Welcome to my practice. The following information pertains to my practice policies. Please read carefully and let me know if you have any questions that I can answer and discuss with you. I look forward to working with you.

**Sessions:**

My 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. At the end of the session, I will provide you with my assessment and work with you to develop a treatment plan. 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. I will also coordinate care with your other providers including primary care physicians and other specialists. Please complete the release of information form at the end of this document for any providers that you would like me to coordinate care with.

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 30 minutes in length.

Psychotherapy sessions are 45 minutes in length and can occur with or without medication management. The frequency of these sessions varies but usually occurs on a weekly basis. Psychotherapy can be short or long term in nature.

**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.

**Contacting Me:**

I have a full time assistant that will answer calls during business hours Monday-Friday. If my assistant is not able to address your specific concern, I will return phone calls within 24 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.
My fee for the initial comprehensive evaluation is $375.00. My fee is $200 for 45 minute therapy sessions (with or without medication management). 30 minute medication management appointments are $175. I accept cash, check and credit cards. Please make checks payable to Dr. Dana Reid, LLC

I understand that it is my financial responsibility for services provided and that insurance is for my reimbursement. 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.

I understand that I 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 $200 for 45 minute therapy sessions and $175 for 30 minute medication management sessions.

Full payment is due at the time service is rendered. I acknowledge responsibility for all fees incurred. 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
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 will 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. I 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.

7. It is advised to not drink alcohol while taking psychiatric medications.

8. Notify me if there are any changes to your address, phone number or e-mail.

9. I am here to help you. Do not hesitate to call if you have questions or concerns.

I have read and understand the preceding Points to Remember.

___________________________________________  __________________ ___
Patient’s Signature      Date
Medication and Prescription Policy

If Dr. Reid is prescribing medications to you/ or your child 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. **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: _________________________________________
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.
Current Medications - List any medications you are currently taking including herbs/supplements

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Why Taking</th>
<th>Response</th>
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Past Medications - List all psychiatric or neurological medications taken in the past

<table>
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<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Why Taken</th>
<th>When Taken</th>
<th>Why Stopped</th>
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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
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

<table>
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<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
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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
- Discharge Summary
- Psychiatric Reports/Tests
- Psychiatric Evaluation
- Treatment Recommendations
- Laboratory Reports
- Summary of Hospitalizations
- Psychological Reports
- Medications
- Course of Treatment
- Consultations
- Progress Notes
- Teachers’ Reports
- Social History
- 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