THE FORT CHRISTIAN PSYCHIATRIC CENTER / SHAW WENDI FORTUCHANG, M.D., P.C.
SHAW WENDI FORTUCHANG, M.D., FAPA
110 NORTH PARK DRIVE, FAYETTEVILLE, GA 30214 (PHONE) 770-376-6726 (FAX) 770-376-6727

PLEASE PROVIDE AN ANSWER FOR EVERY QUESTION!

ADULT MALE QUESTIONNAIRE

How were you referred to us? _____
Do you prefer a Christian-based approach to treatment? Yes ☐ No ☐ Maybe ☐

Full Name (F, M, L): _____ Age: _____ DOB: _____

SSN: _____-_____-_____ Email Address: _____
May we send courtesy appointment reminders to the above email address? Yes ☐ No ☐

Home Number: _____ Mobile Number: _____
May we leave messages for you at these numbers? Yes ☐ No ☐

Home Address: _____
City: _____ State: _____ Zip: _____

Are you currently a student? Yes ☐ No ☐ Full-Time ☐ Part-Time ☐
Name of school: _____ Type of school: _____
Major: _____ What year are you in school? _____
Grades: _____GPA: _____ **Any academic challenges? Yes ☐ No ☐**

If no, where did you last attend school? _____
Highest degree earned: _____ Area of study: _____Year graduated? _____
Type of school: _____ GPA? _____ **Any academic challenges? Yes ☐ No ☐**

Are you currently employed? Yes☐ No☐ Full-Time☐ Part-Time☐ Retired☐ Looking☐
If no, when and where was your last job? _____
What was your position / job title? _____

Current Employer: _____ Type of Work: _____
Work Phone: _____ How long have you worked here? _____
Any work-related issues? Yes☐ No☐ Explain:

Marital status: Married☐ Engaged☐ Separated☐ Divorced☐ Widowed☐ Dating☐
Any relationship issues? Yes☐ No☐ Explain:

Spouse's Full Name (F, M, L): _____Years married: _____

Age: _____ DOB: _____Mobile Phone: _____

EMERGENCY CONTACT Name: _____ Relationship _____

Home_____Mobile_____Work_____

Current Primary Care Doctor (if none, indicate when and with whom you were last seen)

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

Therapist or Other Mental Health Provider (if none, indicate N/A)

Name of Provider and Practice: _____
Full Address: _____
Phone Number: _____ Fax Number: _____

Pastor or Spiritual Leader (if none currently, indicate your last one)

Name: _____ Name of Church: _____
Full Address: _____
Phone Number: _____ Fax Number: _____

Preferred Pharmacy Information

Name & Address: _____
Phone Number: _____

Please describe the primary reason for today's appointment: _____
_____
_____
_____

Past Psychiatric History

Are you currently seeing a psychiatrist? Yes ☐ No ☐ **Who?**_____
If no, have you ever seen a psychiatrist? Yes ☐ No☐
How old were you when you first saw a psychiatrist? _____ Why? _____
How many psychiatrists have you seen? _____ **Diagnosis?** _____
When were you last seen by your current psychiatrist?_____
How long have you been seeing this doctor? _____**Why did you leave?** _____

Are you currently seeing a therapist / counselor? Yes ☐ No☐ **Who?** _____
If no, have you ever seen a therapist / counselor? Yes ☐ No ☐
How many therapists have you seen? _____ Names: _____
How old were you when you first saw a therapist? _____ Why? _____
How long have you been seeing your current therapist? _____
Last time you saw this therapist: _____ Type of therapy: _____

Have you EVER been prescribed any psychiatric medication? Yes ☐ No ☐

Please circle all medications you have EVER been prescribed
Prozac, Paxil, Zoloft, Celexa, Lexapro, Effexor, Pristiq, Cymbalta, Wellbutrin, Buspar, Remeron, Trazodone, Elavil, Luvox, Xanax, Klonopin, Valium, Ativan, Risperdal, Zyprexa, Seroquel, Abilify, Geodon, Lithium, Depakote, Tegretol, Trileptal, Lamictal, Neurontin, Topamax, Ambien, Lunesta, Rozerem, Restoril, Adderall, Concerta, Ritalin, Focalin, Vyvanse, Strattera, Provigil, Namenda, Aricept, Intuniv, Clonidine, Guanfacine, Latuda, Brintellix, Viibryd, Haldol, Halcion, Lyrica, Trintellix, Tenex,
Other _____

