EMORY HEALTHCARE

THE EMORY CLINIC, INC.

PLEASE PRINT OR TYPE

## PRE-REGISTRATION INFORMATION

**For Office Use Only:**

| |
|---|
| Medical Record Number: |
| Appointment Date/ Time: |
| Emory Clinic Physician: |

**Have you ever been treated at the Emory Clinic, Emory Univ. Hospital, Crawford Long or Egleston?_____**

### PATIENT INFORMATION:

| | | | | | | |
|---|---|---|---|---|---|---|
| PATIENT NAME | LAST | FIRST | MIDDLE | SOCIAL SECURITY NUMBER | DATE OF BIRTH | SEX |
| MAIDEN NAME | LAST | FIRST | MIDDLE | EMPLOYER | | MARITAL STATUS |
| STREET | | APT | | OCCUPATION | | |
| CITY | | STATE | ZIP | STREET | CITY | |
| HOME PHONE: ( ) | BUSINESS /DAYTIME PHONE: ( ) | | EXT | CELL PHONE: ( ) | STATE | ZIP |
| E-MAIL ADDRESS | | | | | | |

### PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION):

| | | | | | |
|---|---|---|---|---|---|
| LAST | FIRST | MIDDLE | RELATIONSHIP | SOCIAL SECURITY NO. | D.O.B. |
| STREET | APT | | EMPLOYER | OCCUPATION | |
| CITY | STATE | ZIP | STREET | | |
| HOME PHONE: ( ) | BUSINESS/ DAYTIME PHONE: ( ) | | CITY | STATE | ZIP |

### EMERGENCY CONTACT - IF RESIDING AT A DIFFERENT ADDRESS (e.g., Friend or Relative):

| | | | |
|---|---|---|---|
| LAST | FIRST | MIDDLE | RELATIONSHIP |
| STREET | APT | | HOME PHONE: ( ) |
| CITY | STATE | ZIP | BUSINESS/ DAYTIME PHONE: ( ) |

### REFERRING PHYSICIAN

| | | | | |
|---|---|---|---|---|
| LAST | FIRST | MIDDLE | PHONE: ( ) | |
| STREET | CITY | | STATE | ZIP |

### PRIMARY CARE PHYSICIAN

| | | | | |
|---|---|---|---|---|
| LAST | FIRST | MIDDLE | PHONE: ( ) | |
| STREET | CITY | | STATE | ZIP |

**PLEASE COMPLETE REVERSE SIDE**

**- OVER -**

# FINANCIAL INFORMATION

## PLEASE BRING INSURANCE CARDS, REFERRAL FORMS (HMOs, POSs, PPOs), OR AUTHORIZATION TO BILL WORKMAN'S COMPENSATION OR OTHER THIRD PARTY PAYOR.

### PRIMARY INSURANCE:

| PRIMARY INSURANCE CARRIER NAME | | | POLICY# | GROUP# | COPAY | PLAN TYPE(HMO/PPO) |
|---|---|---|---|---|---|---|
| ADDRESS TO MAIL CLAIMS | | | SUBSCRIBER'S NAME/ DATE OF BIRTH | | VERIF. OF BENEFITS PHONE | |
| CITY | STATE | ZIP | SUBSCRIBER'S SOCIAL SECURITY NUMBER | | PRECERTIFICATION PHONE | |
| BEGINNING DATE: | REFERRAL NO. (IF APPLICABLE) | | PRECERTIFICATION NUMBER (IF APPLICABLE) | | PRIMARY CARE PHYSICIAN | |

### SECONDARY INSURANCE:

| PRIMARY INSURANCE CARRIER NAME | | | POLICY# | GROUP# | COPAY | PLAN TYPE(HMO/PPO) |
|---|---|---|---|---|---|---|
| ADDRESS TO MAIL CLAIMS | | | SUBSCRIBER'S NAME/ DATE OF BIRTH | | VERIF. OF BENEFITS PHONE | |
| CITY | STATE | ZIP | SUBSCRIBER'S SOCIAL SECURITY NUMBER | | PRECERTIFICATION PHONE | |
| BEGINNING DATE: | REFERRAL NO. (IF APPLICABLE) | | PRECERTIFICATION NUMBER (IF APPLICABLE) | | PRIMARY CARE PHYSICIAN | |

### IS THIS VISIT DUE TO A WORK RELATED CONDITION?_____
### WILL YOU BE USING WORKER'S COMPENSATION INSURANCE?_____

| EMPLOYER | | | WORK COMP INSURANCE COMPANY NAME | | | ADJUSTOR NAME |
|---|---|---|---|---|---|---|
| STREET | | | STREET | | | DATE/ DESCRIPTION OF INJURY |
| CITY | STATE | ZIP | CITY | STATE | ZIP | W/C POLICY NO. |
| PHONE TO VERIFY W/C<br>( ) | | | W/C INSURANCE PHONE<br>( ) | | | CLAIM NO. |

### 1. FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by Emory Clinic physicians,unless the services are deemed "paid in full" as a result of a contractual agreement between The Emory Clinic and my insurer.

