COREY
BECK MD
Biologic Behavioral Health
General Adult and Forensic Psychiatry

PATIENT INFORMATION (Please print)

Patient's Legal Name: _____
Preferred Full Name (if different from above): _____

Address:_____ City, State, Zip:_____

Home Phone Number (landline): _____Cell: _____Work:_____

E-Mail Address:_____ Pharmacy Name _____Phone_____

DOB_____ SSN _____ Gender: Female_____ Male _____Other _____

Race:(Please circle one) American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Chose not to disclose Other not listed _____

Ethnicity:(Please circle one) Hispanic or Latino Not Hispanic or Latino Choose not to disclose

Responsible Party Information (If not self)

Guarantor_____ Self_____ Is the address and telephone information the same as the patient? _____

Responsible Party Name_____ DOB_____ Phone_____

Address_____ City, State, Zip_____

Insurance Name_____ Are you the policy holder?_____

Policy Holder's Name_____ DOB_____

Emergency Contact Information

Emergency Contact Name_____ Phone_____

Relationship to patient _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT TO THE PATIENT

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative_____ Date_____

Printed name _____Relationship to patient_____

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PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age: _____ Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Physician initials _____

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PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long? _____

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

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SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y / N At what age?
Do you have regular periods? Y / N

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SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes ☐ No ☐
CANNABIS: Marijuana, hashish, hash oil					Yes ☐ No ☐
STIMULANTS: Cocaine, crack					Yes ☐ No ☐
STIMULANTS: Methamphetamine—speed, ice, crank					Yes ☐ No ☐
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes ☐ No ☐
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes ☐ No ☐
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes ☐ No ☐
HEROIN					Yes ☐ No ☐
STREET OR ILLICIT METHADONE					Yes ☐ No ☐
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes ☐ No ☐
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes ☐ No ☐
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes ☐ No ☐
OTHER: specify)_____ _____ _____					Yes ☐ No ☐

Physician initials _____

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Signature of patient or personal representative_____
Date_____

Printed name _____ Relationship to patient_____

315 W Ponce de Leon Avenue Suite 880
Decatur, GA 30030-1324
P-404-824-1755
F-404-370-1324

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PATIENT NAME_____DATE OF BIRTH_____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

_____ (Patient or Guardian Initials) Financial Agreement. I acknowledge, that as a courtesy, Biologic Behavioral, LLC may bill my insurance company for services provided to me. I agree to pay for services after 60 days that have not been paid or that are not covered, or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. I understand that there is a fee for returned checks.

_____ (Patient or Guardian Initials) Third Party Collection. I acknowledge that Biologic Behavioral, LLC may utilize the services of a third-party business associate or affiliated entity as an extended business office (EBO Servicer") for medical account billing and servicing.

_____ (Patient or Guardian Initials) Assignment of Benefits. I hereby assign to Biologic Behavioral, LLC any insurance or other third-party benefits available for health care services provided to me. I understand Biologic Behavioral, LLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Biologic Behavioral, LLC, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

_____ (Patient or Guardian Initials) Consent to Telephone Calls for Financial Communications. I agree that, in order for Biologic Behavioral, LLC, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Biologic Behavioral, LLC or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Biologic Behavioral, LLC or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

_____ (Patient or Guardian Initials) I agree I have received and fully understand the office policies of Biologic Behavioral Health.

_____ I understand that I am financially responsible for all services provided by Biologic Behavioral LLC. I authorize Biologic Behavioral LLC to submit information needed for claims processing to my medical insurance provider. I am aware that office policy requires payments be made at time of service. I understand that unpaid balances over 30 days may incur a 3% late fee.

_____ (Patient or Guardian Initials) A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse. Guarantor. Parent, Healthcare Power of Attorney, Legal Guardian, Other_____.

315 W Ponce de Leon Ave. Suite 880, Decatur, GA 30030-1755
O-404-824-1755 F-404370-1324

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Card on File: Authorization Form

Information to be completed by cardholder:
The undersigned agrees and authorizes medical practice to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: _____

Patient's Name: _____

Name as it Appears
on the Credit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits of Card: ☐ ☐ ☐ ☐

Expiration Date: _____

I, _____ ~~authorize the~~ above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

_____ _____
Cardholder's Signature Date

kareo
Go Practice

Patient HIPAA Acknowledgement and Consent Form

Patient Name (Printed)_____

MI Date of Birth (MM/DD/YYYY) _____

Notice of Privacy Practices.

