



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!

ADULT FEMALE QUESTIONNAIRE

How did you hear about us? Word of mouth Website Internet Radio Referred by: _____

Do you prefer a Christian-based approach to treatment? Yes No Maybe

Name: F _____ M _____ L _____

Age: _____ DOB: _____ Race: _____ Email: _____

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 student Part-Time student

Name of school: _____ What year are you in school? _____

Type of school: 4-year college/university 2-year community/junior college Associate degree Online

Major: _____ Grades: A B C F Passing Failing GPA: _____

Any academic challenges? Yes No

If no, name of last school attended: _____ Year graduated? _____

Highest degree earned: JD MD DO MBA PhD PsyD BA BS Master's Other: _____

Major: _____ GPA: _____ **Any academic challenges back then?** 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:**

Check all that apply: Married Engaged Separated Divorced Widowed Dating Single

Any relationship issues? Yes No **Explain:**

Spouse's 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: _____

Current 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: _____

Name & Address of Your Church: _____

Do you attend on a regular basis? Yes No Do you pay tithes? Yes No Do you give offerings? Yes No

Preferred Pharmacy Information

Name & Address: _____ Phone Number: _____

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

Past & Current Psychiatric History

Are you currently seeing a psychiatrist (medical doctor)? 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 (psychologist, LPC, LCSW, etc)? 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, 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: _____

Which one(s) have helped you the most? _____

List what you are currently taking (including doses): _____

Who is prescribing this medication? _____

Have you ever been **hospitalized for psychiatric reasons (including drug and/or alcohol)**? Yes No

If **YES**, please describe when, where and why: _____

Have you been consistently depressed or down, most of the day, nearly every day for the past 2 weeks or longer? Yes No 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

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

Have you ever had a period of time when you were totally sober (no alcohol or drugs) AND felt “up” or “high” or “so full of energy” or “so full of yourself” that you were impulsive and reckless and made poor decisions that got you into trouble, OR that other people thought you were not acting like your usual self? Yes No

Have you ever been persistently irritable, for several days, resulting in arguments or verbal or physical fights, or shouted at people OTHER THAN your family members? Yes No With family members? Yes No

Have you ever had an intense rush of anxiety, or what someone might call a “panic attack,” and you suddenly felt very frightened or anxious or suddenly developed a lot of physical symptoms? Yes No

Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people WOULD NOT feel that way? Yes No

In the past 6 months, have you been very anxious about or afraid of situations like going out of the house alone, being in crowds, going to stores, standing in lines, or using public transportation? Yes No

For the past 6 months or longer, have you been unable to stop worrying about RATIONAL 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 making you feel on edge or keyed up? Yes No

In the past 6 months, have you been extremely nervous in social situations, like having a conversation or meeting unfamiliar people OR in performance-related situations, with fear of humiliating yourself? Yes No

In the past 6 months, is there anything you have been afraid to do or felt very uncomfortable doing in front of other people, like speaking, eating, writing or using a public restroom due to fear of humiliation? Yes No

In the past month, have you been bothered by IRRATIONAL 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 though 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

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

Have you ever experienced, witnessed IN PERSON (not on TV) 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

Looking back over your menstrual cycle for the past 12 months, have you had mood symptoms like anger, irritability, anxiety or depression that developed BEFORE your period and then went away during the week after your period? Yes No After your period began, did the problems disappear for at least 1 week? Yes No

In the past 3 months, have you binge-eaten or eaten 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

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

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

Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you WITHOUT EVIDENCE to prove it? Yes No

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

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? Yes No Have you ever felt that you were possessed? Yes No

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 in any way? Yes No

Have your relatives or friends ever considered any of your beliefs to be strange or unusual? Yes No

Have you ever heard things (sounds, voices) others couldn't hear? (Excluding religious experiences) Yes No

Have you ever had visions when you were awake or have you ever seen things that other people couldn't see while totally sober (no alcohol or drugs)? (Excluding religious experiences). Yes No

Suicide History

Are you having suicidal thoughts right now? Yes No Do you have a plan? Yes No

Do you the have means (guns, weapons, lethal drugs, etc)? 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 are currently negatively impacting your life:

- Recently engaged
- Recently married
- Marital discord
- Recently divorced
- Recent breakup
- Difficult family members
- School changes or difficulties
- Work changes
- Work difficulties
- Personal injury
- Personal illness
- Sexual difficulties
- Rape/sexual assault
- Extramarital affair
- Special needs child
- Birth of a child
- Recent move
- Legal difficulties
- Custody battle
- Retirement
- Financial issues
- Lost Job
- Let go from job
- Fired
- Slander
- Gossip
- Scandal
- Spiritual issues
- Drugs
- Robbery/Burglary
- Mugging
- Caring for an elderly relative
- Bullied
- Restraining Order
- Alcohol
- Serious health issues of a loved one
- Death of a loved one
- Un-repent sin
- Un-forgiveness
- 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 alcohol and drug consumption:

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

Drug Use: Check the drugs you have EVER taken or tried (excluding medication prescribed to you):

Marijuana Hashish Medical MJ Inhalants Heroin Mushrooms PCP Hallucinogens
 Amphetamines Speed Meth Ecstasy Opiates (pain pills) LSD Barbiturates
 Bath salts Cocaine Crack K-2 Spice Kratom Synthetic (man-made) drugs
 Sedatives Benzodiazepines (Valium, Xanax, Klonopin, etc) Triple Cs 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:

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

Check ALL that you have ever participated, been affected by or were 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 Spells/Curses Hoaxes Chanting Yoga Mediums

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

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

Your Social History What do you enjoy doing (hobbies)? _____

Are you physically active? Yes No

Are you currently dating? Yes No N/A

Do you have close friends? Yes No

Is it difficult for you to make friends? Yes No

Do you enjoy social situations? Yes No

Do you prefer solitary activities? Yes No

Do you use substances to feel more comfortable socially? Yes No

Are you involved in any groups or organizations? Yes No If yes, which ones and what is your role?

Your Birth History & Childhood

Mother's pregnancy was: normal abnormal

Mother's delivery was: normal abnormal

If abnormal, please explain: _____ I do not have this information

Were there any delays in developmental milestones (walking, talking, toileting, etc)? No Yes Unsure

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

- Afraid to go to school
- Anxiety
- Fear
- Moodiness
- Emotional problems
- Inattention
- Hyperactive
- Ran away from home
- Juvenile detention
- School expulsions
- School detentions
- Truant from school
- Cruelty to animals
- Cruelty to others
- Fire-setting
- Lying
- Stealing
- Cigarettes
- Alcohol
- Drugs
- Frequent accidents
- Divorced parents
- Step-parents
- Disrespectful
- Destruction of property
- Fear of the dark
- Disturbed sleep
- Nightmares
- Night terrors
- Bedwetting after age 5
- Oppositional to authority
- Spiritual issues
- Occult
- Witchcraft
- Voodoo
- Dabbling in other religions
- Frequent Transitions (moves, school changes, etc)
- Poor grades in school
- IEP
- 504 Plan
- Difficulty With: Reading Writing Mathematics
- Psychological testing
- Diagnosed learning disorder(s)
- Failed a grade/Repeated a grade
- No Friends/loner
- Peer pressure
- Bullied by others
- Bullied others
- Abuse
- Incest
- Promiscuity
- Sexually active
- Pregnancy
- Abortion
- Miscarriage
- Socially awkward
- Mispronounced words
- Lisp
- Stuttered/stammered speech
- Tics
- Seizures
- Chronic medical problems
- Other: _____
- None of these pertained to me

Family History

Were you adopted? No Yes Were your parents married? No Yes Did you have step-parents? No Yes

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 Christian

Who lived in the home (including non-relatives)? _____

Who were you closest to in your family? _____ Who were you least close to? _____

What did your parents do for a living? Father: _____ Mother: _____

Family Psychiatric, Family Medical and Family 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 _____

Psychiatric Hospitalizations? Yes No Who and on which side of the family? _____

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

Diabetes 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

Do you have any outstanding warrants? Yes No Are you currently on parole? Yes No

Are you currently on probation? Yes No Do you have any current charges? Yes No

If yes, please list ALL current charges: _____ N/A

Medical History

When was your last physical exam? _____ Doctor: _____

Where? _____ Was blood work done / labs done? Yes No

Sleep: Check all of the following that apply:

Difficulty falling asleep Difficulty staying asleep Feeling tired upon waking Nightmares
Bedwetting Sleepwalking **Do you take anything to help you sleep? Yes No What?**

Smoking:

Do you smoke cigarettes, cigars or other forms of tobacco? Yes No **Which ones?** _____

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 _____	Dose _____	Reason taking _____

