THE FORT CHRISTIAN PSYCHIATRIC CENTER / SHAW WENDI FORTUCHANG, M.D., P.C.
SHAW WENDI FORTUCHANG, M.D., FAPA
P.O. BOX 1288, FAYETTEVILLE, GA 30214 (PHONE) 770-376-6726

PLEASE PROVIDE AN ANSWER FOR EVERY QUESTION!

FEMALE CHILD & ADOLESCENT QUESTIONNAIRE

Child/teen's full name: F: _____ M: _____ L: _____
Age: _____ **Date of birth:** _____/_____/_____ **Race**: _____
How did you hear about us? Word of mouth□ Website□ Internet search□ Radio□ **Referred by**: _____

Name of person completing this form: _____
Relationship to child/teen: mother□ father□ legal guardian□ other: _____
****Do you prefer a Christ-Centered, Bible-Based approach to treatment?** Yes□ No□ Maybe□
***Name and address of your church:** _____

Would you like to receive email correspondence (superbill receipts, etc.)? Yes□ No□
If yes, please provide your email address _____

Describe the reason for today's visit: _____

Child/Teen's Psychiatric History

Please check all of the following that apply to/have ever applied to the child/teen. Then, check "C" for current problem and "P" for past problem:

□Anger (excessive) **C□ P□** □Academic struggles **C□ P□** □Lying / Dishonesty **C□ P□** □Truancy **C□ P□**
□Anxiety / Worries **C□ P□** □Low Energy **C□ P□** □Gender Identity Issues **C□ P□**
□Aggression / Fights **C□ P□** □Learning Disorder **C□ P□** □Vandalism **C□ P□**
□Appetite Changes **C□ P□** □Manipulative **C□ P□** □Divorced Parents **C□ P□**
□Bedwetting **C□ P□** □Soiling the bed **C□ P□** □Vomiting (self-induced) **C□ P□**
□Bullying **C□ P□** □Bullied **C□ P□** □ Time-Consuming Obsessive Thoughts / Urges **C□ P□**
□Carelessness **C□ P□** □Problems with Adults **C□ P□** □Pornography **C□ P□**
□Concentration Issues **C□ P□** □Alcohol Use **C□ P□** □Drugs **C□ P□**
□Cutting/Burning/Injuring Self **C□ P□** □Perfectionism **C□ P□** □Stealing **C□ P□**
□ Excessive Counting / Checking **C□ P□** □Skin-Picking **C□ P□** □Disrespectful **C□ P□**
□Crying Spells **C□ P□** □Paranoia **C□ P□** □Gang Involvement **C□ P□**
□Cruelty to Animals **C□ P□** □Property Destruction **C□ P□** □Hears Voices **C□ P□**
□Destructive **C□ P□** □Unsavory Friend Group **C□ P□** □Visual Hallucinations **C□ P□**
□Day Dreaming **C□ P□** □Frequent Doctor's Visits **C□ P□** □Temper Tantrums **□C□ P□**
□Depression **C□ P□** □People Pleaser **C□ P□** □Follower **C□ P□** □Masturbation **C□ P□**
□Defiance **C□ P□** □Quiet / Shy **C□ P□** □Legal Problems **C□ P□** □Juvenile Detention **C□ P□**
□Disorganization **C□ P□** □Running Away **C□ P□** □Perpetrator of Sexual Abuse **C□ P□**
□Eating Disorder **C□ P□** □Risk Taking **C□ P□** □Social Withdrawal **C□ P□**
□Expelled from School **C□ P□** □Expelled from Camp **C□ P□** □Shame **C□ P□** □Guilt **C□ P□**
□Fears of Germs **C□ P□** □Secretive **C□ P□** □Impulsivity **C□ P□** □Witnessed Violence **C□ P□**
□Separation Anxiety **C□ P□** □Sexual Abuse Victim **C□ P□** □Rape Victim **C□ P□**
□Homicidal Threats/Behavior **C□ P□** □Learning Problems **C□ P□** □Sexually Active **C□ P□**
□Hyperactive **C□ P□** □School Refusal **C□ P□** □Promiscuity **C□ P□** □Problems with Peers **C□ P□**
□Hoarding **C□ P□** □Suicidal Thoughts **C□ P□** □Suicidal Threats **C□ P□** □Suicide Attempt **C□ P□**
□Hopelessness **C□ P□** □Spiritual Issues/Occult/ Etc. **C□ P□** □Self-Esteem Problems **C□ P□**
□Headaches **C□ P□** □Hair Pulling **C□ P□** □ Time-Consuming Compulsions/Rituals **C□ P□**
□Imaginary Friends **C□ P□** □Sleep Problems **C□ P□** (too much□ too little□) _____

Has the child/teen EVER been treated by a psychiatrist (medical doctor)? Yes☐ No☐

If YES, name of doctor and practice: _____

Diagnosis? _____

When was the last appointment? _____

Has the child/teen EVER received psychotherapy or counseling (psychologist, LPC, LCSW, etc)? Yes☐ No☐

If YES, name of therapist and practice: _____

Is child/teen currently in therapy? ☐YES ☐NO

If YES, name of therapist and practice: _____

Since when? _____When was the last appointment?_____

Has the child/teen ever been hospitalized for psychiatric reasons? Yes☐ No☐

Has the child/teen ever been hospitalized for substance abuse reasons? Yes☐ No☐

If yes, **how many times**? _____ **Where?** _____

Abuse and/or Trauma History

1. Has the child/teen ever been a (known or suspected) victim of:

Verbal/emotional abuse? Yes☐ No☐ Physical abuse? Yes☐ No☐ Sexual abuse? Yes☐ No☐

If yes to any of the above, please explain: _____

2. Has the child/teen ever been a (known or suspected) perpetrator of:

Verbal/emotional abuse? Yes☐ No☐ Physical abuse? Yes☐ No☐ Sexual abuse? Yes☐ No☐

If yes to any of the above, please explain: _____

3. Has the child/teen ever been in a situation where they feared that their life, or someone else's life, was in danger of being taken? Yes ___ No ___**If yes, please explain** _____

Child/Teen's Psychiatric Medication History

Are there firearms in the home? Yes☐ No☐ **Does the child/teen have access to them?** Yes☐ No☐

Has the child ever been prescribed any psychiatric medications by anyone? Yes☐ No☐

If yes, what is the name and specialty of the prescribing doctor?_____

Please circle all medications that have EVER been prescribed to the child/adolescent:

Prozac, Paxil, Zoloft, Celexa, Lexapro, Luvox, Effexor, Pristiq, Cymbalta, Khedezla, Wellbutrin, Buspar, Remeron, Trazodone, Trintellix, Viibryd, Vistaril, Elavil, Xanax, Klonopin, Valium, Ativan, Restoril, Risperdal, Perseris, Rexulti, Vryalar, Invega, Saphris, Fanapt, Latuda, Clozaril, FazaClo, Zyprexa, Seroquel, Abilify, Geodon, Latuda, Haldol, Lithium, Lithobid, Eskalith, Depakote, Depakene, Stavzor, Tegretol, Trileptal, Lamictal, Neurontin, Topamax, Epitol. Ambien, Lunesta, Rozerem, Adderall, Concerta, Ritalin, Metadate, Methylin, Daytrana, Desoxyn, Adzenys, Aptensio, Evekeo, Mydayis, Quillivant XR, Quillichew ER, Zenzedi, Cotempla XR-ODT, Dynavel, Focalin, Vyvanse, Strattera, Intuniv, Clonidine, Guanfacine, Provigil, Namenda, Aricept, Halcion, Lyrica, Other: _____

Please list all CURRENT PSYCHIATRIC medications below:

Medication Name:	Medication Name:	Medication Name:
Dose:	Dose:	Dose:
Response:	Response:	Response:

Who prescribed / is prescribing this medication? _____

Is there anything else you want us to know about your child/teen's mental health?

Spirituality (Parents):

Do you believe that Jesus Christ died on the cross for our sins and rose again, giving Christians eternal life? Yes☐ No☐
Have you received Jesus Christ as your personal Lord and Savior? Yes☐ No☐
Do you believe that we were created as a spirit, we have a soul and live in a physical body? Yes☐ No☐
Are you aware that there are biological, spiritual and psychological aspects to mental health? Yes☐ No☐
Are you aware that unresolved spiritual issues can worsen or mimic many psychiatric disorders? Yes☐ No☐
Do you spend quiet, quality alone time with God in prayer and meditation? Yes☐ No☐
Do you believe in the power of prayer? Yes☐ No☐
Do you have difficulty fully trusting God and surrendering your will and/or way for His? Yes☐ No☐
Do you regularly pay your tithes at your local church? Yes☐ No☐
Are you aware that any act or thought that goes against The Word of God (The Holy Bible) is sin? Yes☐ No☐
Do you believe that our sins have already been paid for by Christ's sacrifice on the cross? Yes☐ No☐
Do you believe that sins must be confessed and repented in order to receive God's best for our lives? Yes☐ No☐
Are there any areas of unrepented sin and/or unforgiveness in your life? Yes☐ No☐
Are you aware that there are 4 major areas within which Satan gains access to our lives? Yes☐ No☐
Has the child/teen received Christ as Lord & Savior or been formally dedicated to Christ (confirmation, etc.?) Yes☐ No☐

Check ALL that the CHILD/TEEN has ever done, been affected by or was forced into doing:

1. FEAR: Prolonged worry/anxiety☐ Unbelief☐ Need for control☐ Certainty☐ Social isolation☐ Withdrawal☐

2. OCCULT: Astrology/Horoscopes☐ Fortune-telling☐ Tarot cards☐ Palm-reading☐ Seances☐ Ouija board☐ Voodoo☐ Manipulation☐ Witchcraft☐ Coven☐ Spells☐ Curses☐ Hexes☐ Chanting☐ Yoga☐ Seeking advice from mediums☐ Lucky charms/rabbit's foot/etc.☐ Superstitions☐

3. HATRED: Unforgiveness☐ Bitterness☐ Resentment☐ Envy☐ Gossip☐ Slander☐ Anger☐ Self-loathing☐ Revenge☐

4. SEXUAL: Adultery/Affair☐ Pornography☐ Fornication☐ Lewdness/Lust☐ Molestation☐ Incest☐ Rape/Assault☐ Homosexuality☐ Bisexuality☐ Same-sex "experimentation"☐ Prostitution/"Escort"☐

Developmental History

Was the child/teen adopted? Yes☐ No☐ **Is the child/teen a foster child?** Yes☐ No☐
Is the child/teen a family member for whom you have assumed legal guardianship? Yes☐ No☐
If YES to either, where did the child/teen live prior to your home? _____

Is the child/teen your full biological child? Yes☐ No Are parents married to each other? Yes☐ No☐
Were parents married before the pregnancy? Yes☐ No☐ Was the pregnancy planned? Yes☐ No☐
Was the mother under emotional duress during the pregnancy? Yes☐ No☐ **If YES, describe:**

Check any that applied to this pregnancy:
☐Anemia ☐Elevated blood pressure ☐Toxemia ☐Gestational Diabetes
☐Measles ☐Swollen ankles ☐Bleeding ☐German Measles ☐Influenza
☐Kidney disease ☐Other viruses ☐Strep throat ☐Smoking ☐Threatened miscarriage
☐Psychiatric problems ☐Use of illegal drugs ☐Alcohol use ☐Other illness

Was mother taking prescribed medication during the pregnancy? Yes☐ No☐
What? _____ Why? _____

Was the pregnancy full term? Yes☐ No☐ If NO, how many weeks at delivery? _____
Was the delivery natural? Yes☐ No☐ C-section? Yes☐ No☐ Birth weight: _____
Were there any complications during the delivery for the mother? Yes☐ No☐
Were there any complications during the delivery for the baby? Yes☐ No☐

Were there any developmental delays (walking, talking, toileting, etc)? Yes☐ No☐
If YES, please explain: _____

Child's Menstrual History

Has your child begun having menstrual periods? Yes☐ No☐ Unsure☐
Age at first menstrual period: _____ Does she have regular menstrual periods? Yes☐ No☐

Please check all that apply in the WEEK prior to her period:

Extreme fatigue☐ Food cravings☐ Anger☐ Extreme irritability☐ Increased appetite☐
Problems with family/friends☐ Tearfulness☐ Hopelessness☐ Extreme anxiety☐
Lack of interest☐ Lack of motivation☐ Poor concentration☐ Extreme moodiness☐
Major sleep changes☐ Feeling overwhelmed/out of control☐ Physical pain or tenderness☐

Child's Medical History

Full name of doctor and practice: _____
Address: _____
Phone Number: _____ Fax Number: _____

Please check any of the following medical problems the child/teen has had:

☐Asthma ☐Ear Infections ☐Vision Problems ☐Meningitis
☐Respiratory Problems (lungs) ☐Infections ☐Headaches ☐Seizures
☐Intestinal Problems (gut) ☐Diabetes ☐Fever ☐Heart Problems
☐Sexually Transmitted Disease ☐Encephalitis (brain infection) ☐Nausea/Vomiting ☐Head trauma
☐Broken Bones ☐Skin Problems ☐Hearing Problems ☐Other

Has the child/teen had any surgical procedures? Yes☐ No☐
If YES, please describe: _____

Has the child/teen ever been hospitalized? Yes☐ No☐
If YES, please describe: _____

Does the child/teen take any <u>non-psychiatric</u> medications (prescribed and/or OTC)? Yes☐ No☐
If YES, please list them here:

Medication: Medication:
Dose: Dose:
Reason: Reason:

Does the child/teen have **allergies to any medication**? Yes☐ No☐
If YES, please list the medication and the known allergic response: _____

When was the child/teen's last physical exam? _____
Were any problems noted? Yes☐ No☐
If YES, what problems? _____
Was lab work / blood work done? Yes☐ No☐ **Why?** _____
Was an EKG (heart) done? Yes☐ No☐ **Why?** _____
If yes to the above, what were the results? _____

Has the child/teen ever had an EEG (brain)? Yes☐ No☐ **Why?** _____
Has the child/teen ever had a seizure? Yes☐ No☐**When?** _____

Has the child/teen ever had a head injury with loss of consciousness? Yes☐ No☐
Is the child/teen up-to-date on immunizations? Yes☐ No☐

Overall, how would you rate the child/teen's physical health? _____

Is there anything else you would like us to know about the child/teen's **physical health**?

Preferred Pharmacy Information

Name: _____ Address: _____
Phone Number: _____Fax Number: _____

Living Arrangements and Family

Child/teen's home address: _____
City: _____ State: _____ Zip: _____
Child/teen's mobile number: _____ Child/teen's email: _____
List all family members living in the home: _____

Mother's Full name: _____ Age: _____ Level of education: _____
Address: _____
Home phone: _____Mobile phone: _____
Employer: _____Type of work: _____
Work phone: _____ Preferred email: _____

Father's Full Name: _____Age: _____ Level of education: _____
Address: _____
Home phone: _____Mobile phone: _____
Employer: _____Type of work: _____
Work phone: _____Preferred email: _____

Marital status of parents: Married☐ Divorced☐ Separated☐ Never married☐ Remarried☐ Engaged☐
Are there stepparents involved in the child/teen's life? Yes☐ No☐

In the case of divorce/separation, what are the custody arrangements? _____
Child/teen's primary residence: Both Parents☐ Mother☐ Father☐ Other☐
If OTHER, then please describe: _____

Siblings (indicate whether full, half or step sibling):
Name _____Age _____ Name _____ Age _____
Name _____Age _____ Name _____ Age _____

Other relatives or people currently living in the home, including a step-parent:
Name_____ Age _____Relationship to child _____
Name _____Age _____Relationship to child _____

Has Child Protective Services EVER been involved in the child/teen's life: Yes☐ No☐ If yes, please explain:

Family Psychiatric & Medical History

****Is either parent seeing a mental health specialist?** Yes☐ No☐ Mother☐ Father ☐ Both☐
****Is either parent being prescribed psychiatric medication?** Yes☐ No☐ Mother☐ Father☐ Both☐

Please list all BIOLOGICAL family members affected by any of the following:
Depression _____ Bipolar Disorder _____
ADHD _____ Anxiety Disorder _____
PTSD _____Obsessive Compulsive Disorder _____
Panic Disorder _____ Substance Use _____
Schizophrenia and other Psychotic Disorders _____
Learning Disorders _____ Eating Disorders _____

Psychiatric Hospitalizations Yes☐ No☐ **Who?**_____

****Have there been ANY suicide attempts** Yes☐ No☐ **or completions** Yes☐ No☐ **on either side of the family? If YES, who and which side of the family?** _____

Check all of the following that apply to any family members:
Diabetes☐ Seizures/Epilepsy☐ Heart Problems☐ Obesity☐ High Cholesterol☐ High Blood Pressure☐

School History **1. Name of School:** _____ **2. Grade level:** _____
3. Type of School: Public☐ Private☐ Special☐ Alternative☐ Home-Schooled☐
4. Describe the child/teen's grades: A☐ B☐ C☐ F☐ stellar☐ good☐ average☐ poor☐ failing☐
5. Gifted/advanced classes? Yes☐ No☐ **6. Special Education?** Yes☐ No☐
7. Repeated grades? Yes☐ No☐ **Which ones?** _____ ☐NA
8. Grades skipped? Yes ☐ No☐ **Which ones?** _____ ☐NA
9. Detentions? Yes☐ No☐ **How many?** _____ **10. Suspensions?** Yes☐ No☐ **How many?** ____
11. Extracurricular activities? Yes☐ No☐ **What are they?** _____

Behavior problems? Yes☐ No☐ **What are they?** _____
Has the child/teen ever had any trouble with law enforcement? Yes☐ No☐ *If yes, please explain:*
Has the child/teen ever spent time in juvenile detention? Yes☐ No☐ *If yes, please explain:* _____

Are there any known/diagnosed learning disabilities? Yes☐ No☐ If yes, please explain:

Has there been any psychological testing done to confirm any learning disabilities? Yes☐ No☐
Does the child/teen receive special services at school? Yes☐ No☐ If yes, explain: _____
Does the child/teen have an IEP (Individualized Education Plan) at school? Yes☐ No☐
Does the child/teen have a 504 Plan at school? Yes☐ No☐ **Any accommodations?** Yes☐ No☐

Which of the following problems, if any, does the child have in school? Check all that apply:

☐Does not do homework	☐Poor spelling	☐Poor reading skills
☐Does not remain seated	☐Oppositional in class	☐Makes careless errors
☐Does not finish homework	☐Messy and disorganized	☐Forgets assignments
☐Incomplete class work	☐Talks out inappropriately	☐Poor handwriting
☐Distracted	☐Poor attention	☐Test anxiety
☐Poor math	☐Excessive time to complete assignments	☐None apply

Peer Relations **Describe relationship with peers:** Excellent☐ Good☐ Average☐ Fair☐ Poor☐ Problematic☐
Have a best friend? Yes☐ No☐ **Class clown?** Yes☐ No☐ **Leader or follower?** _____
No friends☐ Few friends☐ Many friends☐ Loses friends☐ Trouble making new friends☐
Has the child ever been bullied? Yes☐ No☐ **Has the child ever been called a bully?** Yes☐ No ☐

Social History **Is child/teen socially isolated or withdrawn?** Yes☐ No☐ *If yes, explain:* _____

Does child/teen engage in sports and other activities OUTSIDE of school: Yes☐ No☐
Attend overnight summer camp? Yes☐ No☐ **Invited for sleepovers with friends?** Yes☐ No☐
Invited for play dates? Yes☐ No☐ **Invited to birthday parties?** Yes☐ No☐
Engage in church-related activities? Yes☐ No☐ **Often left out of social outings?** Yes☐ No☐
Describe child/teen's behavior at the above outings: Appropriate☐ Childish☐ Inappropriate☐ Mature☐
Does child/teen relate well with family members? Yes☐ No☐ Explain: _____
Disciplinary parent: Dad☐ Mom☐ Both☐ Neither☐ **Methods of discipline:** _____
Chores? _____ **Allowance?** Yes☐ No☐
Currently employed? Yes☐ No☐ **How/Where?** _____