Which one(s) have helped you the most? _____
List what you currently taking (including doses): _____
Who is prescribing this medication? _____

Have you ever been **hospitalized for psychiatric reasons (including drug or alcohol)**? Yes☐ No☐
If YES, please describe when, where and why: _____

1. Have you been consistently depressed or down, most of the day, nearly every day for the past 2 weeks or longer? Yes ☐ No☐ 2. In the past 2 weeks or longer, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? Yes ☐ No ☐

3. Have you felt sad, low or depressed most of the time for at least 2 years? Yes ☐ No ☐

4. Have you ever had a period of time when you were feeling "up" or "high" or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self and had not used alcohol or drugs? Yes ☐ No ☐

5. Have you ever been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family members? Yes ☐ No ☐

6. Have you or others noticed that you have been more irritable or overreacted, compared to other people, even in situations that you felt were justified? Yes ☐ No ☐

7. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situation where most people would not feel that way? Yes ☐ No ☐

8. Do you feel anxious or uneasy in places or situations where you might have a panic attack or the panic-like symptoms above, or where help might not be available or escape might be difficult; like being in a crowd, standing in a line, when you are alone away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car? Yes ☐ No ☐

9. For the past 6 months or longer, have you been unable to stop worrying about things (ie: your future, finances, your family/children, your health, etc.), over which you have no control, to the point of it affecting your sleep, creating muscle tension, fatigue, poor concentration, irritability and feeling on edge or keyed up? Yes ☐ No ☐

10. In the past month, were you fearful or embarrassed about being watched, being the focus of attention, or fearful of being humiliated in social situations? This includes public speaking, eating in public or with others, writing while someone watches, or being in social settings. Yes ☐ No ☐

11. In the past month, have you been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? For example, the idea that you were dirty, contaminated or had germs, or fear of contaminating others, or fear of harming someone even thought you didn't want to, or fear you would act on some impulse or fear a superstition that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting or religious obsessions. Yes ☐ No ☐

12. In the past month, did you feel compelled to do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or collecting, arranging things or doing other superstitious rituals—even when you knew it did not make sense? Yes ☐ No ☐

13. Have you ever experiences or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? (Examples include serious accidents, sexual or physical assault, terrorist attack, being held hostage, kidnapping, fire, discovering a dead body, sudden death of someone close to you or war or natural disaster.) Yes ☐ No ☐

14. What is your current weight in pounds? _____. Has your weight increased or decreased by more than 10 pounds during the past few years? Yes ☐ No ☐ If yes, please explain:

15. In the past 3 months, did you have eating binges or times when you ate very large amounts of food in a short period of time, to the point of being uncomfortably full, followed by feelings of disgust and self-loathing. Yes ☐ No ☐

16. Have you ever binged on a large amount of food and then made yourself vomit it back up to avoid gaining weight? Yes ☐ No ☐

17. Have you ever starved yourself, taken laxatives, taken diuretics or excessively exercised in an effort to lose weight due to a fear of being fat, even though you were normal weight or underweight? Yes ☐ No ☐

18. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? Yes ☐ No ☐

19. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone else's mind or hear what another person was thinking? Yes ☐ No ☐

20. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Have you ever felt that you were possessed? Yes ☐ No ☐

21. Have you ever believed that you were being sent special messages through the TV, radio or newspaper, or that a person you did not personally know was particularly interested in you? Yes ☐ No ☐

22. Have your relatives or friends ever considered any of your beliefs strange or unusual? Yes ☐ No ☐

23. Have you ever heard things others people couldn't hear such as voices? (Excluding religious experiences) Yes ☐ No ☐

24. Have you ever had visions when you were awake or have you ever seen things that other people couldn't see? (Excluding religious experiences). Yes ☐ No ☐

When you look over your life, which one or more of the following ways/patterns of being has been relatively stable over time (from childhood to present)?

