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 performed over two sessions which are each 60 minutes in length. During these sessions, I will take the time to get to know your child and family and better understand your concerns. At the end of the second evaluation session, we will work together to develop a treatment plan that is specific to your child’s needs. This may entail psychotherapy (talk therapy), medication management, education or a combination of these. I usually do not perform the therapy but will help you find a therapist that would be a great fit for your child. Some patients may benefit from a longer evaluation process of additional 1-2 sessions before a specific treatment plan can be recommended. If your child is already seeing a 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.

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 your child is experiencing an emergency and you 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 what took place.
My fee for the initial comprehensive evaluation is $200 for each 60 minute session. 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 company. 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, understand and agree to the above policies.

________________________________________             __________ _______

Responsible Party’s Name     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 or guardian. 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.

_________________________________________             _________ ________

Parent/Guardian’s Signature     Date

_________________________________________             _________ ________

Parent/Guardian’s Signature     Date
POINTS TO REMEMBER

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

2. If you feel that your child is at risk of hurting him/herself notify me immediately. If you feel that your child is at imminent risk and needs immediate attention, call 911 or go to your nearest emergency room.

3. 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.

4. If you want to increase, decrease, or discontinue your child’s 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.

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

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

7. I am here to help you and your child. Do not hesitate to call if you have questions or concerns.

I have read and understand the preceding Points to Remember.

___________________________________________  __________________ ___
Parent/Guardian’s Signature     Date

___________________________________________  __________________ ___
Parent/Guardian’s Signature     Date
CONSENT FOR EVALUATION AND TREATMENT

I am legal guardian of (Child’s Name) ________________________ and with full legal authority to consent to treatment. I hereby consent to psychiatric evaluation and treatment of him/her by Dr. Dana Reid.

Parents, Informed Consent & Divorce: If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, please note that you may be in violation of a court order if you fail to inform the other parent of your child receiving psychiatric services. Also note to provide consent for treatment of your child you must either have sole legal custody OR have shared legal custody, and if you have no legal custody you cannot provide consent for treatment. By signing below you are stating that you have the legal right to consent for this child. In the case of separation or divorce, any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to attention that are irrelevant to the child’s welfare may be kept in confidence.

________________________________________________________  _____ ______________
Signature of Guardian/Parent       Date

________________________________________________________  _____ ______________
Signature of Guardian/Parent       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: ____________________________________________________________________

Date: ____________________________________________________________________
**NEW PATIENT INFORMATION SHEET**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date:</strong></td>
<td>_____________</td>
</tr>
<tr>
<td><strong>Referred By:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Name of Child:</strong></td>
<td>___________________________</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td>________</td>
</tr>
<tr>
<td><strong>Date of Birth:</strong></td>
<td>_____________</td>
</tr>
<tr>
<td><strong>Male/Female:</strong></td>
<td>___________________________</td>
</tr>
<tr>
<td><strong>Father’s Name:</strong></td>
<td>___________________________</td>
</tr>
<tr>
<td><strong>Mother’s Name:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Cell Phone:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Cell Phone:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Work Phone:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Work Phone:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Home Phone:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Home Phone:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>E-mail Address:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>E-mail Address:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Occupation:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Occupation:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Education (school/degree):</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Education (school/degree):</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Child’s Legal Guardian (s):</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Primary Residence of Child:</strong></td>
<td>___________________________</td>
</tr>
<tr>
<td><strong>Primary Residence of Child:</strong></td>
<td>__Both Parents ______Mother ______Father ______Other (specify): ______</td>
</tr>
<tr>
<td><strong>Relationship Status of Parents:</strong></td>
<td>___________________________</td>
</tr>
<tr>
<td><strong>Relationship Status of Parents:</strong></td>
<td>__Never Married ______Married/Partnership ______Separated ______Divorced ______Widowed</td>
</tr>
</tbody>
</table>

Please note any custodial or legal arrangements pertinent to the child’s medical care:

_____________________________________________________________________________________

_____________________________________________________________________________________  

**Emergency Contact Information:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Relationship to Patient:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>City:</strong></td>
<td>___________________________</td>
</tr>
<tr>
<td><strong>State:</strong></td>
<td>________</td>
</tr>
<tr>
<td><strong>Zip:</strong></td>
<td>________</td>
</tr>
<tr>
<td><strong>Cell Phone:</strong></td>
<td>(<em><strong><strong>)</strong></strong></em>______</td>
</tr>
<tr>
<td><strong>Cell Phone:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Work:</strong></td>
<td>(<em><strong><strong>)</strong></strong></em>______</td>
</tr>
<tr>
<td><strong>Work:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Home:</strong></td>
<td>(<em><strong><strong>)</strong></strong></em>______</td>
</tr>
<tr>
<td><strong>Home:</strong></td>
<td>________________________________________________</td>
</tr>
</tbody>
</table>

**Primary Care Physician:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Pediatrician:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td>________________________________________________</td>
</tr>
<tr>
<td><strong>Phone:</strong></td>
<td>(<em><strong><strong>)</strong></strong></em>______</td>
</tr>
</tbody>
</table>
Pharmacy Information (If medications are prescribed):

Local Pharmacy Name:____________________________
Address:_______________________________________ Phone: (_____)_ ________________

School Information:
Name of School (indicate if homeschooled):____________________________ Grade:____
Address: ________________________________ City: ________________ State: _____ Zip: _____

Please identify members of the child’s household:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Living In the Home (Yes/No)</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please describe your reason(s) for seeking treatment at this time (include when the problem started):

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Describe your child’s experience and function in school? Are there any problems?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

What are your goals for your child’s treatment?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

What are your child’s strengths and/or unique qualities?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

What are your child’s interests and hobbies?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Psychiatric History:

Is your child currently seeing a psychiatrist and/or therapist?  _____ Yes  _____ No
Name:___________________________________________________________
Location:_________________________________________________________________________

Name:___________________________________________________________
Location:_________________________________________________________________________

Name:___________________________________________________________
Location:_________________________________________________________________________

Has your child received other outpatient psychiatric care in the past? Please provide name of prior providers including psychiatrists and therapists.
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

8
Has your child ever been hospitalized for psychiatric reasons? If so, please provide dates and name of hospitals.
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Is there any family psychiatric history eg. bipolar disorder, anxiety, depression, schizophrenia, substance abuse, learning disorders, ADHD, autism? Please provide condition and which family relative
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Developmental History:**

How much did your child weight at birth? ___ lbs

Where there any developmental delays including speech/walking/gross or fine motor skills? Describe
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Any complications during pregnancy or delivery? If so, please describe
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Medical History:**

List any significant medical problems such as seizures, head injuries, accidents, hospitalizations:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Any history of chest pain, palpitations, murmurs, fainting, or post exercise symptoms? Please describe:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Allergies:________________________________________
List ALL medications that your child is currently taking regularly (include over the counter meds/vitamins/herbal supplements) Please also include dosages and how often medication is taken

•
•
•
•
•
•

Please list other psychiatric medications that your child has taken in the past:

•
•
•
•
•

Any family history of medical problems (include seizures, heart disease, diabetes, cancer, liver disease, stroke, Parkinson’s)? If your child is adopted, please answer based on biological history if known

•
•

Any family history of early heart disease (before age 30)?

•
•

Please note any other information that you think might be helpful for me to better understand your child and family:

•
•
•
•
•
•
•
•
•
•
•
•
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/obtain 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
- Social History

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 Parent/Guardian       Date

________________________________________________________  __________________________
Signature of Parent/Guardian       Date