PIEDMONT PSYCHIATRIC SERVICES

2094 Woodruff Rd. Greenville, SC 29607

Tony R. Goodbar, MD
Jeffrey K. Smith, MD
Joseph A. Friddle, PA-C
Carrie L. Ballenger, PMHNP
Sydney Broxton, PMHNP

Michael D. Smith, MA, LPC
Ingrid L. Miller, MSW, LISW-CP
Zach Adams, LISW-CP

Welcome to Piedmont Psychiatric Services. _____has an appointment with _____on_____at _____.

OFFICE HOURS

- *Our office hours are from 8:00 am – 4:00 pm Mon-Thurs. Our office is closed on Fridays.*

APPOINTMENTS

- *Appointments may be scheduled by calling our appointment line at **864-676-9211 ext.125 or email at** **appointments@piedmontpsych.com** **between the hours of 8 am-4 pm Mon-Thurs.***

PATIENT CONCERNS/QUESTIONS

- *Patients of **Dr. Smith, Joey Friddle and Sydney Broxton** contact their assistant **Niki** at **physicians@piedmontpsych.com** or phone 864-676-9211 ext. 140.*
- *Patients of **Dr. Goodbar and Carrie Ballenger** contact their assistant **Revonda** at **revonda@piedmontpsych.com** or phone 864-676-9211 ext. 138.*
- *For **Therapists** contact **appointments@piedmontpsych.com** or phone 864-676-9211 ext. 125.*
- *After hours calls/weekends are for **emergencies** only. In this case, calls are taken by the answering service and then forwarded to the physician on call. There is a $30 charge for after hour calls.*

MEDICATIONS/REFILLS

- *Medication refills can be obtained during office visits or by calling/emailing the medical assistants with your specific request and pharmacy number. No controlled medications are sent in after hours or weekends.*

CORRESPONDENCES/FORMS

- *Requests for Medical Records dictated letters, and forms (i.e., disability, return to work statements, etc.) can be obtained for a variable charge. Contact **Terri** at **triddle@piedmontpsych.com** or phone 676-9211 ext. 126.*

BILLING/INSURANCE

- *Mon-Thurs. 8:00am-4:00 pm at 1-855-558-4649. We submit claims for up to 2 insurances. Any payments not made at the time of service, will incur a $15 non-payment fee and no scheduled appointment.*

Assignment of Insurance Release

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and is not a substitute for payment. Some companies will pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's ultimate responsibility to pay any deductible amount, co-insurance, or any other balances not paid for by your insurance company. If we are filing your claim, we will allow forty-five days from the billing date for the carrier to process your claim and make payment accordingly. If payment from your insurance company is not received within the time frame specified above, we will notify you to clear your account. Filing to the insurance company is only done as a courtesy to the patient. I certify that I have read and understand fully the provider's billing policy and agree to make payment in full and /or satisfactory arrangements when asked to do so as specified above.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and other health plans. This assignment applies to all charges outstanding as of the date of signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether paid or not by the insurance carrier. I hereby authorize said assignee to release all information necessary to secure payment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

Our patient "Bill of Rights" and "Notice of Privacy Policies" are posted in the lobby of the office. We strongly encourage you to review these notices completely and ask any questions on areas that you do not understand. It is your responsibility to know and abide by both policies.

Signature_____ Date_____

Parent (if minor) _____Date_____

I have read the information stated above and agree with the policies and procedures as presented.

Signed_____ Date_____

Consent to Examination and Treatment

I consent to have Piedmont Psychiatric Services including its professional staff perform/order examination(s), psychotherapy, related mental health treatments, and order/refill medications when deemed necessary. I also understand that Piedmont Psychiatric Services is a ''learning facility" and a student may be present at my appointment.

Signature_____ Date_____

Patient Information

Patient name: First_____Middle_____Last _____

Birth Sex: M or F SS#_____ Marital Status: S M D W DOB_____

Race (Please Circle): American Indian/Alaska Native Asian Black/Africa American Asian White Unknown/Declined

Ethnic Group: (Please circle): Hispanic or Latino Not Hispanic or Latino Declined

Preferred Language: _____

Address_____ Zip_____ City_____ State_____

Home# (_____) _____Cell# (_____) _____Preferred Contact Method: Home or Cell

E-mail_____

Responsible Party Information

****(Parent, Guardian, Power of Attorney) if any information is the same as above, please indicate by writing "same" in appropriate section.***

Relationship to patient: Self Spouse Parent Other

Name: First_____ Middle_____Last _____

Mailing Address _____ City, State, Zip Code_____

Home Telephone ( )_____ Driver's License #_____

Social Security Number _____ Date of Birth_____

Employer_____ Telephone ( )_____

Employer's Address_____ Occupation _____

E-mail_____

Please complete if the patient is under the age of 18

Father's Name: _____ M.I____ Last_____ DOB_____

Mother's Name: _____M. I ____Last _____DOB_____

Father's SSN_____ Mother's SSN _____Legal Guardian_____

Release of Confidential Medical Information (HIPPA)

Patient Name_____ Date of Birth_____

_____ I agree and consent that my current treatment notes be released to the following medical provider(s):

_____ I do not allow my current treatment notes be released to any medical provider(s).

Physician: _____
Name of doctor/or practice name Phone/Fax#

Physician: _____
Name of doctor/or practice name Phone/Fax#

I AGREE AND CONSENT THAT THE FOLLOWING FAMILY MEMBERS, SPOUSE or OTHER INDIVDUAL:

_____
Name Relationship to patient

_____
Name Relationship to patient

_____
Name Relationship to patient

MAY receive the following information:

____ Insurance & Billing
____ Appointment Date & Time
____ Discuss Treatment Plans (ex: medication)
____ All of the above
____ I do not wish to release any of my medical information to any individual.