☐Unjustifiable distrust of other people and suspecting them of being mean; baseless persecution from others.
☐Detached from close relationships (neither wants nor enjoys them) and preferring not to express much emotion.
☐Extreme discomfort in close relationships and preferring activities that other people consider odd or eccentric.
☐Disregarding the rights of other people without concern for how it affects them; going against societal norms.
☐Extremely unstable mood, interpersonal relationships, sense of self and impulsivity; recurrent suicidal behavior.
☐Extreme emotionality and attention-seeking; uncomfortable unless center of attention; extremely dramatic.
☐Extreme arrogance, need for admiration from others and lack of empathy for others; believe you are superior
☐Extreme social inhibition, inferiority and inadequacy; hypersensitive to negative evaluation; fear of rejection.
☐Excessive need to be taken care of resulting in clinging behaviors and fear of separation; poor decision-making
☐Preoccupation with perfectionism, details, rules, lists, and organization; miserly frugality; reluctant to delegate tasks for fear they won't get done right; rigidity and stubbornness—none of which you see as a problem!

Suicide History

Are you having thoughts of suicide right now? Yes☐ No☐ Do you have a plan? Yes☐ No☐
Have you ever had suicidal thoughts in the past? Yes☐ No☐ Did you have a plan? Yes☐ No☐
Have you ever attempted suicide? Yes☐ No☐ How many times? _____
If YES to any, please explain further: _____
Have you engaged in self-injurious behaviors like cutting, burning, etc.? Yes☐ No☐
If YES, when was the last time? _____

Injury to Others

Have you ever thought seriously about harming or killing someone else? Yes☐ No☐
Did you have a plan? Yes☐ No☐
If YES, please describe further: _____

Recent Stressful Life Events

Please **check** all that have affected you within the last 2 years:

Recently Married ☐	Difficulties with Family Members ☐	Financial Issues ☐
Recently Divorced ☐	Work-related Changes or Difficulties ☐	Slander/Gossip/Scandal ☐
Marital Discord ☐	School-related Changes or Difficulties ☐	Extramarital Affair ☐
Restraining Order ☐	Personal Injury ☐	Un-repented Sin ☐
Recent Breakup ☐	Sexual Difficulties ☐	Un-forgiveness ☐
Special Needs Child ☐	Personal Illness ☐	Retired☐
Birth of a Child ☐	Recent Move ☐	Death of a Loved One ☐
Legal Difficulties/Custody Battle ☐		Serious Health Issues of a Loved One ☐
Lost Job/Fired/Let Go ☐	Bullied ☐	Spiritual Issues ☐
Rape/Sexual Assault ☐	Caring for an Elderly Relative☐	Robbery/Burglary/Mugging ☐
Other: _____	I have not experienced any major life stressors☐	

Substance Use History

Alcohol Use:

How often do you drink? _____Do you drink alcohol to self-medicate? Yes ☐ No ☐

Answer the following questions regarding your consumption of alcohol and drugs:

Has anyone ever told you that you were drinking too much? Yes☐ No☐
Have you ever tried to cut down on your drinking? Yes☐ No ☐
Have you ever gotten annoyed at people telling you to cut down? Yes ☐ No ☐
Have you ever felt guilty about your drinking? Yes ☐ No ☐
Have you ever needed a drink in the morning to get you going? Yes ☐ No ☐
Have you ever been diagnosed with alcoholism OR drug dependence? Yes ☐ No ☐

Have you ever received treatment/rehab for alcoholism or drug dependence? Yes ☐ No ☐

If YES, when and where you treated? _____

Drug Use: Circle any of the following drugs you have EVER taken or tried (not including medication prescribed to you by a doctor):

Marijuana	Inhalants	Heroin	Mushrooms	Hallucinogens
Amphetamines / Meth	Ecstasy	Opiates	LSD	Barbiturates
Speed	Cocaine / Crack	K-2	PCP	Other
Sedatives / Benzodiazepines	Cold medicine		Other	NONE

If circled any of the above, please describe further: _____

Have you ever taken prescription medication in an unauthorized manner? Yes ☐ No ☐

If YES, explain:

Spirituality

1. Do you and your family regularly attend church? Yes☐ No☐
2. Is it a Bible-believing church? Yes☐ No☐ Unsure☐
3. If yes, please provide the church's name _____
4. How would you describe your relationship with Christ? _____
5. Is prayer an integral part of your life? Yes☐ No☐
6. Do you believe in the power of prayer? Yes☐ No☐
7. How do you define sin? _____
8. How do you define repentance? _____
9. Any areas of un-repented sin in your life that could be blocking God's best for you? Yes☐ No☐
10. If yes, please describe: _____
11. Are there any areas of un-forgiveness in your life? No☐ Yes☐
12. If yes, please describe: _____
13. Are you aware that unresolved/un-repented spiritual issues negatively impact a person's emotional, mental, psychological and physical wellbeing? No☐ Yes☐ Unsure☐
14. Do you believe that Jesus died for your sins and rose for your victory, your salvation, and for you to change from sinner to saved? No☐ Yes☐ Unsure☐
15. Are you saved? No☐ Yes☐ Unsure☐