### 2. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize The Emory Clinic to release any medical, psychiatric, infectious disease (including AIDS confidential information) or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills releted to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiretion date except to the extent that action haa been taken in reliance hereon.

### 3. GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to The Emory Clinic, the surgical and/or medical benefits. If any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to the Clinic for charges not covered by this agreement.

### 4. MEDICARE, CLAIM AUTHORIZATION AND PAYMENT REQUEST

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurence benefits either to myself or to the party who accepts assignment. Ragulations pertaining to Medicare assigment of benefits apply.

**Signature:**_____ **Date:** _____

EMORY HEALTHCARE

EMORY UNIVERSITY HOSPITAL
THE EMORY CLINIC
EMORY CRAWFORD LONG HOSPITAL
EMORY CHILDREN'S CENTER
WESLEY WOODS GERIATRIC HOSPITAL
BUDD TERRACE
DIALYSIS ACCESS CENTER OF ATLANTA
EMORY MEDICAL AFFILIATES

# Admission/Registration Agreement

USE THIS AREA FOR STAMP OR LABEL WITH PATIENT INFORMATION

I. **CONSENT FOR TREATMENT:** I consent to such routine diagnostic and treatment procedures/examinations and laboratory procedures considered reasonably necessary for the care and treatment of my condition during my admission to an Emory Healthcare Hospital or my outpatient care at an Emory Healthcare facility. I understand that diagnostic and treatment procedures involving material risks will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives and prognosis before allowing the procedures to be performed. I understand that Emory Healthcare's mission includes training physicians and other medical personnel and conducting medical research. I acknowledge that students may participate in my care. If I am asked to participate in a research study, I may refuse to participate and my refusal will not affect or compromise my access to medical services.

II. **INDEPENDENT CONTRACTORS:** I understand that some of the health care professionals providing care, treatment and services at the Emory Healthcare Hospitals or facilities are independent contractors, and are not agents or employees of the Hospitals or Emory Healthcare. Independent contractors are responsible for their own actions and neither the Hospitals nor Emory Healthcare shall be liable for the acts or omissions of any such independent contractors.

III. **ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT AND APPOINTMENT OF REPRESENTATIVE:** If I am entitled to benefits under the Medicare program, the Medicaid program, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for admission to and for services provided to me by an Emory Healthcare facility, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered during my admission to the Emory Healthcare facilities that provide services to me. I authorize payment of benefits directly to such Emory Healthcare facilities, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, not precertified or not preauthorized by my insurance plan.**

If my health care benefits are provided under a self-funded plan under the Employee Retirement Income Security Act - (ERISA), in order to assist me in obtaining my benefits: I authorize and appoint Emory Healthcare to act as my representative, when Emory Healthcare consents in writing to so act, in appealing any adverse benefit determination and to receive notices on my behalf with respect to same. I agree that I will comply with procedures established by my benefit plan relating to this authorization, if any.

IV. **PERSONAL VALUABLES:** I understand that Emory Healthcare Hospitals and Budd Terrace maintain a safe for patient money and valuables and that neither the Hospitals *nor* Budd Terrace nor any Emory Healthcare facility shall be legally responsible for the loss of or damage to any money, jewelry, glasses, hearing aids, dentures, documents or other articles of value, unless deposited with Emory Healthcare staff for safekeeping.

V. **CONSENT FOR DISCLOSURE OF INFORMATION:** I understand the Emory Healthcare facilities are permitted to disclose protected health information about me for purposes of payment, my continued care or treatment, and healthcare operations. If my protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse and/or mental illness, I hereby consent to the disclosure of this information by the Emory Healthcare facilities only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I understand this consent permits release of the identified information to any insurance company, healthcare plan or any other person or entity financially responsible for my treatment if necessary for purposes related to filing a claim for payment, or, if I am being evaluated for a transplant, for purposes of determining eligibility, and to my referring physician and any health care practitioner, nursing home, health care facility, ambulance service, home health agency, government or private agency which may provide medical, mental health, rehabilitation, social or related services to me during or upon my discharge or transfer from an Emory Healthcare facility.

