

•PATIENT INFORMATION•

Patient Name: _____ Gender: M F Date of Birth: _____

Address: _____
Street City State Zip Code

Billing Address if different from above: _____
Street City State Zip Code

Marital Status: Single Telephone: Home: _____
Work: _____

Married Cell: _____
 Divorced Email: _____

Separated Is it OK to call and leave messages at these numbers? Yes No

Widowed Responsible party (if patient is a minor): _____

•PRIMARY INSURANCE INFORMATION•

Policy Holder Name: _____ Gender: M F Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Telephone: Home: _____ Work: _____ Cell: _____

INSURANCE COMPANY: _____

Phone No.: _____

Member ID#: _____ Group #: _____

•SECONDARY INSURANCE INFORMATION•

Policy Holder Name: _____ Gender: M F Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Telephone: Home: _____ Work: _____ Cell: _____

INSURANCE COMPANY: _____

Phone No.: _____

Policy #: _____ Group #: _____

The office of Richard Born, Ph.D. LLC will bill your insurance carrier directly for all services. Your signature expresses your agreement that the dates of service, services rendered, and the diagnosis will be provided with the insurance claim as necessary to process the claim. The records that are associated with your care are private, but if you use your insurance these records may also be requested by and released to the insurance carrier. Your signature expresses your consent for releasing these records. Your signature also indicates that you understand and agree that you are liable for payment of any services not covered by your insurance company.

Signature: _____ Date: _____

Richard Born, Ph.D. LLC
One Huntington Road #205
Athens, Georgia 30606
Applied Psychological Health

Phone: (706) 543-7605
Fax: (706) 543-2397

New Patient Information Sheet – General

YOUR NAME: _____ **DATE:** _____

PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING YOURSELF:

Who referred you to our practice? _____

Who is your primary physician? _____
Address: _____
Telephone: _____

What medications are you taking:

Name of Medication	Date Started	Dosage	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any over-the-counter medications, herbs, or other supplements you take:

Do you have any allergies to medications? ____ Yes ____ No

Please list any allergies you have: _____

Have you ever been to a counselor, psychologist, or psychiatrist, or been admitted to a psychiatric hospital?

Yes ____ No ____ If "Yes", please list who you saw, when, and for what purpose.

What is your occupation? _____

If you are a student, where do you attend school? _____

What level of formal education have you reached? _____

Do you have children? ____ Yes ____ No. If "Yes", please list their names and ages:

Other people living in your home: _____

Whom can we contact in case of emergency? _____

Relationship _____ Phone: _____

If we need to call you, can we leave a message? Yes ____ No ____

Do you smoke cigarettes? Yes ____ No ____ Use other tobacco products? Yes ____ No ____

Do you use alcohol? Yes ____ No ____ Use other psychoactive drugs? Yes ____ No ____

What do you estimate your average caffeine intake is? _____

Have you ever been in trouble with the law? ____ Yes ____ No

Are you presently involved in any litigation? ____ Yes ____ No

Please List any health problems you have: _____

_____ H

Have any of your family members experienced emotional problems? ____ Yes ____ No

If "Yes", who and what type of problem? _____

What is the reason for your current appointment here? _____

What would you like to accomplish from your appointment or treatment here? _____

Please list any specific questions you have for us:

Thank you for taking the time to complete this form. It helps us make the best use of our session time.

**Richard Born PhD LLC
One Huntington Rd #205
Athens, Georgia 30606**

**INFORMATION, AUTHORIZATION, &
CONSENT TO TELEMENTAL HEALTH**

“TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. . . .” (Excerpt from Georgia Code 135-11-.01)

The Different Forms of Technology-Assisted Media Explained

Video Conferencing (VC)

Video Conferencing is a preferred option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. I use a secure site named Doxy.me. This VC platform is encrypted to the federal standard (HIPAA compatible) and thus assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely.

Landline Telephones and Cell phones:

Landline and cell telephones are not completely secure and confidential. It is possible that someone could overhear your conversation or see your telephone bill. Individuals who have access to your cell phone may be able to see who you have talked to, who initiated that call, how long the call was, and where each party was located. However, most people have and utilize a cell phone. I may also use a cell phone to contact you. I do not keep your phone number in my phone.

Text Messaging and Email:

Many people prefer to use these methods to communicate because they are convenient for conveying information. However, they are not private and risk compromising confidentiality. I recommend that you refrain from communicating therapeutic content or clinical information via these means to prevent compromising your confidentiality. They may be used for appointment scheduling.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

I do not use social media to provide TeleMental Health services . It is my policy not to accept "friend" or "connection" requests from any current or former patients on my personal social networking sites because it may compromise your confidentiality and blur the boundaries of our relationship.