16. Do you believe that because you are saved, you have power over sin? No☐ Yes☐ Unsure☐
17. Do you believe that Jesus is more powerful than any sin? No☐ Yes☐ Unsure☐

What is your favorite verse of scripture? Please write it in entirety: _____

Your Social History

What do you like to do for fun? _____
How do you relieve stress? _____ Are you physically active? Yes☐ No☐
Do you have close friends? Yes☐ No☐ Is it difficult for you to make friends? Yes☐ No☐
Who do you trust? _____ Are you currently dating? Yes☐ No☐ N/A☐
Do you enjoy social situations? Yes☐ No☐ Do you prefer to engage in solitary activities? Yes☐ No☐
Do you have to drink alcohol or use drugs to help you feel more comfortable socially? Yes☐ No☐
Are you involved in any groups or organizations? Yes☐ No☐ Which ones and what is your role?

Your Birth History & Childhood

My mother's pregnancy with me was: normal ☐ abnormal ☐
My mother's delivery of me was: normal ☐ abnormal ☐
If abnormal, please explain: _____ I do not have this information ___

Were your developmental milestones met on time (talking, walking, toileting, etc)? No☐ Yes☐ Unsure☐

Please CIRCLE all of the following issues that pertained to you during childhood/teen years:

Afraid to Go to School Seizures / Tics Disrespectful/Destructive to the Property of Others
Ran Away from Home Bullying No Friends Bedwetting after Age 5
Cruelty to Animals Lying / Stealing Disturbed Sleep / Nightmares
Set Fires Frequent Falls Fear of the Dark Spiritual Issues
Truant from School Poor Grades in School Oppositional to Authority
Often Lied to Family and Others Alcohol / Drugs Promiscuity /Sex
Frequent Transitions (moves, school changes, etc) Abuse / Incest
Difficulty with Reading, Writing, Mathematics Awkward at Games or Social Activities
Psychological Testing School Detentions Divorced Parents / Step-Parents
Learning Disorder(s) Expelled from School Mispronounced Words/Lisp/Stuttered/Stammered
Failed / Repeated a Grade IEP / 504 Plan Juvenile Detention None of These Pertained to Me

Family History

Were you adopted? No☐ Yes☐ Who lived in the home? _____
Name, age and gender of siblings: _____
Describe what it was like growing up in your home environment: _____
Check all that applied to the home: Stable☐ Chaotic☐ Abusive☐ Happy☐ Scary☐ Fun☐ Safe☐

Family Psychiatric, Medical and Substance Abuse History

Please list all BIOLOGICAL family members affected by the conditions below. Write N/A if none.

Depression _____ Bipolar Disorder _____
ADHD _____ Anxiety Disorder _____
PTSD _____Obsessive Compulsive Disorder _____
Panic Disorder _____ Substance Use _____
Schizophrenia and other Psychotic Disorders _____
Learning Disorders _____ Eating Disorders _____
List other Psychiatric / Medical Problems _____
Psychiatric Hospitalizations _____
Have there been ANY suicide attempts or completions on either side of the family? Yes☐No☐
If YES, please explain: _____
Diabetes _____ Brain/Nerve Problems _____
Seizures/Epilepsy _____ Heart Problems _____ Obesity _____
High Cholesterol _____ High Blood Pressure _____

Legal History **Have you ever been arrested for ANY reason?** Yes☐ No☐
If YES, please indicate the year(s), the charge(s): _____
If YES, did you spend any time in jail? Yes☐ No☐ Prison? Yes☐ No☐

Medical History

Sleep: Check all that apply:
Difficulty falling asleep☐ Difficulty staying asleep☐ Feeling tired upon wakening☐ Nightmares☐
Bedwetting☐ Sleepwalking ☐ **Do you take anything to help you sleep? Yes☐ No☐ What?**
Smoking: Do you smoke cigarettes, cigars or use other forms of tobacco? Yes☐ No☐ **What?**
Caffeine: Coffee? Yes☐ No☐ Tea? Yes☐ No☐ Soda? Yes☐ No☐ Energy drinks? Yes☐ No☐

