Dr. Dana Reid, LLC
Child, Adolescent and Adult Psychiatrist

5755 North Point Parkway
Suite 67
Alpharetta, GA 30022

Phone: 770-212-2249
Fax: 770-212-2253

Welcome to our practice. The following information pertains to our practice policies. Please read carefully and let us know if you have any questions that we can answer and discuss with you. We look forward to working with you and providing you with the highest quality of care. When you sign this document, you are agreeing and acknowledging these policies.

Sessions:

The initial comprehensive evaluation is 90 minutes in length. During this session, I will take the time to get to know you and understand your specific concerns and treatment goals. At the end of the session, I will provide you with my assessment and work with you to develop a treatment plan that best meets your needs. This may entail psychotherapy (talk therapy), medication management, education or a combination of these. Some patients may benefit from a longer evaluation process of additional 1-2 sessions before a specific treatment plan can be recommended. If you are seeing another therapist, I can provide medication management and coordinate care with your therapist. Please complete the release of information form at the end of this document for any providers that you would like me to have contact with (eg, primary care physician, therapist, etc).

If medications are initiated, follow up appointments are required as long as medications are being prescribed. The frequency of these follow up appointments vary depending on response to medications, severity of illness and side effects. Medication management appointments are 25 minutes in length.

Cancellations and No-Shows:

Your appointment time is reserved for you. Therefore, if you are not able to keep your appointment time, please call as soon as possible to cancel or reschedule your appointment. If you do not provide at least 24 hours' notice of your cancelled appointment or if you fail to show for your appointment, you will be charged for the full cost of the session. Please call by Friday at 1 pm for any cancellations the following Monday.

If multiple appointments are missed without notice, I reserve the right to terminate treatment and you may be discharged from our practice.

Maintaining Regular Follow Up Appointments/No Contact Policy:

Regular follow up appointments are an important part of your care and a necessary requirement to stay in my practice. **If you have not had contact with our office in 6 months, you will no longer be an active patient and will be considered discharged from our practice**. Return to our practice after discharge may require a new evaluation or longer return follow up appointment. It will be at our discretion if you are able to return to our practice.

Contacting Me:

I have a full time office assistant that will answer calls during business hours Monday through Friday. I will return urgent calls as soon as possible. Routine calls will be answered within 24-48 hours with the exception of weekends and holidays. If you are experiencing an emergency and cannot wait to reach me, you should call 911 or go to the nearest emergency room. As soon as you are able to do so, please contact me to inform me of the situation.

Calls under 10 mins will not be charged. Calls over 10 mins will be charged at my hourly rate of $300 and will be prorated.

Fees for Services:

My fee for the initial comprehensive evaluation is **$375**. My fee is **$250** for 45 minute therapy sessions (with or without medication management). 25 minute medication management appointments are **$175**. Extended 60 minute follow up appointments are **$300**. I accept cash, check and credit cards. Please make checks payable to **Dr. Dana Reid, LLC**

Letters/Forms.

Please try to bring forms that need to be completed with you to appointments if possible. For forms/letters that are completed outside of sessions there will be a charge depending on the time spent and extent of the letter/form. The fee will range from $25-100.

By signing this you are confirming that you understand that it is your financial responsibility for services provided. I am considered an out of network provider for all insurance companies. If you have insurance and wish to be reimbursed, I can provide you with a superbill at the end of your appointment so you can file with your insurance. It is your responsibility to file with your insurance company. I do NOT bill your insurance company directly. All reimbursement you obtain from your insurance company is yours.

By signing this you are confirming that you understand that you will be charged for missed appointments and cancellations with less than 24 hours' notice. Your appointment is reserved for you. If you need to cancel an appointment, please notify me as soon as possible. Appointments not cancelled with at least 24 hours' notice will be billed at the full cost of the appointment which is $250

for 45 minute therapy sessions, $300 for extended follow up sessions, and $175 for 25 minute medication management sessions.

Full payment is due at the time service is rendered. I acknowledge responsibility for all fees incurred. Any balances due, will need to be paid in full prior to scheduling an appointment. All balances 30 days past due will be deemed delinquent. Delinquent accounts must be paid in full before any future services will be provided.

I have read and understand the above policies.

_____ _____
Patient's Name Date

_____ _____
Responsible Party's Name (if patient, indicate "self") Date

_____ _____
Responsible Party's Signature Date

Statement of Confidentiality: Under Georgia law communications between patients and psychiatrists are confidential, and under ordinary circumstances this privilege can be waived **only** by the patient. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to him or herself, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child abuse. Although legally and ethically bound to break confidentiality under the aforementioned circumstances, I will not do so without attempting to discuss it with you first.

I have read and understand the above policies.

_____ _____
Patient's Signature Date

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POINTS TO REMEMBER

1. Notify me if there are any significant changes in your psychiatric or medical condition, or if an outside provider changes your medication regimen.

2. Notify me if you suspect or know that you are pregnant or plan to become pregnant in the near future. Pregnancy may affect treatment recommendations.

3. If you feel you are at risk of hurting yourself or others, notify me immediately. If you feel you are an imminent risk and need immediate attention, call 911 or go to your nearest emergency room.

4. We welcome emails for non-urgent, administrative communication. Please note that the confidentiality of your email cannot be guaranteed. To discuss medical concerns, please call me.