Confidentiality & TeleMental Health

Just like in-person visits, the Confidentiality and Privacy of Information concerning you and your TeleMental Health visits is of primary importance. It is your responsibility to ensure that you are using secure technology and are at a secure location for the interaction. All of your interactions with me are considered privileged and confidential. Information regarding your evaluation and treatment here can be released only with your explicit authorization. The only exception is in situations where information is shared regarding potential child or elder abuse, in which cases I am legally obligated to file a report with DFCS. If you do wish to authorize release of information regarding your care here, you can complete the Authorization for Release of Information form found on the Patient Forms page of my website: <https://appliedpsychhealth.com>.

Communication with the Office

Judy is at the front desk from 12 pm till 5 pm Monday – Thursday. If you are not able to reach us you can leave a voicemail and we will return your call within 24 hours. After hours, on weekends, and during Holiday breaks all phone calls coming to the office number go into voicemail that I monitor. Unless there is a critical need, I may not respond to voicemails, texts, or emails until the next work day.

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225 or other 24 hour crisis hotline in your area
- Call the Advantage Behavioral Health Crisis Center direct line: 706.583.7307 located at 240 Mitchell Bridge Road in Athens. This is a Walk-in Center open 24/7 that provides Temporary Observation and Crisis Stabilization Services Call 911.
- Go to the emergency room of your choice. In Athens this is either St. Mary's Hospital, 1230 Baxter St. or Piedmont Athens Regional Hospital, 1199 Prince Avenue in Athens.

Emergency Procedures Specific to TeleMental Health Services

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and TeleMental Health services are not appropriate.
- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here Name: _____ Phone: _____

- You agree to inform me of your location at the beginning of every TeleMental Health session.

In Case of Technology Failure

In the event that the TeleMental Health session is interrupted due to technological problems, efforts will be made to restart the connection. The secondary option would be to use telephone.

Structure and Cost of Sessions

The structure and cost of TeleMental Health sessions are the same as face-to-face sessions described in my general "Information, Authorization, and Consent to Treatment" form. I may require a credit card ahead of time for TeleMental Health therapy for ease of billing. Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, most insurance companies currently cover TeleMental Health services at the same rate as in person services.

Cancellation Policy

In the event that you are unable to keep either a TeleMental Health appointment, we ask that you notify us at least 24 hours in advance. If such advance notice is not received, you may be subject to a \$50.00 late cancellation fee. Please note that insurance companies do not reimburse for missed sessions.

Consent to TeleMental Health Services

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the TeleMental Health methods discussed.

Patient (Please Print)

Patient Signature

Date: _____

SYMPTOM CHECKLIST

Richard Born Ph.D. LLC
One Huntington Rd. #205
Athens, GA 30606 Applied

Phone: 706.543.7605
FAX: 706.543.2397

NAME: _____ AGE: _____ DATE: _____

The following questions are meant to help your therapist determine the types of difficulties you are experiencing. Please check the boxes to the right of each "problem" which you have experienced in the last month. If you have not experienced a problem listed, check the "None" box. Thanks!

F32.XX	NONE	MINIMAL	MODERATE	SEVERE
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest or pleasure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling slowed down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling guilty or worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent thoughts of death or dying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of harming oneself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F31.XX	None	Minimal	Moderate	Severe
Feeling on top of the world with no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased need for sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being more talkative than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling speeded up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overspending, being sexually overactive, driving too fast. etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Brief "attacks" in which any of the following occur (circle which do)- shortness of breath, choking feeling, dizziness, rapid heart beat, trembling, sweating, nausea, or abdominal distress, feelings of unreality, chest pains, overwhelming feelings of doom or imminent death, fear of going crazy or losing control

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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41.1	None	Minimal	Moderate	Severe
Unrealistic or excessive anxiety and worry about things in your life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension, restlessness and fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling keyed up and on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mind going blank because of anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F42 **None** **Minimal** **Moderate** **Severe**

- Persistent thoughts that you can't get out of your mind.....
- Having problems of hoarding, excessive fears of being exposed to germs, washing hands over and over

F10.XX

- Using a larger amount of a drug or alcohol than intended.....
- Using drugs or alcohol despite arguments from spouse, family and/or friends to stop

F50.X

- Overeating, vomiting or abusing laxatives
- Loss of more than 25 pounds in the past year
- Using food to comfort oneself when sad, angry, anxious

F90.2

- Difficulty in sitting still, not fidgeting
- Being easily distracted
- Difficulty sustaining attention
- Acting without thinking, being impulsive
- Currently being physically abused
- Having an outside force control my thoughts
- Hearing a voice when no one is around
- Knowing special secrets known by no one else
- Having someone read my mind or tamper with my thoughts.

- Being able to control the thoughts of others
- Feeling detached from my mind or body
- Feeling like in a trance or dream state
- Memory lapses or altered states of consciousness unrelated to drug or alcohol use
- Having trouble controlling anger
- Having thoughts of harming other people or property
- Difficulty relating to boy or girlfriend, spouse, or romantic
- Difficulty relating to friends
- Difficulty relating to parents, siblings, family

Has there been some event that has happened in the past three months from which most of your problems result? Yes No

If there are other problems you are experiencing that aren't listed, please give a brief description below:
