



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 (OFFICE) 770-376-6726

PLEASE PROVIDE AN ANSWER FOR EVERY QUESTION!

MALE 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/Self-abuse 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 _____

If OTHER, please explain here: _____

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? _____ Date of last appt: _____

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

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: _____

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: _____

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, Zenedi, 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 has prescribed / is prescribing this medication? _____

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 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”

Child/Teen’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 non-psychiatric 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?

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:

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Toxemia | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Bleeding | <input type="checkbox"/> German Measles <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other viruses | <input type="checkbox"/> Strep throat | <input type="checkbox"/> Smoking <input type="checkbox"/> Threatened miscarriage |
| <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Use of illegal drugs | <input type="checkbox"/> Alcohol use | <input type="checkbox"/> 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)? Yes No If YES, please explain:

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):

Name _____ Age _____ Name _____ Age _____
Name _____ Age _____ Name _____ Age _____

Other relatives or persons 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 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 _____

List other Psychiatric / Medical Problems _____

****Have there been any psychiatric hospitalizations on either side of the family?** Yes No

****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 _____

School History

Name of School: _____ **Grade level:** _____

Type of School: Public Private Special Alternative Home-Schooled
Describe the child/teen's grades: A B C F excellent good average poor failing
Gifted/advanced classes? Yes No **Special Education?** Yes No

Repeated grades? Yes No **Which ones?** _____

Grades skipped? Yes No Which ones? _____
Detentions? Yes No How many? _____ Suspensions? Yes No How many? _____
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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Does not do homework | <input type="checkbox"/> Poor spelling | <input type="checkbox"/> Poor reading skills |
| <input type="checkbox"/> Does not remain seated | <input type="checkbox"/> Oppositional in class | <input type="checkbox"/> Makes careless errors |
| <input type="checkbox"/> Does not finish homework | <input type="checkbox"/> Messy and disorganized | <input type="checkbox"/> Forgets assignments |
| <input type="checkbox"/> Incomplete class work | <input type="checkbox"/> Talks out inappropriately | <input type="checkbox"/> Poor handwriting |
| <input type="checkbox"/> Distracted | <input type="checkbox"/> Poor attention | <input type="checkbox"/> Test anxiety |
| <input type="checkbox"/> Poor math | <input type="checkbox"/> Excessive time to complete assignments | <input type="checkbox"/> None apply |

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

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

DISCLAIMER: 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.

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 cancellation 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 cancellations 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 cancellation. **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 and 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 3 months or 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 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 and then contact Dr. Fortuchang.
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 medication changes at 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. 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 any medication refills during the appointment. I am fully aware that 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 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** _____
Parent/Guardian **Printed Name** _____

Date _____
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.