ATLANTA BEHAVIORAL MEDICINE, INC

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Mohammad Ahmad, M.D.

REGISTRATION FORM

(Please Print – ALL INFORMATION MUST BE COMPLETED)

PATIENT INFORMATION

Patient's Last Name	First	Middle	Mr / Mrs Ms / Miss	Marital Status (Circle One) Single / Mar / Div / Sep / Wid / Child

Is this your legal name?	If not, What is your legal name?	Maiden Name		Age	DOB	Sex: Male / Female

Home Address	City	State	Zip Code		Social Security #	Home Phone
Mail Address	City	State	Zip Code		Work Phone	Cell Phone

Occupation	Employer/School	Employer/School Address, City, State, Zip Code

Primary Care Physician	Physician Phone	Physician Fax	Physician Address

Condition Due to an Accident? YES / NO Referral Party:

Other Family Members a Patient of this office? YES / NO If Yes, Please provide Patient Name:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Payments	Date of Birth	Mailing Address (if different)	Home Phone

Is this person a patient here? YES / NO	Work Phone	Cell Phone

Occupation	Employer	Employer Address, City, State, Zip Code

Is this Patient covered by insurance? YES / NO

Please Indicate Primary Insurance ____Medicare ____Medicaid ____BCBS ____Humana

____Aetna ____ Magellan BH ____Other_____

Subscriber's name:	Subscriber's S.S #	Birth Date	Group #	Policy #	Copay

Patient's Relationship to Subscriber ____Self ____Spouse _____Child ___Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ____Self ____Spouse _____Child ___Other _____

IN CASE OF EMERGENCY

Name of Nearest Living Relative NOT living with you	Relationship to Patient	Home Phone	Work Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. As a courtesy to me, the patient, Atlanta Behavioral Medicine, Inc. (Dr. Mohammad Ahmad, M.D.) will file insurance claims on my behalf and I understand that I am financially responsible for all changes and balances due to Atlanta Behavioral Medicine, Inc. (Dr. Mohammad Ahmad, M.D.) In any case where my insurance does not pay or cover the services provided by Atlanta Behavioral Medicine, Inc. (Dr. Mohammad Ahmad, M.D.). I also authorize Atlanta Behavioral Medicine, Inc. (Dr. Mohammad Ahmad, M.D.) or insurance company to release any information required to process my claims.

x

Patient/Guardian Signature Date

Atlanta Behavioral Medicine, Inc

Name _____ Age _____ Sex _____

1: Current Hx:

Briefly describe the problem for which you are currently seeking treatment: (use the back page with Q# for extra space)

Circle issues you are having difficulty with:

Sleep Changes	Anxiety	Abuse Issues	Helpless	Tics/Tourette's
Stress	Manis	Parenting Issues	Crying spells	Panic Attack
Violence/Assaultive	Appetite Changes	Delusions	Wishes not wanting	Mood Swings
Agitated	Memory Problems	Poor Concentration	to live	Marital Issues
Hyperactive	Paranoia	Anger	Relationship	Impulse control issues
Behavior Problems	Substance abuse	Depression	Problems	Other: _____
Eating Disorder	Work Problems	Hopeless	Compulsive Behavior	_____

If you are under care of a psychiatrist care Please list the current medication and dosage: (use the back page with Q# for extra space)

_____

2: Past Hx: (Previous Hx, psychiatric, emotional, or behavioral problems and treatment. Previous medications, any medication reactions, any medications which was helpful: (use the back page with Q# for extra space). _____

_____

3: Alcohol/Drug Hx (Circle the following you have used in the past 30 days)

Tobacco	Sleeping Pills	Amphetamine	PCP
Alcohol	Heroin	speed	Ecstasy
Marijuana	Cocaine	Methadone	Inhalants
Tranquilizer	Crack	LSD	Other:

4: Family Hx: (List the relationship and the nature of psychiatric, emotional, behavioral problems, drugs, alcohol or other similar issues in any of your immediate family member: Use the back of this page with Q# for extra space)

_____

_____

_____

5: Medical Hx: (Please list all the medical problems, list any medications you are taking and any medication allergies, any head injuries, seizures, and loss of consciousness, any pain management issues: Use the back page with Q# for extra space)

