BIRD & BIRD CONSULTING, INC.
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ADULT NEW PATIENT FORM & CONSENT FOR TREATMENT

Name _____ Date of Birth:___/____/____Age:_____

Home Phone: (____)_____Work Phone: (____)_____Cell Phone: (____)_____

May I leave a message at your home #? Y N Work #? Y N Cell #? Y N

Address: _____City_____Zip_____

May I send correspondence to this address? Y N

Email Address:_____@_____

Employer: _____ Occupation:_____

Religious Affiliation _____Church/Synagogue_____Active? Y N

Marital Status*:* (Circle One) Single Married Separated Divorced Widowed If Married, # of Yrs_____

Spouse's Name _____Date of Birth ____/____/_____Age_____

Occupation_____

Please List Children's Names and Ages

_____ _____ _____

_____ _____ _____

Physical problems that require medication or physical care: _____

_____

Current Medications: _____

Physician: _____ Date of last physical ____/____/_____

Previous Counseling/Therapy? Yes No If yes, when? _____

Where and with whom? _____

Does anyone in your family have any history of mental illness (such as depression, anxiety, substance abuse, etc.)? If so, please list_____

Have you ever been given a psychiatric diagnosis? Y N If so, please indicate_____

	Poor				Excellent
How is your physical health?	1	2	3	4	5
How do you sleep at night?	1	2	3	4	5
How is your nutrition?	1	2	3	4	5
How is your mental health?	1	2	3	4	5

Do you drink alcohol? Yes No How much? _____
Do you smoke pot or use other recreation drugs? Yes No Comments_____

In the following list, place a check mark next to each item that identifies an area of concern to you.

_____ Anger/temper
_____ Depression
_____ Education
_____ Family problems
_____ Fearfulness
_____ Marital problems
_____ Physical problems
_____ Problems with social relationships
_____ Problems with children
_____ Religious/spiritual concerns
_____Sexual concerns
_____ Thoughts of suicide/attempt
_____ Trouble making decisions
_____ Unhappy most of the time
_____ Use of alcohol/drugs
_____ Eating disorder
_____ Work or career
_____ Anxiety or worry
_____ Legal problems
_____ Other (specify):_____

In your own words, briefly describe the main problem that prompted you to seek counseling at this time:

_____

_____

_____

_____

_____

What would you like to achieve from your sessions?_____

_____

_____

_____

How did you hear about us?_____

May I send this individual a thank you note for referring you to my office? Yes No
(This will not contain any confidential information regarding your treatment).

GENERAL INFORMATION AND OFFICE POLICIES

CANCELLATION POLICY: A missed appointment is a loss for everyone. We request the courtesy of a **Full 24 hour** notice and so that you will not be charged. If you can give us more than 24 hours we always appreciate it as it gives us more time to offer the time to someone else. To be clear, a **Full 24 hour notice** means that if you have an appointment at 2:00 pm on Tuesday, you must call before 2:00 pm on Monday to cancel. A call after 2:00 pm Monday would be considered a late cancellation and you will be charged for the time.

PAYMENT: Payment is expected at the time of each appointment. If you become an ongoing patient and will be paying by check each week, please have your check written out in advance of your sessions. We accept checks, cash, Amex, Visa and MC. Returned checks will incur a $30.00 service charge. Any monies owed and not paid may be sent for collection and collection costs will be added. A $35.00 late fee is added for every 30 days your account is past due.

INSURANCE REIMBURSEMENT: You will need to file your own insurance claims, as we are not a provider for any insurance plans. If you request it, we will give you a claim form after each session that you may submit to your insurance company for *possible* reimbursement. It is your responsibility to call your insurance company to inquire about your mental health benefits and verify coverage. You are responsible for full payment of fees whether or not your insurance company reimburses you.

If you elect to use your insurance, please be aware that they will ask us to provide a psychiatric diagnosis in order to process your claim. Sometimes this also requires completion of a treatment plan or summary of our work together. Unfortunately, once we provide them with this information, we have no control over what happens to it. This information becomes part of the insurance company files and your insurance company may send it to a national medical information data bank, which may ultimately compromise your confidentiality. Your signature on this form indicates your authorization to release information to your insurance carrier. ***You always have the right to pay for our services yourself and, thereby, avoid communicating with your insurance company altogether. Many of our patients have chosen to do this.***

CONFIDENTIALITY: All communications between a patient and therapist will be held in confidence and will not be revealed to anyone unless authorized ***in writing*** by you or for the following ***exceptions*:** We are required by law to report reasonable suspicion of child/elder abuse or threats of physical harm to self or others. This may include filing a report with the appropriate state agency, contacting family members or others who can help, or notifying potential victims or the police. If we receive a court order to release information, we must comply. Please note that these circumstances occur very rarely and should such a situation arise, we would make every effort to discuss it with you before taking any action. Therapists often find it helpful to consult with other professionals and we are members of a professional monthly consultation group. In these consultations, we avoid giving names or details that would reveal the identity of our patients. The consultant, is, of course, also legally bound to keep the information confidential.

CONTACTING US: You may leave a confidential voice mail 24 hours a day at **770-992-5100.** We check for messages on a regular basis but we do not carry pagers. If you are calling after hours, on the weekend or a holiday, it may be the next business day before we return your call. ***Therefore, in a serious or life-threatening emergency you should call 911 or go to your nearest hospital emergency room.***

YOUR SIGNATURE INDICATES THAT YOU HAVE READ, UNDERSTOOD AND AGREE WITH THESE POLICIES.

I accept responsibility for payment of services rendered by Dr. William Bird or Dr. Beverly Bird. I understand that I, not my insurance company, am responsible for fees, including those not covered or reimbursable by my insurance company. I agree to pay, if necessary, all costs of collection of this account. If my account is sent to a collection agency I waive my right to confidentiality. I understand that my appointment time is reserved for me and there will be a charge for appointments broken or cancelled with less than 24 hours notice. I have read and understood Dr. Bird's office policies.

Signature of Patient:_____Date:____/____/_____