



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? Referred by: _____ Word of mouth Website Internet Radio
 Do you prefer a Christian-based approach to treatment? Yes No Maybe

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

Race: _____ SSN: _____ - _____ - _____ 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 Part-Time
 Name of school: _____ Type of school: _____
 Major: _____ What year are you in school? _____
 Grades: _____ GPA: _____ Any academic challenges? Yes No

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

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

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

Check all that apply: Married Engaged Separated Divorced Widowed Dating Single
 Any relationship issues? Yes No Explain: _____

Spouse's Full Name (F, M, L): _____ Years married: _____
 Age: _____ DOB: _____ Mobile Phone: _____

EMERGENCY CONTACT Name: _____ Relationship _____
 Home _____ Mobile _____ Work _____

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

Name of doctor and practice: _____

Full Address: _____

Phone Number: _____ Fax Number: _____

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: _____

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? Yes No **Who?** _____

If no, have you ever seen a psychiatrist? Yes No

How old were you when you first saw a psychiatrist? _____ Why? _____

How many psychiatrists have you seen? _____ **Diagnosis?** _____

When were you last seen by your current psychiatrist? _____

How long have you been seeing this doctor? _____ **Why did you leave?** _____

Are you currently seeing a therapist / counselor? Yes No **Who?** _____

If no, have you ever seen a therapist / counselor? Yes No

How many therapists have you seen? _____ Names: _____

How old were you when you first saw a therapist? _____ Why? _____

How long have you been seeing your current therapist? _____

Last time you saw this therapist: _____ **Type of therapy:** _____

Have you EVER been prescribed any psychiatric medication? Yes No

Please circle all medications you have EVER been prescribed

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

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 especially 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 doing it, like washing or cleaning excessively, counting or checking things over and over, or collecting, arranging things or doing other superstitious rituals—even when you knew it did not make sense? Yes No

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 had eating binges or times when you ate very large amounts of food in a short period of time, to the point of being uncomfortably full, followed by feelings of disgust and self-loathing? Yes No

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 have affected your life within the last 2 years:

- Recently Engaged Recently Married Marital Discord Recently Divorced Recent Breakup
 Difficulties with Family Members School Changes or Difficulties Work Changes or 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 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-repentant 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: Circle the drugs you have EVER taken or tried (excluding medication prescribed to you):

Marijuana / Medical MJ	Inhalants	Heroin	Mushrooms	Hallucinogens
Amphetamines / Speed / Meth	Ecstasy	Opiates	LSD	Barbiturates
Bath salts	Cocaine / Crack	K-2 / Spice	PCP	Synthetic drugs
Sedatives / Benzodiazepines	Cold medicine / 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 Coven Spells Curses Hoaxes Chanting Yoga Seeking mediums
3. **HATRED:** Unforgiveness Bitterness Resentment Envy Gossip Slander Anger Self-loathing Revenge
4. **SEXUAL:** Adultery/Affair Pornography Fornication Lewdness/Lust Molestation Incest Rape/Assault Homosexuality Bisexuality Same-sex "experimentation" Prostitution/"Escort"

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

Your Childhood

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

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

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

Family History

Were you adopted? No Yes Who lived in the home? _____

Name, age and gender of siblings: _____

Describe what it was like growing up in your home environment: _____

Who were you closest to in your family? _____

Check all that applied to the home: Stable Chaotic Abusive Happy Scary Fun Safe

Family Psychiatric, Medical and Substance Abuse History

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

- Depression _____ Bipolar Disorder _____
 ADHD _____ Anxiety Disorder _____
 PTSD _____ Obsessive Compulsive Disorder _____
 Panic Disorder _____ Substance Use _____
 Schizophrenia and other Psychotic Disorders _____
 Learning Disorders _____ Eating Disorders _____

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

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

- Diabetes _____ Brain/Nerve Problems _____
 Seizures/Epilepsy _____ Heart Problems _____ Obesity _____
 High Cholesterol _____ High Blood Pressure _____

Legal History

Have you ever been arrested for ANY reason? Yes No

If YES, please indicate the year(s), the charge(s): _____

If YES, did you spend any time in jail? Yes No **Prison?** Yes No

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 circle all that apply:

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

Are you seeing any 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: Male ___ Female ___

SSN: _____ Phone number: _____

Employer's Name/Address: _____

Phone number: _____

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

Patient / POA Signature: _____ Date: _____

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

GUARANTOR AGREEMENT:

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

CONSENT FOR TREATMENT AT A CHRISTIAN PSYCHIATRIC FACILITY:

I fully understand that The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C. is a Bible-based, Christian psychiatric practice that purposefully uses The Bible, Scripture, and prayer as the foundation for treatment, as 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
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Please read each section very carefully and write your initials where highlighted.

