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

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? □Referred by: _____ Word of mouth□ Website□ Internet□ Radio□

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

May we email courtesy appointment reminders to you? 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□** □Self-Abuse/ Self Harm / Cutting **C□ P□** □Spiritual Issues/Occult/ Etc. **C□ P□**
□Headaches **C□ P□** □Self-Esteem Problems **C□ P□** □ Time-Consuming Compulsions/Rituals **C□ P□**
□Imaginary Friends **C□ P□** □Hair Pulling **C□ P□** □Sleep Problems **C□ P□** (too much□ too little□)

If OTHER, please explain here: _____

Has the child/teen EVER been treated by a psychiatrist? Yes☐ No☐

If YES, name of doctor and practice: _____

Diagnosis? _____

When was the last appointment? _____

Has the child/teen ever received psychotherapy or counseling? 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**? _____ **List hospitals, dates and reasons for each admission:**

_____

_____

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

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 participated, 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☐ Hoaxes☐ Chanting☐ Yoga☐ Seeking mediums☐

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

Doctor's name: _____ 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 this 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 _____
Other Psychiatric Problems _____
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?** _____

Diabetes _____ Brain/Nerve Problems _____
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 (speech therapy, physical therapy,etc)? 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☐
Are there any accommodations? _____

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, 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 with reimburse for 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 to 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)**. X____

*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 extremely 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 (office@thefortchristian.com). These reminder emails are typically sent about 3-7 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 scheduled at the end of your session.** Again, if you receive a reminder with incorrect information and you miss your appointment, or if the reminder goes to junk or spam and you never receive it, you will be held solely responsible and will be charged the full cost 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 business hours prior to the exact date and time of the appointment in order to avoid being charged. A cancellation made after 48 business hours to the exact date and time of the appointment will be charged the full fee for the missed session. *Tuesday appointments must be cancelled by the previous Thursday. All no-shows are charged the full fee for the session and are not granted a future appointment. 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 business-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. **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 fax line (770-376-6727). 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. **If you leave a message**, Dr. Fortuchang can 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 will 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, 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 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. 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): $35/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 at a Christian-Centered Medical/Psychiatric Facility

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 (POA).

Printed Name of Patient/Parent/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 notify Dr. Fortuchang immediately. If my child is suicidal or has a medical emergency needing immediate attention, I will call 911 or go to the nearest 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 an urgent follw-up appointment. I will inform Dr. Fortuchang of any medication changes made during the hospital visit 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. Fetching (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 an addictions specialist.

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

9. I fully understand that The Fort Christian Psychiatric Center does not engage in email correspondence 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 regarding the treatment.

10. 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.

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

12. 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

13. I understand that failure to follow these pearls of wisdom could result in my child's termination from The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C.

14. I have read the office policies for The Fort Christian Psychiatric Center (TFCPC) in their entirety. I understand them, I agree with them, and I understand that failure to follow them may result in termination of treatment.

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

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____ Date _____