5. If your medication makes you drowsy or slows your reaction time, refrain from driving and notify me. Also, notify me if your medication causes you other significant side effects.

6. If you want to increase, decrease, or discontinue your medication regimen, call first. Medication management is a collaborative process. Changes without consultation are potentially dangerous and may interfere with our ability to work together.

I have read and understand the preceding Points to Remember.

_____ _____

Patient's Signature Date

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Medication and Prescription Policy

If Dr. Reid is prescribing medications to you as part of your treatment, regular follow up visits with her are required to closely monitor for efficacy, safety and potential side effects. Medication management requires working together to ensure the best response to medications. This includes maintaining scheduled follow up appointments.

- You will be prescribed enough medication to last until your next follow-up appointment. Please allow 2 days for medication refill requests if you need a refill. **Prescriptions will not be called in for patients that cancel/ or miss regularly scheduled medication follow-up appointments.**

- If you have to reschedule an appointment, please ensure that you schedule another appointment before you run out of medication. Our office will do our best to reschedule you, but keep in mind it may take several days to weeks to find an appointment that will be conducive to your schedule. **It is your responsibility to make sure you do not run out of medicine.**

- Recognize that stimulant medications are considered controlled substances and cannot be called in to or faxed to pharmacies.

Dr. Reid is committed to providing professional services of the highest quality and standards. In order to serve her patients efficiently and responsibly, she requires agreements be made as to the policies stated above. Patients are encouraged to ask questions before signing.

I have read the medication policies, understand, and agree with them.

Patient's Signature: _____

Guardian if Minor: _____

Date:_____

NEW PATIENT INFORMATION SHEET

Name _____ Age _____ DOB _____

Address _____

_____ Zip Code _____

May I send mail to this address? Y N

Home Phone _____ May we leave a message? Y N

Work Phone _____ May we leave a message? Y N

Mobile Phone _____ May we leave a message? Y N

Email: _____

Employer_____ Occupation _____

Education: Years Completed _____ Degrees Obtained_____

Marital Status: single married domestic partnership separated divorced widowed

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____

How were you referred? (please be specific) _____

Please briefly describe the problem or situation that has prompted you to call and seek treatment

_____
_____
_____

What are your goals for treatment? What would you like to gain from working with me?

_____
_____

Have you received psychiatric care in the past for this problem or for any other problems? Please provide names of prior providers including therapists and psychiatrists

_____
_____

Have you ever been hospitalized for psychiatric reasons? If so, please provide dates and name of hospitals

_____
_____
_____

Medical History

Date of most recent physical exam_____ Results _____

List any medical problems (include cardiac, respiratory, thyroid, seizures, head injuries, loss of consciousness, hearing or vision problems)

_____
_____

Allergies_____

List any serious illnesses, accidents, operations or hospitalizations:

_____
_____

Any family history of medical problems (include seizures, heart disease, diabetes, cancer, liver disease, stroke, Parkinson's)?

_____
_____

Any family history of psychiatric conditions?

_____
_____

Name of primary care physician

Name _____
Address_____
Phone_____

For purposes of continuity of care, may we contact your physician to let him/her know of your visit today?
Yes_____ No_____

If Yes, I, _____, give permission to Dr. Dana Reid to send a general statement notifying my primary care physician of my visit today. The information sent will be used for coordination of care, and will be limited to a brief description of the problem area and /or diagnosis, and a general outline of treatment.

_____ _____
Patient's Signature Date

Current Medications -List any medications you are currently taking including herbs/supplements

Medication Name	Dosage	Why Taking	Response

Past Medications -List all psychiatric or neurological medications taken in the past

Medication Name	Dosage	Why Taken	When Taken	Why Stopped

Substance Use History-Please specify amount and frequency

Alcohol Past___Current____ _____

Tobacco Past___ Current____ _____

Marijuana Past___Current____ _____

Cocaine Past___Current____ _____

Opiate Past___Current____ _____

Benzodiazepines Past___Current_____ _____

Stimulants Past___Current____ _____

Ecstasy Past___Current____ _____

Other Past___Current____ _____

Have you ever been in substance abuse treatment or rehab in the past? Please describe

_____

_____

Please note any other information about yourself that you think might be helpful in understanding you

_____

_____

_____

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CONSENT FOR RELEASE OF INFORMATION

Please complete for any providers that you would like me to collaborate with including therapists, primary care physicians and other specialists

Patient Name Date of Birth

I _____, hereby authorize Dr. Dana Reid to release information from my medical records as described below to

Name:_____

Address:_____

Phone Number:_____ Fax:_____

The request and authorization applies only to the following information:

_____Medical History/Physical Exam	_____Laboratory Reports	_____Consultations
_____Discharge Summary	_____Summary of Hospitalizations	_____Progress Notes
_____Psychiatric Reports/Tests	_____Psychological Reports	_____Teachers' Reports
_____Psychiatric Evaluation	_____Medications	_____Social History
_____Treatment Recommendations	_____Course of Treatment	____Developmental Hx

Other_____

The purpose of the release of information is: ____Coordination of Care _____Continuation of Care

The release will expire in 12 months unless specified by you.
I understand that I can cancel this authorization at any time, except for action that has already been taken.

_____ _____
Signature of Patient (12 years and older) Date

_____ _____
Signature of Guardian Date