_____ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name Relationship Contact Number:

1.

2.

3.

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communication about My Healthcare

I agree the Provider, or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have

provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specially includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature_____

Relationship to Patient (self, parent, legal guardian/representative, etc.) _____

Date_____

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. For us to release a prescription to your family

member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____I do want (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

Name Relationship

_____I do not want (Patient/Representative Initials) to designate anyone to pick up my prescription order.

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OFFICE POLICIES

OFFICE HOURS AND EMERGENCY INFORMATION

Office hours are Monday through Friday, 10AM-6PM. If you have a medical emergency, please call 911 or go to your local emergency room. If you have an urgent question after normal business hours, please call Dr. Beck at 404-395-5025 and leave a message. Otherwise, all routine calls will be answered by the following business day.

PAYMENT POLICY

All patients are required to pay the session fee in full at the time services are rendered. We accept checks, cash and credit cards. We kindly request that you provide your credit card at each visit. We will file claims with insurance companies that we accept, and if insurance does not pay for services rendered within 60 days, you will be responsible for the balance.

APPOINTMENT CHANGES/CANCELLATIONS

Your appointment times are reserved and if you cancel an appointment with less than 24 hours' notice, you will be charged $100. After hours, you may leave notice of cancellation on our voicemail. If for any reason the doctor must cancel an appointment with you, all efforts will be made to notify you as soon as possible. Dr. Beck does not double book patients, your appointment time is reserved just for you. Please allow plenty of time for traffic and parking. If you are more than 10 minutes late, you will likely need to reschedule.

OFFICE PHONE POLICY

Please be aware that our doctors are meeting with patients throughout the day and may not be able to return your phone call until a later time. When leaving a message for your doctor, please leave both daytime and evening telephone numbers. Please note that this is for brief phone calls only and you must schedule a phone appointment for extensive calls.

EXTENSIVE PHONE CALL POLICY

For longer phone calls, you may call the office and schedule a phone appointment with your doctor. There will be a routine charge for phone appointments based on the length of call. Please note that there may be an additional charge for after hour calls, except for life threatening emergencies.

MEDICATION REFILL POLICY

We make every effort during your appointment to provide enough medication to reach your next appointment. However, we are aware that emergencies may arise and appointments may have to be rescheduled for a later date. Medications refills may be requested during regular office hours by calling the office. We will complete medication requests within 24-48 hours from the time of the request. If requesting a stimulant (controlled medication), please call the office for more information. Stimulant medications require a prescription in hand which may be picked up at the office or mailed to your address. There may be a charge of $10- $25 for all refill request when patients are due for an appointment. Prescriptions may only be called in for current patients who maintain their regularly

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scheduled appointments. We encourage patients to pay close attention to your medication supply to ensure that we have enough time to complete each medication request.

REQUEST FOR FORMS OR LETTERS POLICY
We will attempt to complete forms and letters during your office visit. Forms and letters requiring additional time are subject to a $50 preparation fee.

TERMINATION OF TREATMENT
You are under no obligation to continue services and may opt to terminate treatment. Should you decide to discontinue treatment, we strongly urge you to notify the doctor of your decision so that it may be discussed openly. Biologic Behavioral LLC/ Dr. Beck reserves the right to terminate the doctor/patient relationship for reasons including treatment noncompliance, financial delinquency, and abusive behavior.

FINANCIAL GUARANTOR AGREEMENT his agreement will remain in effect until written notice of alternate payment arrangements
are provided to Biologic Behavioral, LLC. The current Guarantor is responsible for any and all charges incurred prior to receipt of notification of other arrangements. If you wish to change Guarantors, please have the newly appointed Guarantor complete a separate Guarantor Agreement with Biologic Behavioral LLC.

Please note we are not in network with any insurance policies purchased on the exchange. We do everything possible to verify that you have in-network benefits, but in the event your insurance rejects or denies claim/s, you are financially responsible.

PLEASE RETAIN THIS PAGE FOR YOUR RECORDS AND RETURN THE SIGNATURE PAGE TO THE OFFICE.

_____ _____
Signature Date