I understand my consent to disclosure of information related to treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse, or mental illness is valid until all bills related to my treatment have been paid and utilization and/or quality assessment have been completed. I further understand I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

VI. **AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION:** I agree that any claim or dispute arising out of or related to the provision of health care services to me by Emory University, Inc. d/b/a Emory University Hospital and Emory Crawford Long Hospital; The Emory Clinic, Inc.(and the Ambulatory Surgery Center); Emory Healthcare, Inc.; Emory Children's Center, Inc.; Wesley Woods Center of Emory University, Inc., or their employees or agents ("Emory"), except as otherwise provided herein, shall be resolved by final and binding arbitration. I agree that this provision is governed by the terms of the Federal Arbitration Act. I understand and agree that this agreement includes and encompasses any claims arising out of or relating to health care services which shall be provided to me upon this admission as well as all health care services provided to me by Emory in the future, provided, however, that this agreement does not include and encompass any claim or dispute by either party arising out of or related to the billing or payment for health care services. I understand and agree that by agreeing to arbitrate, I am waiving my right to a jury trial (if otherwise available). I understand that this agreement is also binding on any individual or entity claiming by or through me or on my behalf. I understand that this agreement is voluntary and is not a precondition to receiving health care services. The arbitration of any claim or dispute hereunder shall be conducted in the State of Georgia in accordance with the Rules and Procedures of Henning Arbitration and Mediation Services, Inc., a copy of which is available to me upon request . I understand that I have the right to revoke this agreement no later than ten (10) days following signature and that, if I choose to revoke, I must request and execute a revocation form within this time period.

**NOTE:** If the individual signing this agreement is doing so on behalf of his or her minor child or any other person for whom he or she is legally responsible, the signature below affirms that he or she has the authority or obligation to contract with Emory for the provision of health care services to that minor child or other person, and that his or her execution of this agreement is in furtherance of that authority or obligation.

DATE:_____ _____

PATIENT, PARENT, GUARDIAN OR
AUTHORIZED REPRESENTATIVE

VII. **PHOTOGRAPHS, VIDEOTAPES, AND RECORDINGS:** I understand that the physicians or staff at certain of the Emory Healthcare facilities may request to take photographs, videotapes or other recordings of me for purposes of ensuring proper patient identification or for medical documentation, care or treatment purposes, and I consent to being photographed, videotaped, or recorded for these purposes. I further acknowledge that such photographs, videotapes, recordings, and related information may be used for internal operations purposes of Emory Healthcare, including, but not limited to medical education, training programs, quality assessment and improvement activities, outcomes evaluation, case management, and related functions that do not include treatment. I understand that such photographs, videotapes and recordings will be maintained in a secure manner and will not be disclosed for external use, except upon written authorization from me or my authorized representative or as required or permitted by law.

VIII. **HOSPITAL PATIENT DIRECTORY:** If I am a hospital patient, I understand the following information will be included in the Hospital Directory – my Name, my Room Number/Location, my General Condition such as Fair, Stable or Critical, and my Religious Affiliation (if expressed). I understand that my location in the hospital and my general condition will be provided to persons who inquire about me by name, and that my religious affiliation along with the other directory information will be provided to members of the clergy who request information on patients based on their religious affiliation. Patients in an Emory Healthcare Mental Health Unit are not included in the Hospital Directory.

*If you are a hospital patient and do not want your information included in the Hospital Directory, please check Opt-Out of Hospital Directory below and initial.*

- I Opt Out of the Hospital Directory _____ *(please initial)*

IX. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received the Emory Healthcare Notice of Privacy Practices. _____ *(please initial)*

The date of this Admission Agreement is (insert today's date) _____

_____ _____

Witness Signature of Patient or Patient's Representative

_____

Relationship of Representative to Patient

# Child and Adolescent Mood Program

12 Executive Park Drive NE, Suite 200
Atlanta, GA 30329
Phone: 404.727.3973 Fax: 404.727.3421

**New Patient History:** Today's Date: ___/___/____

Name _____ Date of Birth ___/___/_____ Age _____

Gender: ☐ M ☐ F Patient's Race _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Occupation _____ County: _____

