includes **amount due for the current visit** and any **previous balance** (which has been calculated after receiving an EOB- Explanation of Benefits from your Insurance Company, after we filed claims on your behalf for prior visits) or previous co-payments / deductibles not paid by you. If you dispute the amount due, you need to contact your Insurance Company to clarify the matter.
- For a **child living in two separate households** , the parent / guardian that brings the child for the appointment is responsible for the payment at the visit.
- We may **charge for missed late canceled appointments** (less than 48 hrs. notice) (fee of 50 \$).
- **Fee for Bounced checks is 35 \$**, paid by cash or credit /debit card.
- There is a **fee for transfer / copying of Medical records**, for **transcription of records**, / completion of any **disability papers**, **payable prior to the execution of such a request**. The fee for the same depends on the amount of work involved.
- There may be **fee charged for the time spent in collaborative treatment planning** with your therapist / physician / attorney. You will be informed if such a charge will be applied prior to such a discussion.
- Your **initial visit is for a Diagnostic Evaluation**. Subsequent visits are for **medication management**. You will be referred to a therapist if that is needed in your case.
- **48 hour notice is required for prescription refills**. Lost prescriptions for controlled substances including stimulants will not be replaced.
- Routine messages can be left on the voice mail. Dr. Pol can be paged for emergencies.

- Unpaid amounts after repeated billing may be referred over to **Collections**.

Patient/ Guardian Signature

Patient Name

Date

INITIAL QUESTIONNAIRE

NAME: _____ AGE _____ DATE _____
GENDER M/F _____ MARITAL STATUS _____ S _____ M _____ D _____ W _____
SCHOOL (GRADE)/ WORK _____ D.O.B _____
How were you referred to us ? : _____
Reason for today's visit: _____

Please answer / put a check mark against all the questions that apply :

Have you experienced the following in the past (MOOD CHANGES) ? _____ Yes _____ No

_____ Sad/ depressed	_____ Elevated / euphoric mood
_____ Low self esteem	_____ Grandiosity/inflated self-esteem
_____ Guilt feelings	_____ Rapid speech/ racing thoughts
_____ Sleep disturbance	_____ Reduced need for sleep
_____ Appetite increase or decrease	_____ Irritability
_____ change in Energy level	_____ Excess goal directed activity
_____ Reduced Concentration	_____ Distractibility/ reduced concentration
_____ Irritability	_____ Impulsivity (sexual / financial)
_____ Physical problems (eg headaches, stomachs)	_____ Poor judgment/ planning
_____ Motivation/ lack of interest in things that you usually enjoy	
_____ wt. change (gain) (decrease)	
_____ Any thoughts of Suicide	_____ Any Suicide attempts / self mutilation

Any problems with ATTENTION span, distractibility, poor organization, hyperactivity, Impulsivity

_____ Yes _____ No _____

Any TRAUMA in the past (such as) : _____ Yes _____ No

_____ Physical Abuse _____ Sexual Abuse _____ Emotional Abuse _____ Accidents

Any Problems with Your SLEEP ? _____ Yes _____ No

Any Fears or Phobias / ANXIETY Problems : _____ Yes _____ No

_____ Excessive hand washing, excessive need for organization / perfection / checking , persistent thoughts

_____ Fear of speaking in front of others / groups, fear of social situations

_____ Fears or Phobias eg Fear of heights, elevators, closed spaces,

_____ Sudden severe anxiety, fear of death, physical symptoms _____

_____ Anxiety episodes due to past experiences of trauma or accidents _____

_____ Excessive worry eg about family, finances, health, fear of death _____

_____ Refusal to go to school, severe anxiety being away from family, _____

Any Disorganized thoughts, behaviors:

Any hallucinations _____ Change in self care, poor hygiene _____
Fixed , false beliefs _____, _____ Abnormal body movements _____
Paranoid thoughts _____
Change in memory, concentration, academic or intellectual decline _____
Strange thoughts/ behaviors _____

Any problems/ dependency with Alcohol / Drugs / Prescription Drugs :

Any (___ DUI's ___ Blackouts ___ Seizures ___ DTs ___ Head trauma ___ Legal problems)
Any use of Inhalants (eg gasoline, paint, aerosol sprays) _____ Any use of Intravenous drugs _____
Use/ Frequency/Last use of Alcohol, Drugs _____

Any treatment in Inpatient Detox/ Rehab _____ Any participation in Self Help groups (AA/ NA) _____
Any use of Cigarettes _____ Any use of Caffeine _____

Any Legal Problems:

Current _____ Past _____ None : _____ Any history of Probation _____

Any problems associated with severe impulsivity, such as :

Any major rage episodes / explosive behaviors _____ Any problems with stealing _____
Any Fire setting episodes _____ Excessive Gambling or money spending _____
Any problems with hair pulling _____