Is teen dating? Yes☐ No☐ **Is teen sexually active?** Yes☐ No☐ **Does teen use vapes?** Yes☐ No☐
Does teen smoke cigarettes? Yes☐ No☐ **Is teen using alcohol or drugs?** Yes☐ No☐

DISCLAIMER: Completing these forms does NOT guarantee an appointment. A doctor-patient, provider-patient, or therapist-patient relationship is NOT established until the decision is made to create such a relationship at the conclusion of your initial psychiatric diagnostic appointment. Therefore, you will NOT be considered a patient of Shaw Wendi Fortuchang, M.D., PC / The Fort Christian Psychiatric Center or its associates until then. If we determine our services are not adequate to meet the level of care required, we will notify you within a reasonable time frame.

GUARANTOR / GUARDIAN INFORMATION:

Relationship to Patient: _____
Full Name: _____
Address: _____
City: _____State: _____Zip: _____
Date of Birth: ___/___/___ Gender:_____ SSN: _____/____/_____ Phone Number: _____
Employer's Name & Address: _____
Employer's Phone Number: _____

I, the undersigned, agree that I am financially responsible for all services provided by The Fort Christian Psychiatric Center. I am aware that office policy requires payment at the time of service. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% of the outstanding balance. I understand that outstanding balances over 90 days may be referred to a collection agency.

Parent / Guardian/Guarantor: _____ Date: _____
***This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney.**

I. GUARANTOR AGREEMENT POLICY:

This agreement will remain in effect until written notice of other payment arrangements are provided to The Fort Christian Psychiatric Center. The current guardian will be responsible for any and all charges incurred prior to receipt of notification of other arrangements. If you wish to change your guarantor information, you must have the appointed guarantor complete a separate agreement.

II. *PARENT/GUARDIAN CONSENT FOR TREATMENT POLICY:

I hereby certify that I have legal custody of the child / adolescent being treated and am legally empowered to make medical decisions concerning him/her. I hereby give consent for the above child/adolescent to be treated by physicians and/or mental health professionals associated with The Fort Christian Psychiatric Center (TFCPC). I understand that TFCPC is a Christian psychiatric facility that purposefully uses The Bible, Scripture, and prayer as the foundation for treatment, as led by The Holy Spirit. I agree that I am personally responsible for ensuring that all charges for services rendered are paid by myself. I authorize The Fort Christian Psychiatric Center to provide information concerning the above child/adolescent's treatment to any physician or therapist who referred me to The Fort Christian Psychiatric Center, as well as to any physician/therapist to whom my child/adolescent may be referred following the initial diagnostic evaluation.

Parent/Guardian: _____ Date: _____

III. CUSTODY AGREEMENT POLICY:

If the parents are divorced with joint legal custody, <u>both</u> parents will need to sign the consent for treatment. In cases regarding primary custodial agreements, a copy of the custody agreement must be provided to The Fort Christian Psychiatric Center. This agreement must reflect which parent obtains authority over medical decision-making. In this case, custody agreement must be provided at the initial appointment.

Parent /Guardian: _____Date: _____
(2nd signature required only if parents are divorced)

Parent /Guardian: _____Date: _____
***This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney.**

The Fort Christian Psychiatric Center
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Please read each section very carefully before initialing where highlighted.

Insurance: The Fort Christian Psychiatric Center does not accept insurance. If you wish to be reimbursed by your insurance company, you will be responsible for filing the claim on your own. You will receive a superbill receipt from us via email containing all the information needed by your insurance company, but we cannot guarantee that your insurance company will reimburse for services rendered. **Therefore, it is your responsibility to find out which CPT procedural codes are reimbursable. Further, we do not submit any billing claims to insurance companies. We do not manage any billing-related insurance issues. All insurance company correspondence should be mailed directly to you, not to us! We reserve the right to charge administrative fees related to insurance claims, when applicable.** X_____

Appointments: Our office hours follow the Fayette County School calendar. When Fayette County schools are closed due to inclement weather, we will also be closed. **At least 1 parent must be present and/or available for feedback at some point during every child/adolescent patient appointment.** X____

HOURS: We are open Mon through Thu from 7am – 7pm. Appointments are on Tuesday, Wednesday & Thursday. Monday is an administrative day. We are closed on Friday, Saturday & Sunday. X____

Scheduling and Punctuality: To provide safe medical care, appointments are scheduled as frequently as the patient's clinical symptoms require. Patients are expected to arrive on time for their appointments. Arriving 10 minutes after your appointment time is considered late. As a courtesy, we will allow late arrivals to be seen up to 15 minutes after the scheduled appointment time, allowing for the remainder of the time to be used (this policy does NOT apply to 15-minute sessions). *Once 15 minutes have elapsed, the appointment will be automatically canceled. The patient's credit card on file will be charged the full cost for the canceled session + the $2 manual transaction fee. X_____