Grade in School: _____ Patient's School (*note if home schooled*): _____

Numbers (H): _____ (C): _____ Other: _____

Reason for Visit _____

**Minor Patient:** Is the patient a minor? ☐ Yes ☐ No
*If yes, please complete the following information regarding patient's primary caretaker(s) (e.g., parents, grandparents, aunts, uncles, foster parents, etc.).*

| | **Caretaker 1** | **Caretaker 2** |
|---|---|---|
| *Name* | | |
| *Relationship to Patient* | | |
| *Address* | | |
| *Phone #s* | | |
| *Occupation* | | |

What is the marital status of the patient's parents? _____

With which caretaker(s) does the patient currently live? _____

Which caretaker(s) has legal rights for the patient? _____

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

_____

**Patient's Current Psychiatric Status:**

Is the patient currently seeing a psychiatrist and/or therapist? ☐ Yes ☐ No

**Name**: _____

Location: _____

How Long: _____

**Name**: _____

Location: _____

How Long: _____

**Psychiatric History:**

**Previous Outpatient Psychiatric Treatment**: Where and when? For what period of time?

_____

_____

_____

_____

**Previous Psychiatric Hospitalizations**: Where and when? For what period of time?

_____

_____

_____

_____

Does the patient have any history of suicide attempts or self injury? ☐ Yes ☐ No

***If yes***, please provide additional details below.

_____

_____

_____

_____

Does the patient have any history of violence or harm to others? ☐ Yes ☐ No

***If yes***, please provide additional details below.

_____

_____

_____

_____

**MEDICATIONS**: List **ALL** medications the patient takes regularly (include over the counter meds/herbal supplements).

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list any medications taken in the past 6 months that the patient is no longer taking:

_____

**Review of Symptoms:** *Please place a check (√) by any symptoms experienced recently.*

| | | | |
|---|---|---|---|
| __Sad Mood | __Suicidal Ideation | __Agoraphobia | __Irritability |
| __Tearfulness | __Homicidal Ideation | __Nightmares | __Hyperactive/Impulsive |
| __No Pleasure | __Low Self-esteem | __Flashbacks | __Confused Thinking |
| __No Energy | __Poor Concentration | __Obsessions | __Disorganization |
| __Sleep Disturbance | __Anxiety/Worry | __Compulsions | __Hallucinations |
| __Appetite Disturbance | __Panic Attacks | __Elation/Mania | __Delusions |

## FAMILY HISTORY

☐ *Please check if patient is adopted (if so, complete based on biological history if known)*

Mother: ☐ Living ☐ Deceased-Cause: Age:

Father: ☐ Living ☐ Deceased-Cause: Age:

Siblings: Number living _____ Number deceased _____

Cause(s) of death & age at death _____

**HAVE ANY OF THE PATIENT'S RELATIVES BEEN DIAGNOSED WITH THE FOLLOWING?**
*Please circle all that apply:*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ADD/ADHD | NONE | MOTHER | FATHER | SIBLING: BROTHER/SISTER | GRANDPARENT | OTHER | UNKNOWN |
| ALCOHOLISM/DRUG ABUSE | NONE | MOTHER | FATHER | SIBLING: BROTHER/SISTER | **GRANDPARENT** | OTHER | UNKNOWN |
| ANXIETY | NONE | MOTHER | FATHER | SIBLING: BROTHER/SISTER | **GRANDPARENT** | OTHER | UNKNOWN |
| BIPOLAR DISORDER | NONE | MOTHER | FATHER | SIBLING: BROTHER/SISTER | **GRANDPARENT** | OTHER | UNKNOWN |
| DEPRESSION | NONE | MOTHER | FATHER | SIBLING: BROTHER/SISTER | **GRANDPARENT** | OTHER | UNKNOWN |
| PANIC ATTACKS | NONE | MOTHER | FATHER | SIBLING: BROTHER/SISTER | **GRANDPARENT** | OTHER | UNKNOWN |
| POSTTRAUMATIC STRESS DISORDER | NONE | MOTHER | FATHER | SIBLING: BROTHER/SISTER | **GRANDPARENT** | OTHER | UNKNOWN |
| SCHIZOPHRENIA | NONE | MOTHER | FATHER | SIBLING: BROTHER/SISTER | **GRANDPARENT** | OTHER | UNKNOWN |
| SUICIDE ATTEMPT | NONE | MOTHER | FATHER | SIBLING: BROTHER/SISTER | **GRANDPARENT** | OTHER | UNKNOWN |
| VIOLENCE | NONE | MOTHER | FATHER | SIBLING: BROTHER/SISTER | **GRANDPARENT** | OTHER | UNKNOWN |