I understand that I may revoke this consent at any time except to the extent that action has been taken based on this authorization. I also understand that this authorization shall not expire unless I revoke it in writing.

_____ _____
Signature of patient or Legal Guardian Date

_____ _____
Witness Date

If this release pertains to alcohol or drug abuse information, please note that: This information is protected by federal law. Federal regulation (42c F.R. Part 2) prohibits you from making further disclosure of it without specific written consent of the patient whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Mental Health Checklist

Name _____ ***Age*** _____ ***Marital Status*** _____

Educational Level _____

Employment Status/Occupation _____

Name of Referring Physician or Therapist _____

	Yes	***No***
Cannot Sleep		
Sleeping Too Much		
Loss of Appetite		
Recent Weight Loss		
Increased Appetite		
Recent Weight Gain		
Loss of Energy		
Loss of Motivation		
Loss of Interest in Pleasurable Activities		
Decreased Interest in Sex		
Difficulty Concentrating		
Feelings of Hopelessness		
Suicidal Thoughts		
Frequent Crying Spells		
Too Much Energy		
Racing Thoughts		
Periods of Quick Anger or Agitation		
Periods of Excitement of Elation		
Overspending Money		
Anxiety Attacks		
Recurrent of Repetitive Thoughts or Worries		
Repetitive Behaviors or Rituals		
Hearing Voices		
Seeing Things that Others Do Not See		

Paranoid Feelings of Suspiciousness		

Areas of Stress

Problems with Primary Family: _____

_____

Occupational/Work Problems: _____

_____

Financial Problems: _____

_____

How Much Alcohol do you Drink? _____

Is There Anyone in Your Family with a History of Psychiatric Problems or Treatment?

_____

General Information

Have you previously received psychiatric treatment? _____

_____

Please list all Current Medications: _____

_____

_____

Please list any allergic and/or adverse reactions to medications: _____

_____

_____

Please list active medical problems: _____

_____

Controlled Medication Agreement

Patient Name (please print): _____

Should the providers of Piedmont Psychiatric Services, P.A. and I decide that a controlled medication is the appropriate course of treatment, I understand that I will be required to abide by the following policies:

- I will take all medications as prescribed. I understand that the controlled medication will be prescribed ONLY by Piedmont Psychiatric Services, P. A. and ONLY according to the agreed upon schedule.
- Prescription refills for the above medications will be provided only during regularly scheduled business hours and never on weekends, holidays, or after hours.
- I understand that lost or stolen medications will not be filled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children and animals.
- Should I require anxiety medications, I will not take any sedative, alcohol, or pain medications without the approval of my psychiatrist. I will not seek or accept any medication for anxiety other than those prescribed by Piedmont Psychiatric Services, P. A. "Medications for anxiety" include prescriptions from other doctors, medications borrowed or accepted from family and friends and any illicit or street drugs.
- I understand that Piedmont Psychiatric Services, P. A. is under no obligation to provide these medications to me and that we reserve the right to discontinue these medications at any time. At my psychiatrist's discretion, I agree to cooperate with random drug testing which may be required at any time. If I refuse, I understand the medication will be discontinued and I may be discharged from this practice.
- I agree to obtain anxiety medications from only one provider. I will not give, sell or in any way distribute prescribed medications to any other person (s). I will not, in any way, attempt to forge or alter a prescription.
- I agree to fill prescriptions for controlled substances at the pharmacy I list below. If I change pharmacies, I will need to contact Piedmont Psychiatric Services, P. A. and provide them with the name, address, and phone number of the new pharmacy.

Under no circumstance will I obtain medications for controlled substances from more than one pharmacy or Physician at a time.

Pharmacy Name_____
Pharmacy Address_____
Pharmacy Telephone_____

I understand that by signing this agreement, I must abide by the rules above and that failure to abide by this agreement will result in termination of services from Piedmont Psychiatry.

Patient
Signature_____Date_____

****AGREEMENT MUST BE SIGNED OR NO CONTROLLED MEDICATIONS WILL BE GIVEN****

PIEDMONT PSYCHIATRIC SERVICES PA
2094 WOODRUFF ROAD
GREENVILLE, SC 29607
864-676-9211

TELEHEALTH INFORMED CONSENT

I agree to participate in technology-based health care related visits to exchange healthcare information and treatment with the providers of service at Piedmont Psychiatric Services PA. I understand and authorize information of my medical record to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named provider. It may also mean that my private health information may be transmitted from my providers mobile device to my own or from my device to that of my provider via an application.

I understand that a variety of alternative methods of healthcare may be available to me and that I may choose one or more of these at any time. My healthcare provider has explained the alternatives to my satisfaction.

I represent that I am using my own equipment to communicate and not equipment owned by anyone else. I understand that I can never use my employer's computer or network systems. I understand that any information that I enter into any employer's computer can be considered by the courts to belong to my employer and my privacy may be compromised.

My provider has explained how the telehealth sessions will be performed and how they may differ from in person services.

I understand that telehealth services have potential risks. An example is that the technology could fail before or during the visit. In that case I understand that I will be allowed to call my provider and be connected telephonically to continue my visit.

While security protocols are in place to protect the confidentiality of client information transmitted via electronic channel, I understand that in rare instances, security protocols could fail, causing breach of privacy of personal health information.

I have been informed of any cost differences for services provided in person versus through technology.

Below are the names and telephone numbers of my local emergency contacts:

_____	_____	_____
Name	Relationship	Telephone Number
_____	_____	_____
Name	Relationship	Telephone Number

_____
Patients Printed Name

_____	_____	_____
Signature of Patient or Guardian	Date	Printed Name of Person Signing