Medication List

Please list any prescription medications you are currently taking, including dosage and prescribing physician.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Directions</th>
<th>Prescribing Physician</th>
</tr>
</thead>
<tbody>
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</table>
WELCOME TO ATLANTA PSYCHIATRY AND PSYCHOTHERAPY ASSOCIATES

The following information will be helpful for your appointment:

Clinic address: 2150 Peachford Road Suite A
               Atlanta, GA 30338

Contact phone: 770-674-0553
Email contact: appa.frontdesk@gmail.com

You are expected to confirm to your appointments.

Please bring with you a list of medications that you are on at present. Please arrive 10-15 minutes before your scheduled visit.

Payment is expected at the time of service. Please be aware that some doctors and/or therapists do not participate in health insurance reimbursements.

Mode of payments accepted: Cash, Check, Credit Card

NO SHOW VISITS ARE CHARGED.

Please call at least 48 hours prior to your visit if you need to reschedule or cancel an appointment to avoid a no-show charge.

Thanks for your attention, and we are looking forward to working with you!

Sincerely,

APPA Staff
INFORMED CONSENT FOR TREATMENT

I, _____________________________ (name of client), agree and consent to participate in behavioral health care services offered and provided by APPA, a behavioral health provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within:

1. The scope of the provider’s license, certification, or training, or

2. The scope of the license, certification, and training of the behavioral health care provider(s) directly supervising the services received by the client, or

3. If the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am able to initiate and consent for treatment and/or legally authorize and consent to treatment on behalf of this individual.

Client’s name: ____________________________________________________________

Client’s Signature: _______________________________________________________

Legal Guardian’s Relationship to Client: ________________________________

Legal Guardian’s Signature: _____________________________________________

Date: ___________________
Cancellation Policy, Missed Appointments, Telephone Calls, & Prescription Refills

Cancellation Policy: Please note that last minute cancellations are considered therapy-interfering behavior. Cancellation with less than 48 hours’ notice will incur a full-fee charge fee unless rescheduled within the same week. Our doctors are committed to your care and would prefer to see you within the same week, rather than charge an empty fee. We will need to know your reason for cancelling, as we need to ensure that our patients are not at risk for self-harm or the harm of others. You will be liable for any incurred fees under our cancellation policy, even in the absence of a reminder call, and fees must be paid before your next visit. Two or more absences for non-therapeutic reasons will be considered therapy-interfering behavior and may result in the termination of therapy.

Telephone calls requested by the patient from the doctor outside of scheduled appointment time may be subject to a fee which is payable at the time of the phone session or the next scheduled appointment.

Requests for refills on prescriptions after a missed appointment will be subject to a $25 fee and will be filled within 48 hours.

Requests for phone calls to insurance providers or pharmacy management companies for prior-authorization will be subject to a $25 fee.

Special typed reports from various entities may be subject to a fee determined by the amount of physician time to complete the report.

Copies of medical records are subject to a minimum copy fee of $15 and additional fees based upon the number of pages requested.

I have read and understand the policies listed above and acknowledge my responsibility to abide by the requirements and expectations set forth.

Client’s Signature: ___________________________________________ Date: ______________

Legal Guardian’s Signature (if applicable): ____________________________________________

Please direct any disputes with this policy to your doctor or therapist.
I, ____________________________, on ______________ (date) authorize APPA to bill my (circle one):

Mastercard   Visa   Discover   American Express

for the amount pertaining to services rendered.

I understand that I am responsible for all fees that are not authorized by credit card or reimbursed by my insurance carrier. Outstanding balances over 60 days will result in a suspension of services until account is brought current. My signature below indicates that I am providing authorization to charge my credit card for services rendered.

***Please Print Clearly***
Name on card: _____________________________________________
Address: __________________________________________________
City/State: ________________________________________________
Zip Code: __________________________________________________
Card #: ____________________________________________________
Expiration Date: ____________________ Security Code:___________
Signature:__________________________________________________
AUTHORIZED TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. Member Information

I, ____________________________________, whose date of birth is (MM/DD/YY) ______________,
hereby give permission to APPA

2. Recipient Information

to (please check one or both) ___DISCLOSE TO and/or ___OBTAIN information from

+(name of person or title of organization)

Street:________________________________________ City:  __________________________
State:_________________________________________ Zip Code:_____________________
Phone Number:_________________________________ Fax:_________________________________

3. Description of Protected Health Information to be Used or Disclosed

___Psychiatric Assessments       ___Lab Reports/Toxicological Reports
___Discharge/Transfer Summary    ___Continuing Care Plans
___Medical/Nursing History      ___Other

4. Expiration of Authorization) - This date (no more than one year from today): ______/_______/_______

5. Your Rights

a. You can choose to end this authorization at any time by writing to APPA. If you make a request to end this
authorization, it will not include information that has already been used or disclosed based on your previous
permission.

b. APPA does not condition treatment or payment on your signing this form.

c. You do not have to agree to this request to use or disclose your information.

d. You have a right to a copy of this signed authorization. Please keep a copy for your records.