Insurance

The Fort Christian Psychiatric Center is not contracted with any insurance companies. This means that we do not accept insurance and we do not submit any billing claims to insurance companies. We are considered an “out-of-network” provider. If you wish to be reimbursed by your insurance company, you will be responsible for filing the claim on your own. You will be given a receipt containing all the codes needed by your insurance company, but we cannot guarantee that your insurance company will reimburse 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_____

Appointments are scheduled as frequently as necessary considering the patient’s clinical condition, and the need for supervision and changes in the medication regimen to properly provide safe medical care. Patients are expected to arrive on time for their appointments. Please note that arriving 10 minutes after your appointment time is considered late. As a courtesy, we will allow late arrivals to be seen up to 15 minutes after the scheduled appointment time, and the remainder of the time may be used (This policy does NOT apply to 15-minute sessions). ***Once 15 minutes have elapsed, the appointment will be automatically cancelled. Payment for the full fee of the cancelled session will be expected prior to rescheduling the appointment.** X_____

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

Appointment Reminders for Established Patients

It is always your responsibility to remember the date and time of your appointment. However, as a courtesy (and only after you have provided consent to receive them), an unencrypted appointment reminder will be sent via email from our business email address (office@thefortchristian.com). These reminder emails are typically sent about 3-7 days prior to the appointment. If, for any reason, the email does not get sent, is sent to your spam folder, or is sent with incorrect information resulting in a late arrival or a missed appointment, TFCPC will not be held responsible. Dr. Fortuchang will never change an appointment date or time without notifying you first. Please always adhere to the appointment date and time scheduled at the end of your session. **Again, if you receive a reminder with incorrect information and you miss your appointment, or if the reminder goes to junk or spam and you never receive it, you will be held solely responsible and will be charged the full cost for that session.** X_____

Payment Options

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

Initial Diagnostic Evaluations & Consultations

Initial Diagnostic Evaluations and Consultations are typically conducted in the morning on Tuesdays, Wednesdays and Thursdays. If you choose to cancel your appointment, then you must do so at least **48 business hours** prior to the exact date and time of the appointment in order to avoid being charged. **A cancellation made after 48 business hours to the exact date and time of the appointment will be charged the full fee for the missed session. *Tuesday appointments must be cancelled by the previous Thursday.** All no-shows are charged the full fee for the session and **are not granted 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. There will be a routine charge for these phone sessions based on the time spent per call. (Please see fee schedule outlined above). This includes phone calls lasting longer than 10 minutes. X_____

***Please note that most insurance companies will not reimburse for phone consultation fees. X_____**

After Hours, Urgencies and Emergencies

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

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

During normal business hours, please call the office for any urgent matters. **For urgent matters occurring outside normal business hours that cannot wait until the next business day to be addressed, please call our fax line (770-376-6727).** Your call will be routed directly to Dr. Fortuchang's private voicemail. **Please leave a message** including your name, the patient's name (if different), the best contact number where you can be reached, and the issues concerning you/the patient. **If you leave a message**, Dr. Fortuchang can be notified and your call will be returned as soon as possible. X_____

For emergent matters, please call 911 or go to the nearest emergency room. Also available to you is the Georgia Crisis and Access Line 1-800-715-4225, and the National Suicide Prevention Lifeline at 800-273-8255.

****Patients are expected to call our office to schedule an appointment following any and all emergencies. X_____**

Medication Refill Policy

Part of providing quality care is safe monitoring of medication. We make every effort during your appointment to provide enough medication refills to last until your next appointment. Once you have requested your last refill from your pharmacy, we require you to schedule a follow-up appointment before the next refill. X_____

****We charge \$25 for ALL medication refill requests made between appointments. X_____**

****Prescriptions are only "called in" for current patients of The Fort Christian Psychiatric Center who maintain their regularly scheduled appointments. Refills for controlled substances will always require an appointment with Dr. Fortuchang. X_____**

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

Medication refills will not be called in after hours, over the weekend, or on holidays. X_____

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

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.

