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 24 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

ARUN A. POL, M.D., P.C.
(CHILD, ADOLESCENT & ADULT PSYCHIATRY)
6290 ABBOTTS BRIDGE ROAD, SUITE 502, JOHNS CREEK, GA 30097
TEL # (770) 623-8830 **www.foryourmindonly.com** FAX# (770) 623-8846

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, stomaches)	_____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 wih 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, aeroso sprays) _____Any use of Intravenous drugs

Use/ Frequency/Last use of Acohol, Drugs_____

_____ Any treatment in Inpatient Detox/ Rehab __Any participation n 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.)_____

ANY PREVIOUS PSYCHIATRIC HISTORY (eg ADHD, Depression, Bipolar Disorder, Anxiety Disorders, Schizophrenia, Alcoholism or Drug Addiction) : _____Yes ____No

Outpatient treatment _____

Therapy_____

Inpatient treatment or Long term hospitalizations_____

Any previous history of violent behavior_____

LIST OF PSYCHIATRIC MEDICATIONS IN THEPAST and RESPONSE (including those for treatment of ADHD) : _____

List of all FAMILY MEMBERS at home and their ages :

Any FAMILY MEMBERS (Biologically related) with any PSYCHIATRIC / EMOTIONAL PROBLEMS (eg ADHD, Depression, Bipolar Disorder, Anxiety Disorders, Schizophrenia, Alcoholism or Drug Addiction) : ____Yes ____No

Any Completed SUICIDES in family members ? ____Yes ___No_____

Do you AUTHORIZE us to release clinical information to your :

Primary Care Physician (Name / Tel. No.) ___Yes ___No_____

Therapist (Name / Tel. No.) : ____Yes ___No _____

Additional Questionnaire for CHILDREN and ADOLESCENTS :

Any BEHAVIOR PROBLEMS characterized by: ____Yes ___No

_____Oppositional
_____Vindictive
_____Makes others angry
_____Aggression
_____h/o use of a weapon
_____destruction of property
_____Defiant
_____Spiteful
_____Is angry easily
_____Cruelty to animals
_____h/o gang membership
_____h/o run away behavior

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

Any concerns about any AUTISTIC DISORDERS : ____Yes ___No

__Delay in speech
__Poor social interaction
__Communication problems
__Other dev. Delays
__Stereotypical behaviors / movements
__Used to routines / rituals
__Restricted range of activities

Any concerns about severe MENTAL DEVELOPMENTAL DELAYS : ____Yes ___No

__Very childish or infantile behaviors compared to peers
__Low IQ based on previous testing

SCHOOL ENVIRONMENT and history:

__Reg. Ed. __Sp.Ed. __E.B.D
__h/o Learning disability __h/o School violence __h/o alternative schools

Has PSYCHOLOGICAL TESTING been done in the past ? : ___Yes ___No

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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

	Never or Rarely	Sometimes	Often	Very Often
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? _____
- Atwhat age did you first notice the distractibility, difficulty following through with directions? _____