Missed Appointments: Patients who cancel 3 consecutive appointments are subject to termination. Additionally, if a patient has not been seen in 6 months or longer, they may be subject to termination. Patient safety is our top priority at The Fort Christian Psychiatric Center. Making and keeping regularly scheduled appointments, and adherence to the treatment plan are integral components of this safety process—especially when medication is prescribed. The frequency with which appointments are scheduled is an important and methodical medical decision, involving extensive clinical experience and wisdom, sound judgment and guidance from The Holy Spirit. Close adherence to our office policies and pearls of wisdom agreement is vitally important to us as a Christian-centered medical practice, which helps us to ensure the safety of the patients we have been called by God to treat. X_____

Appointment Reminders for Established Patients: It is always the patient's responsibility to remember the date and time of an appointment. However, as a courtesy we will provide an appointment reminder card at the conclusion of appointments. Also, at the bottom of the superbill receipt we send to patients via email, we will write the date, time and length of the next appointment. And, within the body of these emails, we will write the date, time and length of the next appointment. If you miss an appointment due to receiving an email with incorrect information, or because your email goes to junk/spam and never reaches your inbox, you will be held responsible and will be charged the full cost for that session. **Therefore, always write down the date and time of your next appointment**. X_____

Payment Options: We operate on a fee-for-service basis. We accept cash, checks, most major credit cards (American Express, Discover, MasterCard and Visa), debit cards and health savings / flex spending cards. Full payment is expected at the time services are rendered. A $35 fee will be assessed for any returned checks. More than 1 bad check will result in revocation of all check-writing privileges. X_____

Initial Diagnostic Evaluations & Consultations: Initial Diagnostic Evaluations and Consultations are typically conducted in the morning on Wednesday through Saturday. If you choose to cancel your appointment, you must do so exactly **48-hours to the date and time of the appointment in order to avoid being charged the full cost**. **Otherwise the appointment is considered late and will be charged the full cost for the session. Cancellations must be made via email or via our website.** All no-shows are charged the full cost for the session and *are not granted another appointment with us*. X____

The Initial Diagnostic Evaluation is always considered an evaluation, not a patient appointment. The decision of whether or not a doctor-patient relationship will be established and whether or not subsequent appointments are scheduled is a decision made by Dr. Fortuchang and The Fort Christian Psychiatric Center. In the event that the initial evaluation does not result in a doctor-patient relationship being formed, names of other mental health professionals will be provided. The individual or their designated guarantor will be responsible for the full payment at the time of the evaluation. X_____

Cancellation Policy for Established Patients: Appointments ***must be canceled electronically** (via email or website) within exactly **48 hours to the date & time of the appointment**, otherwise the cancelation is considered late and patients will be charged the full cost for the session. For example, a 4 PM Wed appointment ***must be canceled electronically** (via email or website) by 4 PM on the previous Mon (exactly 48 hours). *Electronic cancelations provide us with date/time stamped documentation, which is printed and placed in the patient's chart. **Do not cancel by calling our office.** X_____

Appointment Cancellation Method: **All appointment cancellations must be made electronically via email to** dr.fortuchang@thefortchristian.com or office@thefortchristian.com, **OR via our website** www.thefortchristian.com. Therefore, please do not call our office to cancel an appointment. X____

- To cancel an appointment via email: please only use the email address(es) you provided to us (you are solely responsible for ensuring that our email address is entered correctly). Please include the date and time of the appointment you are choosing to cancel in the body of the email and in the subject line. You will immediately receive an automatic reply to your email and should consider this your confirmation of our receipt of your appointment cancelation. **We will not contact you to confirm our receipt of your cancellation**. X____

- **To cancel an appointment via our website:** simply log onto it, go to the APPOINTMENT CANCELLATION page and submit the form. You will immediately receive an automatic reply to your submission land should consider this your confirmation of our receipt of your appointment cancellation. **We will not contact you to confirm our receipt of your cancellation.** X____

Rescheduling a Cancelled Appointment: You must call our office to reschedule a canceled appointment for a new date and time. All appointments are scheduled by telephone. X_____

No-Shows: No-shows occur when a patient does not contact us to cancel their appointment and does not show up for it. No-shows are always charged the full fee for the missed session and will jeopardize a patient's standing at The Fort Christian Psychiatric Center. Repeat no-shows will result in termination from the practice. Please note that insurance companies do not reimburse these fees. X____

Telephone Policy: To provide quality care to her patients, Dr. Fortuchang prefers to personally return their calls. Messages left during business hours (7am to 7pm on Mon through Thu) will be returned as soon as possible. Messages left after 7pm on Thu will be returned on the next business day (Mon). X___

After Hours, Urgent Matters and Emergencies: An urgent matter is anything requiring Dr. Fortuchang's attention, which can be fully addressed in the office or via telephone (prescription refill, medication questions, a recent non-life-threatening stressor, etc.), but something that cannot wait until the next business day. In other words, it is not an emergency but not something that can wait. X____