6. Re-disclosure by Recipient

Except as described below, information that is disclosed as a result of this authorization form may be subject to
re-disclosure by the recipient and no longer protected by law. APPA has to follow laws that protect your health
information, but not all persons or organizations have to follow these laws.

Signature: _______________________________________ Date: ____________________
Authorization for Internal Release of Information

I, _________________________, recognize the integrative nature of the services provided at Atlanta Psychiatry & Psychotherapy Associates, LLC (APPA) which operates under an interdisciplinary, collaborative treatment team approach. I hereby authorize internal communication between the professionals practicing at APPA and 2150 Peachford Road, Suite A, Atlanta, GA 30338 for the purpose of collaborative and comprehensive care. These treatment team professionals include:

- Eamon Dutta, MD, PC
- Daniel David, PhD
- Sandra Thomas, MD
- Hillary Ely, LAPC
- Andrew Morse, LAPC, NCC
- Jon Parker, LAPC, MAMFT

I understand that this Release of Information is in effect for the period of time necessary to facilitate comprehensive collaborative care, and that I can revoke this release in writing at any time.

Signature: __________________________________ Date: _____________________
Beck's Depression Inventory

Circle/highlight the answer that best describes you. This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1. 
0     I do not feel sad.
1     I feel sad
2     I am sad all the time and I can't snap out of it.
3     I am so sad and unhappy that I can't stand it.

2. 
0     I am not particularly discouraged about the future.
1     I feel discouraged about the future.
2     I feel I have nothing to look forward to.
3     I feel the future is hopeless and that things cannot improve.

3. 
0     I do not feel like a failure.
1     I feel I have failed more than the average person.
2     As I look back on my life, all I can see is a lot of failures.
3     I feel I am a complete failure as a person.

4. 
0     I get as much satisfaction out of things as I used to.
1     I don't enjoy things the way I used to.
2     I don't get real satisfaction out of anything anymore.
3     I am dissatisfied or bored with everything.

5. 
0     I don't feel particularly guilty
1     I feel guilty a good part of the time.
2     I feel quite guilty most of the time.
3     I feel guilty all of the time.

6. 
0     I don't feel I am being punished.
1     I feel I may be punished.
2     I expect to be punished.
3     I feel I am being punished.

7. 
0     I don't feel disappointed in myself.
1     I am disappointed in myself.
2     I am disgusted with myself.
3     I hate myself.

8. 
0     I don't feel I am any worse than anybody else.
1     I am critical of myself for my weaknesses or mistakes.
2     I blame myself all the time for my faults.
3     I blame myself for everything bad that happens.

9. 
0     I don't have any thoughts of killing myself.
1     I have thoughts of killing myself, but I would not carry them out.
2     I would like to kill myself.
3     I would kill myself if I had the chance.
10. I don't cry any more than usual.
   0 I don't cry any more than usual.
   1 I cry more now than I used to.
   2 I cry all the time now.
   3 I used to be able to cry, but now I can't cry even though I want to.

11. I am no more irritated by things than I ever was.
   0 I am no more irritated by things than I ever was.
   1 I am slightly more irritated now than usual.
   2 I am quite annoyed or irritated a good deal of the time.
   3 I feel irritated all the time.

12. I have not lost interest in other people.
   0 I have not lost interest in other people.
   1 I am less interested in other people than I used to be.
   2 I have lost most of my interest in other people.
   3 I have lost all of my interest in other people.

13. I make decisions about as well as I ever could.
   0 I make decisions about as well as I ever could.
   1 I put off making decisions more than I used to.
   2 I have greater difficulty in making decisions more than I used to.
   3 I can't make decisions at all anymore.

14. I don't feel that I look any worse than I used to.
   0 I don't feel that I look any worse than I used to.
   1 I am worried that I am looking old or unattractive.
   2 I feel there are permanent changes in my appearance that make me look unattractive.
   3 I believe that I look ugly.

15. I can work about as well as before.
   0 I can work about as well as before.
   1 It takes an extra effort to get started at doing something.
   2 I have to push myself very hard to do anything.
   3 I can't do any work at all.

16. I can sleep as well as usual.
   0 I can sleep as well as usual.
   1 I don't sleep as well as I used to.
   2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
   3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. I don't get more tired than usual.
   0 I don't get more tired than usual.
   1 I get tired more easily than I used to.
   2 I get tired from doing almost anything.
   3 I am too tired to do anything.

18. My appetite is no worse than usual.
   0 My appetite is no worse than usual.
   1 My appetite is not as good as it used to be.
   2 My appetite is much worse now.
   3 I have no appetite at all anymore.