Current Non-Psychiatric Medications, Allergies and Medical Conditions

Please ***list all allergies***, including allergies to medications (if none, indicate "N/A"): _____

List ALL current medications, including over- the counter medications and herbal supplements:

Name_____ Dose_____ Reason taking_____
Name_____ Dose_____ Reason taking_____

Name and title of person who prescribed your medication: _____
What medical conditions do you have currently? Please **circle all that apply**:

Diabetes	Anemia	Endocrine Problems (hormones)
High Blood Pressure	Heart Problems	Allergies
High Cholesterol	Pain Problems	Thyroid Problems
Neurological Problems / Seizures	Joint Problems	Skin Problems
Liver Problems	Eye Problems	Kidney Problems
Headaches	Musculoskeletal Issues	Gynecologic Problems
Sinus Issues	Gastrointestinal Problems	Lung Problems
Dental Problems	Sexually Transmitted Diseases	NONE OF THESE

Other: _____

Are you seeing any specialists? Yes☐ No☐ Explain further: _____
Have you ever hit your head and lost consciousness? Yes☐ No☐ Describe: _____
Have you ever had a CT scan? Yes☐ No☐ Explain: _____
Have you ever had an MRI? Yes☐ No☐ Explain: _____
Have you ever had an EEG? Yes☐ No☐ Explain: _____
Have you ever had a seizure? Yes☐ No☐ Explain: _____

Your Children

List your children's ages, gender, whether or not they have EVER been diagnosed with any major **medical and/or psychiatric** illnesses, and what medication they take.
Name _____Age____ Gender____ Diagnosis / Medication _____
Name _____Age____ Gender ____ Diagnosis / Medication_____

Abuse/Trauma History

Have you ever been a victim of verbal/emotional abuse? Yes☐ No☐ Perpetrator? Yes☐ No☐
If yes to either, please explain: _____

Have you ever been a victim of physical abuse? Yes☐ No ☐ Perpetrator? Yes☐ No☐
If yes to either, please explain: _____

Have you ever been a victim of sexual abuse? Yes☐ No☐ Perpetrator? Yes☐ No☐
If yes to either, please explain: _____

Have you ever been in a situation where you feared that your life, or someone else's life, was in imminent danger? Yes☐ No☐ **If "yes," please explain** _____

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 INFORMATION (if not patient):

Full Name:

_____

(First) (MI) (Last)

Relationship to patient: _____ Gender: M ____ F ____

Address: _____ City: _____ State: _____

Zip Code: _____ DOB: _____ SSN _____

Phone number: _____ Email Address: _____

Employer's Name & Address: _____

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.

Patient / POA Signature: _____ 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.

GUARANTOR AGREEMENT:

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 with The Fort Christian Psychiatric Center.** Our "Change of Guarantor" forms are available upon request.

CONSENT FOR TREATMENT AT A CHRISTIAN PSYCHIATRIC FACILITY:

I fully understand that The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C. is a Bible-based, Christian psychiatric practice that purposefully uses The Bible, Scripture, and prayer as the foundation for treatment— as guided by The Holy Spirit. Therefore, I agree to be treated by physicians and/or mental health professionals associated with The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C. I am fully aware that The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C. does not accept health insurance, and I agree that I am personally responsible for ensuring that all fees are paid at the time services are rendered. I authorize The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C. to provide information concerning my treatment to any referring physician or therapist, as well as to any physician/therapist to whom I may be referred following the initial consultative diagnostic evaluation.

Patient's Signature _____ 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.**

Signature of POA: _____ Date: _____

The Fort Christian Psychiatric Center
Shaw Wendi Fortuchang, MD, FAPA
110 North Park Drive, Fayetteville, GA 30214
(Phone) 770-376-6726 (Fax) 770-376-6727

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Please read each section very carefully, and write your initials where highlighted.