An emergency is any life-threatening situation in need of immediate attention, typically requiring a call to 911 or a trip to the nearest emergency room. *Patients must be seen soon after any emergency. X___

During normal business hours, please call the office (770-376-6726) for any urgent matters. X_____

For urgent matters occurring after business hours that cannot wait until the next business day to be addressed, please call our after-hours line. Please leave a brief message including your name, the patient's name (if different), your telephone number, and the issues concerning you/the patient. If Dr. Fortuchang is unable to answer immediately, you must leave a message if you expect a return to your call. **Do not call the after-hours line for a medication refill.** X___

**Also available to you is the Georgia Crisis and Access Line 1-800-715-4225, and the National Suicide Prevention Lifeline at 800-273-8255. X____

**If you are experiencing a life-threatening emergency call 911 or go to the emergency room. X_____

**Patients are expected to contact us immediately AFTER contacting emergency services. X_____

Medication Refill Policy: While we make every effort during your appointment to provide enough medication refills to last until your next appointment, patients share the responsibility of monitoring their need for a medication refill. Patients should either bring their medication bottles to each appointment OR write down how many pills are left in each bottle AND whether or not any refills remain. X____

Medication Refill Policy, continued: **We charge $25/medication for all medication refill requests made between appointments. **To avoid this is to either bring your medication bottles to appointment, OR write down how many pills are in each bottle AND whether or not any refills remain.** X____

**Prescriptions are only "called in" for current patients of The Fort Christian Psychiatric Center who are in good standing and who maintain their regularly scheduled appointments. X____

WE WILL NOT HONOR MEDICATION REFILL REQUESTS FAXED TO US FROM YOUR PHARMACY. PATIENTS MUST CALL OUR OFFICE DURING NORMAL BUSINESS HOURS TO REQUEST MEDICATION REFILLS. X____

Medication refills will not be called in after hours, on days when we are closed, or on holidays. X____

Without exception, prescriptions that are lost in the mail, lost by the patient, or lost by the pharmacy will be charged a $25 fee. X___ ***Duplicate prescription refill requests are always charged a $25 fee. X___

Outside Food & Beverages: Because this is a physician's office, we do not allow outside food and beverages (excluding water) in our office. **Please do not bring these items with you.** X_____

Photocopies: I agree that photocopies and electronic copies of this form are as valid as the original. X_____

Email Policy: We use email to receive appointment cancellations and to send superbill receipts. Email containing clinical information is strictly prohibited and goes directly against our office policy. Clinical concerns and urgent matters are to be addressed via telephone by calling our office. X____
Note: By choosing to communicate via Email or Internet, you are assuming a certain degree of risk of breach of privacy. The Fort Christian Psychiatric Center cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. We will save email correspondence with you and they will be considered part of the medical record. Therefore, you should consider that any electronic communication may not be confidential and will be included in your medical chart. X_____

Policy for Termination of Treatment: Patients are under no obligation to continue services should they choose to terminate treatment. However, it is required that we be notified, *in writing*, in order to properly begin the termination process. Similarly, The Fort Christian Psychiatric Center reserves the right, under any circumstances (including choosing to go against medical advice, failure to adhere to the treatment plan, office policies and pearls of wisdom agreement, etc.) to terminate the doctor-patient relationship at the discretion of Dr. Fortuchang. Patients with inactive charts for 6 months and longer are subject to termination. A formal letter of termination will be mailed to the home address on file. X____.

Terminations occur for a reason. Therefore, it is our policy not to re-establish the doctor-patient relationship—regardless of how the termination process was initiated. **Please note that patients are fully responsible for any and all outstanding balances at the time of termination. X_____

Policy Changes: The Fort Christian Psychiatric Center reserves the right to change/modify/amend/update our office policies at any time. You will be notified of any changes. The updated version will always be available on our website and at our front desk for your review. X_____

Prior-Authorization, Records, Forms and Other Fees: Medical records: $25/request. X____
Completion of forms (school, camp, work, jury duty, prior authorization): $35/form. X____
Requests for medication refills made between appointments: $25/refill. X____
Manual credit/debit card transaction for payment of services: $2 convenience fee/transaction. X_____
Telepsychiatry services: $10 convenience fee + the cost of the session X_____
After-hours appointments: $50 convenience fee + the cost of the session X_____

Session Fees: Our fees are subject to change to keep pace with inflation, business overhead, and other factors to the discretion of Shaw Wendi Fortuchang, M.D, P.C. / The Fort Christian Psychiatric Center. X____

Consent for Treatment at a Christian-Centered Medical/Psychiatric Facility: I have read and initialed the office policies of The Fort Christian Psychiatric Center (TFCPC). I understand them and I agree to adhere to them. I understand that TFCPC is a Christian, Bible-based practice. I understand that The Bible, Scripture and prayer are used as the foundation for the treatment—as is dictated by The Holy Spirit. I hereby consent to be treated by physicians and/or mental health professionals associated with The Fort Christian Psychiatric Center and Shaw Wendi Fortuchang, M.D., P.C. I understand this consent does not constitute a guarantee about the results of my treatment. I understand that I can terminate this consent for treatment at any time. I also understand that my doctor, prescribing provider, therapist or counselor may terminate consent for treatment at any time, and will discuss the reasons with me if this should occur. Potential reasons include misuse of prescribed medications or mental health services, failure to reimburse for services rendered, failure to keep appointments or repeated cancellations of appointments, etc. I agree that I am personally responsible for ensuring that all charges for services rendered are paid by me, at the time services are rendered. X_____