19. I haven't lost much weight, if any, lately.
   0 I haven't lost much weight, if any, lately.
   1 I have lost more than five pounds.
   2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.
0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it’s hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score____________________Levels of Depression
1-10_________________________These ups and downs are considered normal
11-16_________________________Mild mood disturbance
17-20_________________________Borderline clinical depression
21-30_________________________Moderate depression
31-40_________________________Severe depression
over 40________________________Extreme depression

A PERSISTENT SCORE OF 17 OR ABOVE INDICATES THAT YOU MAY NEED MEDICAL TREATMENT.
Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Not At All</th>
<th>Mildly but it didn’t bother me much.</th>
<th>Moderately - it wasn’t pleasant at times</th>
<th>Severely – it bothered me a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness or tingling</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling hot</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Wobbliness in legs</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Unable to relax</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Fear of worst happening</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Dizzy or lightheaded</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Heart pounding/racing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Unsteady</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Terrified or afraid</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Nervous</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Feeling of choking</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hands trembling</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Shaky / unsteady</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Fear of losing control</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Difficulty in breathing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Fear of dying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Scared</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Indigestion</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Faint / lightheaded</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Face flushed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hot/cold sweats</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Column Sum

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here ____________ .

Interpretation

A grand sum between 0 – 21 indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to “mask” the symptoms commonly associated with anxiety. Too little “anxiety” could indicate that you are detached from yourself, others, or your environment.

A grand sum between 22 – 35 indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not “panic” time but you want to find ways to manage the stress you feel.

A grand sum that exceeds 36 is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a counselor if the feelings persist.
Welcome to Ateliers Psychiatric & Psychotherapy Associates, LLP.

Informed Consent (1 of 4 Pages)
Guardian's Signature:

Date

Printed Name

Signature

Date

Printed Name

Signature

I, ________________________, have read and agree with the terms and conditions of this professional relationship.

Agree to its terms during our professional relationship.

Your signature below indicates that you have read the information in this document and clearly understand and agree to its terms.

Signature

Date

Signature

Date

Signature

SIGNATURE

We will work together to determine the time to terminate our working relationship. In the event that I do not hear from you after three (3) attempts to contact you, your non-response will be deemed as a self-discharge. In the event that I do not hear from you within 30 days after your last session, our professional relationship will be considered terminated and from that date, this document is no longer applicable.

INITIALS) TERMINATION OF TREATMENT

Consultation is also bound to keep your information confidential. I will occasionally consult other professionals in this office about your care and treatment. In these cases, the taking action:

court order

- a patient who is a danger to him/herself or others

ongoing child abuse, elder abuse, or abuse of a disabled person

Some exceptions to confidentiality are:

- can release that information only if I have your written permission.

In most cases, the privacy of all communications between a patient and psychologist is protected by law, and I

(INITIAL) CONFIDENTIALITY (2 OF 4 PAGES)
Atlanta Psychiatry & Psychotherapy Associates, LLP (3 OF 4 PAGES)

___(initial) Informed Consent Information about Appointments & Expectations

Patient Procedures and Policy

1. Appointments: Appointments can be made by calling 770-674-0553 and speaking with Dane at extension 4.

2. Missed or Late Canceled Appointments:
   a) Cancellation requires 48 hours prior notice.
   b) Patients who miss appointments or cancel late (48 hours from their appointment time) will be billed for the full session.
   c) If you must cancel late, you may be given the option to reschedule during the same week if there are session times available. We do this to encourage continuity of therapeutic care. We do not guarantee that appointment times will be available.

3. Emergencies: All emergencies require that you call: 911. CALL 911 FIRST AND THEN CALL YOUR THERAPIST. Patients are to call 911 and upon arrival at the hospital may give hospital administration your therapist’s contact information.

4. Doctor/Psychiatrist Release of Information: We practice “continuity of care” with all our patients. We request that you get a signed release of information and authorization from your doctor/psychiatrist so that your therapist and your doctor/psychiatrist may exchange confidential communications about their concerns with your health and progress.
5. Termination of Professional Therapy Services:

Informed Consent Information about Termination & Self-Discharge

Allana Psychiatry & Psychotherapy Associates, LLP (4 of 4 Pages)
Late insurance does not pay for missed appointments.

7. As an insurance client, you will be charged $50 per session if you miss or cancel an appointment or cancel late.

6. As a self-pay client, you will be charged the full amount per session if you miss an appointment.

5. If you have short-term disability or other paperwork requests to be completed, I will charge $25 to fill out the paperwork.

4. If you have any questions or concerns regarding your referral, please call Andrew Morse, LCSW/RP, at 480-674-0533.

3. In order to contact me outside of office hours, please email me at andrewmorsecounseling@gmail.com.

2. In case of emergency, call 911 and then notify APPA.

1. We require a 48-hour notice for cancellations or reschedulings.

Important Reminders for Counseling with Andrew Morse and Office Policies

Atlanta Psychiatry & Psychotherapy Associates, LLP