Name and title of person who prescribed your medication: _____

What medical conditions do you have currently? Please CHECK all that apply:

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

Other: _____

Are you seeing any medical specialists? Yes No

If yes, which type? Why? _____

1. **Have you ever hit your head and lost consciousness?** Yes No

If yes, describe: _____

2. **Have you ever had a head CT scan?** Yes No If yes, explain:

3. **Have you ever had a MRI (brain)?** Yes No If yes, explain:

4. **Have you ever had an EKG (heart)?** Yes No If yes, explain

5. **Have you ever had an EEG (brain)?** Yes No If yes, explain:

6. **Have you ever had a seizure?** Yes No If yes, explain:

Reproductive History

What was your age at your first menstrual period? _____ What grade were you in? _____

Do you have regular periods? Yes No Have you ever missed a period? Yes No

Are you currently trying to get pregnant? Yes No Menopausal? Yes No

Are you currently taking an oral contraceptive? Yes No

Which one and for how long: _____

Does your oral contraceptive affect your mood in any way? Yes No

If "yes," please indicate how _____

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

- Extreme fatigue
- Food cravings
- Anger
- Extreme irritability
- Problems with family/friends
- Tearfulness
- Hopelessness
- Extreme anxiety
- Lack of interest
- Lack of motivation
- Poor concentration
- Extreme moodiness
- Major sleep changes
- Feeling out of control

Are you currently pregnant? Yes No Have you ever been pregnant? Yes No

Number of pregnancies: _____ Did pregnancy affect your mood? Yes No

Your Children

List your biological 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 _____
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 _____

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!

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): **Relationship to Patient:** _____

Full Name: _____
(First) (MI) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: MaleFemale SSN: _____

Phone number: _____ Email address: _____

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 led 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

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 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 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 – 7pm. Appointments are scheduled on Tuesdays, Wednesdays and Thursdays. We are closed on Fridays and weekends. X_____

Scheduling and Punctuality: 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_____

Missed Appointments: Missing appointments makes it extremely difficult for us to provide 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. Making and keeping regularly scheduled appointments is an integral component of this safety process—especially when medication is prescribed. The frequency of which appointments are scheduled is an important medical decision, involving clinical experience and guidance from The Holy Spirit. 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 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 Friday. All no-shows are charged the full fee for the session and are not granted another 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 becomes a consultation, a brief 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. 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 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. Phone sessions are charged the same rate as in-office sessions, based on the time spent. (Please see fee schedule on the website). 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 (prescription refill, medication questions, 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 emergencies, 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 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/medication 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_____

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_____

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

Email Policy: *Please note that we prefer to communicate via telephone and we do not engage in email communication with patients or their representatives. However, as a courtesy, we agree 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 OUR 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 TFPCP 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. 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_____

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, 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. 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 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: 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. Patients are encouraged to ask questions before signing.

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 immediately notify The Fort Christian Psychiatric Center (TFCPC) / Dr. Fortuchang if there are any significant changes in psychiatric symptoms and/or medical condition (pregnancy, etc.).
2. If I have thoughts of hurting myself, I will notify Dr. Fortuchang immediately. If I am suicidal or have a medical emergency requiring immediate action, I will call 911 or go to the nearest ER and contact Dr. Fortuchang afterward.
3. If I ever require emergent psychiatric treatment and/or hospitalization, I will make sure that Dr. Fortuchang is promptly notified. I will call TFCPC on the next business day to schedule an urgent follow-up appointment. I will inform Dr. Fortuchang of any medication changes made during hospital visit and/or hospitalization.
4. I will take medication as prescribed. If I want to increase, decrease, or discontinue 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 impair my standing as a patient at TFCPC.
5. I understand that it is extremely important not to share my medication with anyone, and 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 psychiatric medications 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 The Fort Christian Psychiatric Center.
7. I understand that it is dangerous to misuse alcohol and 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 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, I will follow the treatment plan (medication, frequency of appointments, etc.) outlined by Dr. Fortuchang. I will ask questions whenever I do not understand something about the treatment.
11. I understand that it is my responsibility to keep track of my medication and request medication refills during my appointment. I am fully aware that refill requests made between appointments are subject to a \$25 fee.
12. 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 may have adverse effects, may interact with prescribed medication and could worsen certain psychiatric disorders.
13. I fully understand that signing this form does not create a doctor-patient relationship between me 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.
14. 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 treatment at The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C., once becoming a patient.

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.