Any problems with poor self /body image and / or Eating disorder issues such as :

Anorexia _____ Bulimia _____ Binge eating _____
Reduced food intake _____ Poor self (body) image _____
Purging _____ Laxatives etc. _____
Abnormal menstrual cycles _____ Wt. loss _____
Any target wt. _____ Previous tx. _____

Medical History:

Any Allergies (food / drug) _____
Primary Care Physician : Name and Phone Number _____
Any Major Medical Illness(es) (eg Asthma, Diabetes, THYROID gland disorders , High Blood Pressure, Heart Problem , Seizures, Head Injuries) _____

Are you Pregnant (for childbearing age female pts. only) No / Yes

Please list ALL Current Medications and Dosage (including over the counter meds/herbal supplements/vitamins/Rx.) _____

Outpatient treatment _____
Therapy _____
Inpatient treatment or Long term hospitalizations _____
Any previous history of violent behavior _____

[illegible]

Primary Care Physician (Name / Tel. No.)	Yes	No
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Any BEHAVIOR PROBLEMS characterized by: ____ Yes ____ No

Any Problems (mother's pregnancy &/ or child's GROWTH & DEVELOPMENT) : ___Yes ___No

<input type="checkbox"/> Delay in speech	<input type="checkbox"/> Stereotypical behaviors / movements
<input type="checkbox"/> Poor social interaction	<input type="checkbox"/> Used to routines / rituals
<input type="checkbox"/> Communication problems	<input type="checkbox"/> Restricted range of activities
<input type="checkbox"/> Other dev. Delays	

Very childish or infantile behaviors compared to peers
Low IQ based on previous testing

Reg. Ed. Sp.Ed. E.B.D
h/o Learning disability h/o School violence h/o alternative schools

4

ARUN A. POL, M.D., P.C.
CHILD, ADOLESCENT AND ADULT PSYCHIATRY

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JOHNS CREEK, GA 30097

TEL # (770) 623-8830

www.foryourmindonly.com

FAX# (770) 623-8846

**MEDICATION CONSENT / RULES FOR
CONTROLLED MEDICATIONS**

(Please initial each line and sign below)

_____ Controlled medications are monitored by the DEA database. This includes monitoring of patients and Physicians.

_____ Medications are to be taken as directed and dose adjustment should not be done by the patient without approval from the doctor

_____ Prescriptions that are lost or misplaced cannot be re-written / replaced by the doctor

_____ Prescriptions cannot be written ahead of the scheduled due date

_____ Concurrent use of Alcohol or illegal street drugs is dangerous and can have very severe consequences

_____ It is illegal to obtain similar prescriptions simultaneously from other doctors

_____ Combining medications such as Benzodiazepines (e.g Valium, Xanax, Klonopin, Ativan, Temazepam) with Narcotic /Pain medications can potentially lead to extreme sedation with serious consequences such as respiratory suppression and even death. I am aware of the risks.

_____ Non-compliance with the above recommendations may lead to termination of treatment from the clinic

I have read the above and understand the rules for taking controlled medications

Date: _____

Patient name _____

Patient/Parent/Guardian signature _____

ADHD RATING SCALE IV - HOME VERSION

Child's Name: _____ Sex: M _____ F _____ Age: _____ Grade: _____
 Completed by: Mother _____ Father _____ Guardian _____ Grandparent _____

Circle the number that **best describes** your child's home behavior over the past 6 months

	<u>Never or Rarely</u>	<u>Sometimes</u>	<u>Often</u>	<u>Very Often</u>
1. Fails to give close attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2. Fidgets with hands or feet or squirm in seat.	0	1	2	3
3. Has difficulty sustaining attention in tasks or play activities.	0	1	2	3
4. Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
5. Does not seem to listen when spoken to directly.	0	1	2	3
6. Runs about or climbs excessively in situations in which it is inappropriate.	0	1	2	3
7. Does not follow through on instructions and fails to finish work.	0	1	2	3
8. Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
9. Has difficulty organizing tasks and activities.	0	1	2	3
10. Is "on the go" or acts as if "driven by a motor."	0	1	2	3
11. Avoids tasks (e.g., schoolwork, homework) that requires sustained mental effort.	0	1	2	3
12. Talks excessively.	0	1	2	3
13. Loses things necessary for tasks or activities.	0	1	2	3
14. Blurts out answers before questions have been completed.	0	1	2	3
15. Is easily distracted.	0	1	2	3
16. Has difficulty awaiting turn.	0	1	2	3
17. Is forgetful in daily activities.	0	1	2	3
18. Interrupt or intrude on others.	0	1	2	3

- At what age did you first notice increased activity, fidgetiness, on the go tendency? _____
- At what age did you first notice the distractibility, difficulty following through with directions? _____