Dunwoody Psychiatry & Psychotherapy Center (DPPC)

Demographic Information

Patient Information (Please Print):

First Name: _____ Middle Initial: ___ Last Name: _____

Date of Birth: _____

Cell Phone Number: _____

Home Phone Number: _____

*Social SS #: _____-_____-_____

Billing Address: _____

_____

Emergency Contact: _____

Relationship: _____

Phone Number: _____

Email Address: _____

Please circle one:

May we leave confidential messages on your_____? **Home phone / Cell phone**

Reason for your visit today: _____

Employment Information:

Employment Status (circle): Employed Unemployed Other: _____

Occupation:_____

Employer Name: _____

Work Phone Number: _____

Insurance Information:

Primary Insurance: _____

Member ID/Policy # _____ Group # _____

Patient is Subscriber/Policy Holder please circle **Yes or No**

Secondary Insurance: _____

Patient is Subscriber/Policy Holder please circle **Yes or No**

Insured Information (If Other Than Patient):

Policy Holder: _____ Relationship to patient: _____ Phone #: _____

Dunwoody Psychiatry & Psychotherapy Center

2150 Peachford Road Suite V

Atlanta, GA 30338

Office Phone #: 770-674-1540 Fax #: 770-674-1765

Informed Consent for Treatment

I voluntarily agree to receive treatment by Dr. Michael Vaughn M.D. and/or Sanaz Rezaei-Vaughn PH.D. for mental health services. This may include the use of telecommunications to provide mental and behavioral health services. I understand and agree that I will participate in my treatment plan, and that I may discontinue treatment and/or withdraw my consent for treatment and any time.

Printed Name: _____

Signature: _____

Date: _____

Cancellation Policy

All cancellations must be done within a minimum of 24-hour notice. For appointments that are cancelled within less than 24 hours or for "no show" appointments, there will be a charge of $75 added to your account that will be due prior to your next visit.

Insurance and Self Pay Rates

Our practice participates with many insurance plans. Each plan has different requirements, coverage limitations and exclusions, it is the responsibility of the patient to understand and meet the requirements of their individual plan. Most patients will have a "co-pay" (portion of their charges which is not covered by insurance) or a "co-insurance" (percent of the charge covered by insurance). Those covered by Medicare and some other insurance plans may have "deductibles" as well. Co-pays, co-insurances, deductibles, non-covered charges, and self-pay payments are payable at the time services are rendered. We accept payments in the form of cash, personal checks, Visa, and MasterCard. **All outstanding balances will be billed a monthly charge of $25 until the entire balance is paid in full.**

For self-pay rates please contact our office.

Prescription Refills

Obtaining a prescription refill routinely requires an office visit with your physician. In extenuating circumstances short term prescriptions can be called in without an appointment with the physician but will generate a $25 fee. Prescriptions will not be refilled on weekends or holidays.

Telephone Services

A request for a telephone call from your doctor(s), outside of your scheduled appointment time, **will be subject to a fee.** The fee must be paid before your next scheduled appointment. For further information please contact our office.

Prior Authorizations

Due to the time it takes to complete medication authorizations, there will be $80.00 fee. The fee must be paid before the prior authorization process is started and does not guarantee the approval of the medication. Please allow 7 business days for completion of this process.

Returned Check Policy

There will be a **fee of $25** for any check returned by the bank.

Medical Reports

Special typed reports requested from various entities will generate an administrative fee. The fee is determined by the amount of time that is required for your doctor(s) to complete the report. This includes the completion of disability paperwork. There is a **minimum charge of $50** for reports.

Medical Records

You will need to sign a Release of Information Form prior to the release of your records to any third party. Obtaining a personal copy of your medical records will generate a **minimum fee of $25.**

Demographic and Insurance Updates

Patients are responsible for providing accurate and updated health and demographic information to Dunwoody Psychiatry & Psychotherapy Center.

Please notify the office of any insurance changes three days prior to your scheduled appointment. If insurance is not updated to the correct policy/plan prior to your appointment day, you will be responsible to pay the doctors Self-Pay rate for that date of service.

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

Guardian Information if Applicable:

Print Guardian Name: _____ **Date:** _____

Relationship to the patient: _____

Guardian Signature: _____ **Date:** _____

MEDICATION(S) PRESCRIBED

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Dunwoody Psychiatry & Psychotherapy Center

2150 Peachford Road Ste. V

Atlanta, GA 30338

T: 770-674-1540 F: 770-674-1765

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE: ☐ Michael R. Vaughn, M.D. ☐ Sanaz Rezaei-Vaughn, Ph.D.

RELEASE TO/FROM: _____

Name of Person/Healthcare Provider/ Physician/Family Members

RE: Patient Name: _____

Date of Birth: _____

The Following Information: *Please put a check mark in each applicable box.*

☐ Psychiatric Evaluation ☐ Psychological Evaluation ☐ Consultation
☐ Treatment Plan ☐ Progress Notes ☐ Laboratory Reports
☐ Other (Specify): _____

I, _____, AUTHORIZE THE ABOVE NAMED PERSON/ ORGANZATION/ MEMBERS OF THEIR STAFF TO FURNISH INFORMATION, INCLUDING PHOSTATIC COPIES OF MY MEDICAL RECORDS, CONCERNING MY TREATMENT, TO THE ABOVE ORGANIZATION OR ITS AGENTS, AND I FUTHER AGREE TO INDEMNIFY AND HOLD HARMLESS ITS STAFF FROM ALL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION HEREIN REQUESTED. ANY INFROMATION OBTAINED FROM THIS AUTHORIZE REALEASE SHOULD NOT BE RELASED TO ANY OTHER PERSON(S) UNLESS I SPECIFICALLY AUTHORIZE.

I UNDERSTAND THAT THE RECORDS RELEASED MAY CONTAIN ALCOHOL AND DRUG TREATMENT INFORMATION, AIDS/HIV OR PSYCHIATRIC/PSYCHOLOGICAL INFORMATION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN ELIANCE THEREON, AND THAT THIS AUTHORIZATION IS VALID FOR A PERIOD OF 365 DAYS FROM THE DATE OF MY SIGNATURE.

_____

DATE PRINT NAME SIGNATURE

_____

WITNESS PARENT/ LEGAL GUARDIAN

Dunwoody Psychiatry & Psychotherapy Center
2150 Peachford Rd Suite V
770-674-1540

Patient Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with DPPC. In providing us with your credit card information, you are giving DPPC permission to automatically charge your credit card on file for your co-pay [or any other patient(s) you have listed on this form] at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays: Co-pays are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, DPPC will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize DPPC, *to charge co-pays and outstanding balances on my account to the following credit card:*

Visa	MasterCard	American Express	Discover
☐	☐	☐	☐

Credit Card Holder's Name: _____

Last 4 digits of Credit Card: _____

Expiration Date: _____

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient Full Name: _____
(Please Print)

Patient Full Name: _____

Patient Full Name: _____

Patient Signature: _____ Date: _____

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

http://www.med.navy.mil/sites/NMCP2/PatientServices/SleepClinicLab/Documents/Beck_Depression_Inventory.pdf

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Date: _____ Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.