Insurance

The Fort Christian Psychiatric Center is not contracted with any insurance companies. This means that we do not accept insurance and we do not submit any billing claims to insurance companies. We are considered an "out-of-network" provider. If you wish to be reimbursed by your insurance company, you will be responsible for filing the claim on your own. You will be given a receipt containing all the codes needed by your insurance company, but we cannot guarantee that your insurance company will reimburse services rendered. We reserve the right to charge additional administrative fees related to insurance claims, when appropriate. X_____

Appointments

Our office hours (summer and regular) follow the Fayette County School calendar. When Fayette County schools are closed due to inclement weather, we will also be closed. X____

HOURS: Mon-Thu from 7am – 7pm. Appointments are scheduled on Tuesdays, Wednesdays and Thursdays. We are closed on Fridays and weekends. X____

Appointments are scheduled as frequently as necessary considering the patient's clinical condition, and the need for supervision and changes in the medication regimen to properly provide safe medical care. Patients are expected to arrive on time for their appointments. Please note that 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, and the remainder of the time may be used (**This policy does NOT apply to 15-minute sessions**). *Once 15 minutes have elapsed, the appointment will be automatically cancelled. Payment for the full fee of the cancelled session will be expected prior to rescheduling the appointment. X_____

Missing appointments makes it difficult for us to provide safe and efficient patient care. Patients who cancel 3 or more consecutive appointments are subject to termination. Additionally, if a patient has not been seen in 3 months or longer, they may be subject to termination. Patient safety is our utmost concern at The Fort Christian Psychiatric Center, and making and keeping regularly scheduled appointments is an integral component of this safety process—especially when patients are prescribed medication. The frequency of which appointments are scheduled is an important decision made solely at the discretion of Dr. Fortuchang and her clinical judgment. Close adherence to our office policies and pearls of wisdom covenant agreement is vitally important to us as a Christian-centered medical practice. X_____

Appointment Reminders for Established Patients

It is always your responsibility to remember the date and time of your appointment. However, as a courtesy (and only after you have provided consent to receive them), an **unencrypted** appointment reminder will be sent via email from our business email address (Dr.Fortuchang@thefortchristian.com or Dr.Fortuchang@gmail.com). These reminder emails are typically sent about 3 days prior to the appointment. **If, for any reason, the email does not get sent, is sent to your spam folder, or is sent with incorrect information resulting in a late arrival or a missed appointment, TFCPC will not be held responsible. Dr. Fortuchang will never change an appointment date or time without notifying you first. Please always adhere to the appointment date and time that you and Dr. Fortuchang schedule together at the end of your session.** Therefore, if the system sends a reminder email with incorrect information and you are late to or miss your appointment as a result, then you will be held solely responsible and will be charged the full amount for that session. X_____

Payment Options

We operate on a fee-for-service basis. We accept American Express, Discover, MasterCard and Visa credit cards, cash, checks, debit cards and health savings cards. Full payment is expected at the time services are rendered. A $35 fee will be assessed for any returned checks. Writing more than 1 bad check will result in revocation of all check-writing privileges at The Fort Christian Psychiatric Center. X_____

Initial Diagnostic Evaluations & Consultations

Initial Diagnostic Evaluations and Consultations are conducted typically conducted in the morning on Tuesdays, Wednesdays and Thursdays. If you choose to cancel your appointment, then you must do so at least 48-hours prior to the exact date and time of the appointment in order to avoid being charged. A cancellation made after 48 hours to the exact date and time of the appointment will be charged the full fee for the missed session. All no-shows are charged the full fee for the session. X____

The Initial Diagnostic Evaluation is always considered a consultation. The decision of whether or not subsequent appointments are scheduled, and whether or not a patient-doctor relationship will be established, is made completely by Dr. Fortuchang and The Fort Christian Psychiatric Center. In the event that the initial evaluation is solely a consultation, a consultation report may be made available to you upon request. The individual or their designated guarantor will be fully responsible for all fees incurred at the time of the consultation. X_____

Cancellations and No-Shows for **Established Patients** Only

Your appointment time is reserved specifically for you. Therefore, The Fort Christian Psychiatric Center adheres to a strict cancellation and no-show policy. Missed appointments not cancelled within 24 hours to the exact date and time of the scheduled appointment will be charged the full rate for the session. No-shows occur when a patient does not call to cancel their appointment and does not show up for it. No-shows are ALWAYS charged the full fee for the missed session. Please note that insurance companies DO NOT reimburse these fees. X____

To cancel an appointment, you may call and speak with a representative of TFCPC or leave a voice message. To reschedule an appointment, you must speak directly with a representative of TFCPC. Patients with outstanding balances may NOT schedule a follow-up appointment until after the balance is paid in full. When possible, patients are asked to please cancel appointments during business hours. X_____

