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 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 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 10-15 mins will not be charged. Calls that are longer will be charged.

Fees for Services:

My fee for the initial comprehensive evaluation is **$400**. 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.

<u>Full payment is due at the time service is rendered.</u> 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, 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

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

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. 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

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

CONSENT FOR EVALUATION AND TREATMENT

I am legal guardian of (Child's Name) ________________________ and hereby certify that I have legal custody of the child/adolescent being treated and am legally empowered to make medical decisions concerning him/her.

Custody Agreement: If the parents are divorced and the custody is "joint legal", both parents will need to sign the consent for treatment. However, if parents are divorced and only one parent signs the consent for treatment a copy of the custody agreement must be provided. This agreement must reflect which parent obtains authority over medical decision making. 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.

____ ___________________

Signature of Guardian/Parent Date

____ ___________________

Signature of Guardian/Parent Date

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

Medication and Prescription Policy

If Dr. Reid is prescribing medications to your child as part of their 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

Date: _____________ Referred By:___________________________________

Name of Child: __________________Age:______ Date of Birth:__________ Male/Female:___________

Father's Name: ____________________________ Mother's Name:__________________________

Address:__________________________________ Address:________________________________

Address:__________________________________ Address:_______________________________

Cell Phone:________________________________ Cell Phone:_____________________________

Work Phone:_______________________________ Work Phone:____________________________

Home Phone:_______________________________ Home Phone:____________________________

E-mail Address;_____________________________ E-mail Address:__________________________

Occupation:________________________________ Occupation:_____________________________

Education (school/degree):____________________ Education (school/degree):_________________

Child's Legal Guardian (s): ____

Primary Residence of Child: __ Both Parents __Mother __Father __ Other (specify): _______

Relationship Status of Parents: __Never Married __Married/Partnership __Separated __Divorced __Widowed

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

____

____

Emergency Contact Information:

Name:_____________________________ Relationship to Patient:___________________________

Address: ________________________________ City: ________________ State: ______ Zip: ________

Cell Phone: (_____)___________Work : (_____)_______________ Home: (_____)_________________

Primary Care Physician:

Name of Pediatrician: ___________________________

Address:______________________________________ Phone: (_____)_________________

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:

Name	Age	Relationship	Living In the Home (Yes/No)	Occupation

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

____
____
____
____
____
____

How does your child's current problem impact family relationships or family functioning?

____
____
____
____

Describe how your child gets along with other children? Has your child's current problem affected peer relationships?

____
____
____
____
____

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.

____
____
____
____
____

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:

____
____
____
____
____
____
____

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

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 _____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 Parent/Guardian Date

____ ___________________
Signature of Parent/Guardian Date