Statement of Confidentiality: Under Georgia law communications between patients and psychiatrists are confidential, and under ordinary circumstances, only the patient may waive this privilege. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to him or herself, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child abuse. Although legally and ethically bound to break confidentiality under these circumstances, we will attempt to discuss with you first. X_____

I authorize The Fort Christian Psychiatric Center (TFCPC) to provide information concerning my treatment to any physician or therapist who referred me to TFCPC, as well as to my primary care physician for the sole purpose of collaborating fasting baseline lab work when needed. X_____

ACCEPTANCE OF THE OFFICE POLICIES OF TFCPC: We are committed to providing professional services of the highest quality and standards, and we consider it an honor to serve you. In order to provide our patients with the most efficient and responsible care, we require agreements be made to the policies stated above.

I have read and initialed the office policies of The Fort Christian Psychiatric Center (TFCPC) in their entirety. I understand them, I agree with them, and I will adhere to them. X_____

I have read and signed the Pearls of Wisdom of The Fort Christian Psychiatric Center (TFCPC) in their entirety. I understand them, I agree with them, and I will adhere to them. X_____

Signature of Patient/Guardian: _____
*This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney (POA).
Printed Name of Patient/Guardian: _____ Date: _____
(POA Signature (if applicable): _____ Date: _____)

TFCPC Pearls of Wisdom Covenant Agreement

Please read the following pearls very closely and in entirety before signing…

1. I will notify The Fort Christian Psychiatric Center / Dr. Fortuchang, immediately, if there are any significant changes in my child's psychiatric symptoms and/or medical condition (pregnancy, etc.).

2. If I am concerned that my child is having thoughts of hurting him/herself I will call Dr. Fortuchang immediately. If my child is suicidal or has a medical emergency needing immediate attention, I will call 911 or go to the ER.

3. If my child ever requires psychiatric treatment in an ER and/or hospitalization, I will make sure that Dr. Fortuchang is notified within 24 hours. I will call TFCPC on the next business day to schedule a follow-up appointment. I will inform Dr. Fortuchang of any medication changes at the hospital and/or hospitalization.

4. My child will take medication as prescribed. If I want to increase, decrease, or discontinue the medication, I will discuss with Dr. Fortuchang first. I understand that making changes without Dr. Fortuchang's permission and guidance is strictly prohibited, potentially dangerous and will affect my child's standing as a patient at TFCPC.

5. I understand that it is extremely important for my child not to share his/her medication with anyone, and not to take any medication prescribed to someone else. I understand that such actions are strictly prohibited.

6. I understand that obtaining psychiatric medications for my child from any doctor(s) other than Dr. Fortuchang (except during hospitalization) violates the trust and open communication essential to a functional doctor-patient relationship. Such actions are strictly prohibited and may result in termination from TFCPC.

7. I understand that it is dangerous for my child to drink alcohol, misuse prescription medication or use illegal drugs— especially when taking psychiatric medication. I understand that substance abuse/dependence may result in termination of treatment with referral to an addictions specialist, as Dr. Fortuchang is not one.

8. **I will notify Dr. Fortuchang if there are any changes to my child's contact info and credit/debit card on file.**

9. I fully understand that The Fort Christian Psychiatric Center does not engage in email correspondence with patients and/or their families, other than under special circumstances or to send office-wide information. ***I will regularly check my email inbox. *I will reply to all emails (& phone messages) requesting a response!**

10. I will not expect to receive any response to any email(s) I choose to send, and I will not send any emails containing urgent/emergent/clinical questions or information regarding the treatment.

11. Because safety is extremely important, my child and I will follow the treatment plan outlined by Dr. Fortuchang, and I will ask questions when I do not understand something regarding the psychiatric treatment.

12. I understand that it is my responsibility to keep track of my child's medication and request medication refills during the appointment. I am fully aware that refill requests made between appointments result in a $25 fee.

13. I will not allow my child to take any over-the-counter supplements (diet pills, herbal supplements, etc)— especially if being prescribed medication, without first discussing it with Dr. Fortuchang. Such supplements may have adverse effects, may interact with prescribed medication and could worsen certain psychiatric disorders.

14. I fully understand that signing this form does not create a doctor-patient relationship between my child and Shaw Wendi Fortuchang, M.D., and that it is not until after the initial evaluation when it may be mutually agreed upon to create such a doctor-patient relationship.

15. I have read, understand, and agree with the above Pearls of Wisdom and the office policies for TFCPC, and I understand that failure to comply with them could result in termination of my child's treatment at The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C., once becoming a patient.

Parent/Guardian **Signature** _____ Date _____
Parent/Guardian **Printed Name** _____ Date _____
***This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney.**