# Psychiatrist Supplement

Child and Adolescent Mood Program
12 Executive Park Drive NE, Suite 200
Atlanta, GA 30329
Phone: 404.727.3973 Fax: 404.727.3421

**Patient Information:**

Name _____ Today's Date: _____/_____/_____

Date of Birth _____/_____/_____ Age _____

Race: _____ Gender: ☐ M ☐ F

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

## Medical and Surgical History

List previous surgeries and dates:

1. _____
2. _____
3. _____

List significant illnesses and dates:

1. _____
2. _____
3. _____

*Please indicate if the patient currently has or has ever had the following:*

| PAST | CURRENT | ILLNESS/DISEASE | | PAST | CURRENT | ILLNESS/DISEASE |
|---|---|---|---|---|---|---|
| | | ADD/ADHD | | | | Heart Murmur |
| | | Anemia | | | | Heart Disease |
| | | Anorexia | | | | High Blood Pressure |
| | | Anxiety | | | | Kidney Disease/Stones |
| | | Arthritis | | | | Liver Disease |
| | | Asthma | | | | Lung Disease |
| | | Anesthesia Reaction | | | | Lupus |
| | | Bipolar Disorder | | | | Migraines/Headaches |
| | | Blood Transfusion | | | | Obesity |
| | | Bowel Problems | | | | Pneumonia |
| | | Blood clot (leg/lungs) | | | | Rheumatic Fever |
| | | Bulimia | | | | Seizures |
| | | Cancer | | | | Stroke |
| | | Depression | | | | Thyroid Disease |
| | | Diabetes | | | | Tuberculosis |
| | | Diverticulitis | | | | Ulcers |
| | | Gallbladder Disease | | | | Urinary Tract Infection |
| | | Gastric Reflux | | | | *Other*: |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Hallucinations | | | | *Other*: |

**ALLERGIES**: List any allergies the patient has to medication, drugs, chemicals or foods.

_____

_____

## GYNECOLOGIC HISTORY (*female patients only)*

Age of first period _____ First day of last menstrual period ____/____/_____

Please list any gynecological issues that the patient has had:

_____

## SEXUAL HISTORY (*You may omit this if you prefer*):

Is the patient currently sexually active? Yes No Has the patient ever had sex? Yes No

Sexual Orientation: Heterosexual Homosexual Bisexual Age of first intercourse

_____

Current method of birth control: _____

Past method(s) of birth control: _____

## SOCIAL HISTORY

Does the patient smoke? Yes No Packs per day? ____ Number of Years ____

Past smoker? Yes No Number of years since patient quit ____

Does the patient drink? Yes No Number of drinks per day ____ # of days per week ____

Does the patient exercise? Yes No Times per week ____ Type _____

Does the patient use other drugs? Yes No *If yes, please list below*

| Substance: | Beginning: | Frequency: |
|---|---|---|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |

**Review of Symptoms:** *Please place a check (√) by any symptoms experienced recently.*

## GENERAL

__Fevers __Headaches __Deafness __Heat/Cold Intolerance
__Recent Weight Gain __Visual Changes __Nosebleeds/Bleeding __Breast Lumps
__Recent Weight Loss __Glasses/Contacts __Night Sweats __Breast Tenderness
__Increased Body Hair __New/changing mole __Rash __Muscle Weakness
__Decreased Body Hair

## LUNGS AND HEART

__Skipped Heartbeat __Palpitations __Swelling of Legs __Awakening short of breath
__Irregular Heartbeat __Chest pain with breathing __Shortness of breath __Coughing up blood
__Difficulty breathing when lying down __Chest discomfort on exertion

## GASTROINTESTINAL

__Nausea/Vomiting __Constipation __Involuntary loss of gas or stool
__Change in Bowel Movements __Diarrhea __Hemorrhoids
__Painful Bowel Movements __Bright blood in stool __Abdominal Pain

## GENITO-URINARY

__Painful Urination __Excessive Urine __Other urinary problems
__Frequent Urination __Frequent Night Urination __Wetting Bed
__Difficulty Holding Urine/Urgency __Change in Color of Urine __Incomplete emptying of urine
__Difficulty Starting Urine __Blood in Urine

Child and Adolescent Mood Program (CAMP)
*A Part of The Emory Clinic Child & Adolescent Psychiatry Section*
12 Executive Park Drive NE, Suite 200, Atlanta, GA 30329
Phone: 404.727.3973 ◆ Fax: 404.727.3421

## CONSENT TO COMMUNICATE VIA EMAIL

The staff at the Child and Adolescent Mood Program (CAMP) understands that email is a very common and convenient method of communication. It is, however, less secure and therefore less confidential than other methods of communication. Because of this, CAMP discourages the use of email for confidential matters. While we understand that this method of communication may be preferable, some clinicians prefer not to communicate electronically. If you would like to communicate with your clinician via email, please discuss this option with your clinician and get his or her permission to do so. By signing below, you are indicating that you would like to use email to communicate with your clinician for non-clinical matters (e.g., scheduling) and that you understand the limits of email communication. Again, emailing for clinical purposes is strongly discouraged.