_____

_____

_____

6: Personal/Legal Hx: (Circle all which apply to your situation) — Current/ Previous legal charges Employed — unemployed — homemaker — disabled — retired — seeking medical leave have paperwork that needs to be completed current student — graduated high school — GED some college — advance degree — current or past probation/parole support network (family, friends, neighbors, religious organization)

_____

_____

_____

Atlanta Behavioral Medicine, Inc

Following charges are not covered by your insurance and payment in full is it required before or at the time of service. **All the adults coming in for ADHD/ADD evaluation will have to take CPT computer test**

Copays	Variable
CPT testing fee (**not covered by Insurance**):	$200
Cancellation without 24 hour of a notice:	$30
Appointment no-show:	$30
FMLA	$50
Other paperwork and letters:	$50 to $250
Returned checks	$25
Hospital homebound	$30
N-648 for immigration	$250
Urine drug screen drug testing (Mandatory for All the adult ADD and Suboxone patients)	$50
Copy of records	$50 administrative fee + .50 cents per page

Miscellaneous policies

24-hour notice is required for any canceled appointment. If the appointment is not canceled there will be a $30 charge for missed appointment.

Please update your insurance information immediately if there's a change in coverage. Please note that you are responsible for the payment. we file insurance for you your convenience only

Bills are sent each month and are due upon receipt if you are unable to make a payment in full please call the billing office at 770-458-1594 to make payment arrangements we have the right to send all the returned checks not paid within 30 days and any other unpaid charges after 60 days to collection

We appreciate your continued association with Atlanta Behavioral Medicine INC.

My signature below indicates that I have read, understood and agree to comply with the ABM INC, s policies mentioned in this document.

Patient/Parent/Guardian_____DOB_____Date_____

Witness_____Date_____

Atlanta Behavioral Medicine, Inc

AGREEMENT

Consent for treatment

I hereby authorize Atlanta Behavioral Medicine INC (ABM INC). to provide (Circle one) me or my dependent _____DOB_____ Psychiatric diagnosis, psychiatry, psychotherapy and such other psych psychiatric services, as required. I understand that I may withdraw my consent for any specific treatment at any anytime. I understand that there is no assurance or guarantee that I will feel better and that in course assessment, treatment and therapy certain medications would be tried and or materials may be discussed, or certain question will be asked and certain remarks may be made, or will I be confronted about certain issues which might be painful or disagree or I might feel negative about, or have negative effects or consequences but according to provider's professional opinion may be necessary for me to help to get better.

Confidentiality

I understand that my health information is private and confidential. ABM Inc. will continue to make an effort to protect the privacy and confidentiality of my personal health information, except in following situations in which my information might be disclosed to third parties

1- if I sign a waiver requesting the release of information to certain person or parties
2- if a court orders the release of my medical records or during the course of other legal proceedings involving my mental status or competency.
3- if there is reason to believe that there is clear and imminent probability that I will seriously harm myself or others
4- if there is evidence or strong suspicion of child abuse
5- if I am using insurance to pay for the services then to handle billing, payment and other administrative issues regarding insurance payments and claims. I understand that insurance will have total and unrestricted access to all of my record available in this office.

I will assist ABM INC by following office procedures to obtain medical records, that is, providing written request to where records are being sent, a reasonable time for completion and copying and paying the charges and information about the communication by the available method of choice.

Authorization of release of information to other healthcare providers

I hear by authorized ABM INC to release and obtain information from other professionals who might have provided services for me I understand that the nature of this communication is solely for the purpose of continuity of my care. this is only to verify therapeutic modalities and their efficacy rather than disclosure of specific issues during the treatment process

My signature below indicates that I have read and understood current copy of ABM Inc. agreement and notice of privacy practices

Patient/Parent/Guardian_____DOB_____Date_____

Witness_____Date_____

Atlanta Behavioral Medicine, Inc

Preferred Email: _____

Pharmacy Name: _____

Address: _____

_____

Phone #: _____

Notice

Effective Immediately

Due to more stringent requirements from the DEA and for your safety, we have implemented a company policy requiring Urine Drug Screens for patients on certain medications as well as new patients.

This policy is for your safety as well as the providers.

Please Sign below to acknowledge you have read and understand this policy

Sign: _____ Date: _____

Atlanta Behavioral Medicine, Inc

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
⑤	⑤	⑤	⑤