Telephone Policy

To provide quality care to her patients, Dr. Fortuchang prefers to personally return calls to her patients. Messages left between the hours of 7am and 7pm on Monday through Thursday will be returned within 24 hours. All messages left after 7pm on Thursday will be returned on the next business day (Monday). X____

If you are experiencing a life-threatening emergency, do not call the office first. Please call 911 or go to the emergency room. X_____

Extensive Phone Call Policy

For more extensive phone calls please schedule a phone appointment with Dr. Fortuchang. There will be a routine charge for these phone sessions based on the time spent per call. (Please see fee schedule outlined above). This includes phone calls lasting longer than 10 minutes. X____
*Please note that most insurance companies **will not** reimburse for phone consultation fees. X_____

After Hours, Urgencies and Emergencies

An urgent matter is anything requiring Dr. Fortuchang's attention, which can be fully addressed in the office or via telephone (needing a prescription, having questions about your medication, a recent non-life-threatening stressor, etc.). In other words, it is NOT an emergency. X____

An emergency is anything that is life-threatening which requires immediate attention and cannot be fully addressed in the office or via telephone. Typically, emergencies require you to call 911 or to go to your nearest emergency room. X____

During normal business hours, please call the office for any urgent matters. For urgent matters occurring outside normal business hours that cannot wait until the next business day to be addressed, please call our after-hours line (our fax line). Your call will be routed directly to Dr. Fortuchang's private voicemail. Please leave a message including your name, the patient's name (if different), the best contact number where you can be reached, and the issues concerning you/the patient. Dr. Fortuchang will be notified and your call will be returned as soon as possible. X____
For emergent matters, please call 911 or go to the nearest emergency room. 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.
**Patients are expected to call our office to schedule an appointment following any and all emergencies. X_____

Medication Refill Policy

Part of providing quality care is safe monitoring of medication. We make every effort during your appointment to provide enough medication refills to last until your next appointment. Once you have requested your last refill from your pharmacy, we require you to schedule a follow-up appointment before the next refill. X____
**We charge $25 for ALL medication refill requests made between appointments. X____
**Prescriptions are only "called in" for current patients of The Fort Christian Psychiatric Center who maintain their regularly scheduled appointments. Refills for controlled substances with always require an appointment with Dr. Fortuchang. 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, over the weekend, or on holidays. X____

Therefore, we urge you to pay close attention to your medication supply. We encourage you to make prescription requests during your appointment in order to avoid being assessed a $25 fee. X_____

Photocopies

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

Email Policy

*Please note that Dr. Fortuchang prefers to communicate via telephone and no longer engages in email communication with patients or their representatives. However, as a courtesy, she agrees to receive brief emails simply to cancel appointments ONLY. Emails sent with any other information is strictly prohibited and goes directly against our office policy. X____

Emails are not checked after hours or on weekends. Again, if you are experiencing an urgent matter, then call our office. If you are experiencing an emergency, then call 911 or go to your nearest emergency room. **URGENT AND/OR EMERGENT MATTERS SHOULD NEVER BE BROUGHT TO DR. FORTUCHANG'S ATTENTION VIA EMAIL** Doing so is in direct violation of our office policies and may result in revocation of email privileges. Again, emails sent to TFCPC may only be in reference to an appointment cancellation. Be aware that emails will typically not receive a reply. All other concerns may only be addressed 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 these communications should be considered part of the medical record; therefore, you should consider that our electronic communications 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 their treatment. However, we strongly suggest that the doctor be notified regarding this decision in order to properly begin the termination process. Similarly, The Fort Christian Psychiatric Center reserves the right, under any circumstances (including failure to adhere to the treatment plan, office policies and pearls of wisdom covenant agreement, etc.) to terminate the doctor-patient relationship at the discretion of Dr. Fortuchang. Patients with inactive charts for 3 months and longer are subject to termination. We charge $25 for medical records to be forwarded. X_____

Once treatment is terminated, 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_____

Outside Food & Beverages

Because this is a physician's office, it is the policy of The Fort Christian Psychiatric Center to refuse to allow consumption of outside food and beverages (not including water) within our office. X_____

Prior-Authorization, Records, Forms and Other Fees

Requests for medical records: $25/request. X ____

Requests for completion of forms (school, work, jury duty, insurance companies, prior auth, etc.): $15/form. X____

Requests for medication refills made between appointments: $25/refill. X_____

Use of the credit card form on file for payment of services will result in a surcharge of $2/use. 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