**PLEASE SELECT ONE OPTION AND CHECK THE APPROPRIATE BOX:**

☐ OPTION 1

I, _____, understand that communication via email is not secure and may result in a breach of my confidentiality. I do, however, consent to confidential communication via email with my clinician and will only email my clinician if I have his or her permission.

*Please write up to two email addresses you will use to communicate with CAMP:*

(1) _____ (2) _____

☐ OPTION 2

I, _____, do not want to be contacted via email, and I will not contact my clinician via email.

**Patient Name**: _____

_____ Date:_____

Signature of Patient or Legal Representative

**Emory Child and Adolescent Mood Program**
*A Part of The Emory Clinic Child & Adolescent Psychiatry Section*
12 Executive Park Drive, Suite 200
Atlanta, GA 30329
Phone: 404-727-3973 Fax: 404.727.3421

# CONSENT TO VIDEOTAPE

I, _____, consent for the staff, employees, agents, or representatives of the Emory Child and Adolescent Mood Program (CAMP) to videotape record my group skills training sessions and/or assessment sessions. I understand that the videotape recording may contain details about my current or past medical or mental health condition(s). I understand that these videotapes will be used to provide clinical care as well as for training purposes, including the teaching of students or practitioners who are learning or working to improve their skills in conducting group psychotherapy.

I hereby waive any privilege that might otherwise apply to any information concerning my child captured in the videotape recording consent above, including any privilege(s) relating to treatment of physical or mental illness, chemical dependency or alcohol abuse, or testing or treatment of for any communicable or infectious disease, such as acquired immunodeficiency syndrome (AIDS), immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis (TB) or hepatitis.

I may revoke this consent in writing except to the extent any action has already been taken based on it. Revocation must be made in writing and sent to Dr. W. Edward Craighead, Ph.D. at the above address.

I further understand that these videotapes will be kept in locked cabinets when not in use and that these tapes are the property of the Emory CAMP. Please note that we are not able to make copies of these videotapes for personal use.

_____ Date:_____
Participant Name (print)

_____
Participant Signature

_____ Date:_____
Witness Signature

**Attachment:** A

## MEMORANDUM OF UNDERSTANDING FOR MISSED APPOINTMENT CHARGES

Date _____

I, _____ (Print Name), understand and agree that I will be billed for any missed appointments or appointments cancelled within 24 business hours of my scheduled visit in the amount of $50 per incident. I understand such charges are my responsibility and not the responsibility of my insurance provider.

If I do not authorize the use of a credit card below, I understand that it is my responsibility to pay the cancellation fee within 30 days.

These charges do not apply if Medicare or Medicaid is my primary insurance.

_____ _____
Signature of Patient Date

---

I authorize The Emory Clinic, Inc. to keep my signature on file and to charge my Visa/MasterCard/Amex/Discover account for the above-referenced charges for psychiatric appointments that I miss or cancel upon less than 24 hours notice. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

_____
Patient Name

_____
Cardholder Name

_____
Cardholder Address

_____
Cardholder City/State/Zip

_____ _____
Charge Account Number Expiration Date

_____
Cardholder Signature

# PRESCRIPTION REFILLS


To be sure you get refills when you need them, please review the CAMP **prescription refill policy.**

**Verbal** (over the phone) refills will require notice of:

3 business days

**Written** (pick up) refills will require notice of:

5 business days

**Please note** that all written prescriptions must be picked up during business hours. It is clinic policy that we do not mail prescriptions.

Please plan ahead accordingly for all future refills so that we can make sure you get your prescriptions when you need them. Be advised that in order to get a refill, you need to keep your follow-up appointments. Due to regulations, the doctor may refuse to refill the prescription without following treatment plan.

Print Patient's Name: _____

Patient's Signature (18yrs. or older):_____

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

**Thank you for your cooperation**

**CAMP**

Child and Adolescent Mood Program