I have read and initialed the office policies of The Fort Christian Psychiatric Center. I understand them and I agree to adhere to them. I understand that The Fort Christian Psychiatric Center 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. All balances 30 days past due will be deemed delinquent and may carry a late fee equivalent to 1.5% per month of the outstanding balance. Outstanding balances over 90 days may be referred to a collection agency. Delinquent accounts must be paid in full before any future services will be provided. 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 the aforementioned circumstances, we will not do so without attempting to discuss it with you first. X_____

I authorize The Fort Christian Psychiatric Center to provide information concerning my treatment to any physician or therapist who referred me to The Fort Christian Psychiatric Center, as well as to my primary care physician for the sole purpose of collaborating my psychiatric care. X_____

ACCEPTANCE OF THE OFFICE POLICIES OF TFCPC

Dr. Fortuchang is committed to providing professional services of the highest quality and standards, and she considers it an honor to serve you. In order to provide her patients with the most efficient and responsible care, Dr. Fortuchang requires agreements be made as to the policies stated above. Patients are encouraged to ask questions before signing.

The invalidity of any provision of this agreement will not affect the validity of any other provision.

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/Parent/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.

Printed Name of Patient/Parent/Guardian: _____

POA Signature: _____ Date: _____

The Fort Christian Psychiatric Center
Shaw Wendi Fortuchang, M.D., P.C.

Pearls of Wisdom Covenant Agreement

1. I will notify Dr. Fortuchang, immediately, if there are any significant changes in my psychiatric symptoms and/or medical condition.

2. If I feel that I am at risk of hurting myself, I will notify Dr. Fortuchang immediately. If I feel that I am at imminent risk and need immediate attention, I will call 911 or go to the nearest emergency room.

3. If I ever end up requiring emergent psychiatric treatment and/or hospitalization, I will see to it that Dr. Fortuchang is notified within 24 hours. Afterward, I will follow-up with the office on the next business day to schedule an appointment. I will also inform Dr. Fortuchang of any medication changes made at the hospital.

4. I will take my medication as prescribed. If I want to increase, decrease, or discontinue my medication regimen, I will call Dr. Fortuchang first. I understand that changes made without Dr. Fortuchang's permission are strictly prohibited, potentially dangerous and will affect my standing as a patient at The Fort Christian Psychiatric Center.

5. I understand that it is extremely important not to share my medication with anyone else, as well as not to take any medication that has been prescribed to someone else. I understand that such actions are strictly prohibited.

6. I understand that obtaining psychotropic medications from any doctor(s) other than Dr. Fortuchang (without her knowledge) violates the trust and open communication essential to a healthy therapeutic relationship. Therefore, such actions are strictly prohibited and may result in termination from The Fort Christian Psychiatric Center.

7. I understand that it is strongly advised to not drink alcohol or use illegal drugs— especially while taking psychiatric medications. I understand that substance abuse/dependence may result in termination of treatment and referral to an addictions specialist. I am aware that Dr. Fortuchang is NOT an addictions specialist.

8. I will notify Dr. Fortuchang if there are any changes to my home address, phone number or e-mail address.

9. I fully understand that the Fort Christian Psychiatric Center does NOT engage in email communication with patients and/or their families. Therefore, 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.

10. I will adhere to the treatment plan (medication, frequency of appointments, etc.) prescribed by Dr. Fortuchang, and I will ask questions when I do not understand something regarding my psychiatric treatment.

11. I understand that it is fully my responsibility to keep track of my medication and request any refills during my appointment. I am fully aware that requests made between appointments are subject to a $25 fee.

12. I have read the office policies for The Fort Christian Psychiatric Center in their entirety. I understand them, I agree with them, and I understand that failure to adhere to them may result in termination of my treatment.

13. I agree NOT to take any over-the-counter supplements (diet pills, herbal supplements, etc)—especially if I'm being prescribed medication, without first discussing it with Dr. Fortuchang. Such supplements have been known to have adverse effects and may worsen certain psychiatric disorders. I understand that failure to adhere to this pearl could jeopardize my status as a patient at The Fort Christian Psychiatric Center.

14. I understand that failure to adhere to the aforementioned pearls of wisdom could result in my termination from The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C.

I have read, understand, and agree with the above Pearls of Wisdom.

Patient's Signature _____ Date _____

Patient's 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.**