Email Policy

*Please note that Dr. Fortuchang prefers to communicate via telephone and no longer engages in email communication with patients or their representatives. However, as a courtesy, she agrees to receive brief emails simply to cancel appointments ONLY. Emails sent with any other information is strictly prohibited and goes directly against our office policy. **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 EMERGENCY MATTERS SHOULD NEVER BE BROUGHT TO DR. FORTUCHANG'S ATTENTION VIA EMAIL**** Doing so is in direct violation of our office policies and may result in revocation of email privileges. Again, emails sent to TFCPC may only be in reference to an appointment cancellation. Be aware that emails will typically not receive a reply. All other concerns may only be addressed by calling our office. 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.

Policy for Termination of Treatment

Patients are under no obligation to continue services should they choose to terminate their treatment. **However, it is required that we be notified, *in writing*, in order to properly begin the termination process.** Similarly, The Fort Christian Psychiatric Center reserves the right, under any circumstances (including failure to adhere to the treatment plan, office policies and pearls of wisdom covenant agreement, etc.) to terminate the doctor-patient relationship at the discretion of Dr. Fortuchang. Patients with inactive charts for 3 months and longer are subject to termination. **We charge \$25 for medical records to be forwarded.**

Once treatment is terminated, it is our policy NOT to re-establish the doctor-patient relationship—regardless of how the termination process was initiated. ****PLEASE** note that patients are fully responsible for any and all outstanding balances at the time of termination.

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.

Prior-Authorization, Records, Forms and Other Fees

Requests for medical records: \$25/request.

Requests for completion of forms (school, work, jury duty, insurance companies, prior auth, etc.): \$35/form.

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

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

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.

Consent for Treatment at a Christian-Centered Medical/Psychiatric Facility

I have read and initialed the office policies of The Fort Christian Psychiatric Center. I understand them and I agree to adhere to them. I understand that The Fort Christian Psychiatric Center is a Christian, Bible-based practice. I understand that The Bible, Scripture and prayer are used as the foundation for the treatment—as is dictated by The Holy Spirit. I hereby consent to be treated by physicians and/or mental health professionals associated with The Fort Christian Psychiatric Center and Shaw Wendi Fortuchang, M.D., P.C. I understand this consent does not constitute a guarantee about the results of my treatment. I understand that I can terminate this consent for treatment at any time. I also understand that my doctor, prescribing provider, therapist or counselor may terminate consent for treatment at any time, and will discuss the reasons with me if this should occur. Potential reasons include misuse of prescribed medications or mental health services, failure to reimburse for services rendered, failure to keep appointments or repeated cancellations of appointments, etc. I agree that I am personally responsible for ensuring that all charges for services rendered are paid by me, at the time services are rendered. All balances 30 days past due will be deemed delinquent and may carry a late fee equivalent to 1.5% per month of the outstanding balance. Outstanding balances over 90 days may be referred to a collection agency. Delinquent accounts must be paid in full before any future services will be provided. X_____

Statement of Confidentiality: Under Georgia law communications between patients and psychiatrists are confidential, and under ordinary circumstances, only the patient may waive this privilege. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to him or herself, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child abuse. Although legally and ethically bound to break confidentiality under the aforementioned circumstances, we will not do so without attempting to discuss it with you first. X_____

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

ACCEPTANCE OF THE OFFICE POLICIES OF TFCPC

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

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

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

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

Signature of Patient/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: _____)



PEARLS OF WISDOM COVENANT AGREEMENT

1. I will notify Dr. Fortuchang, immediately, if there are any significant changes in my psychiatric symptoms and/or medical condition (pregnancy, etc.).
2. If I feel that I am at risk of hurting myself, I will notify Dr. Fortuchang immediately. If I feel that I am at imminent risk and need immediate attention, I will call 911 or go to the nearest emergency room.
3. If I ever end up requiring emergent psychiatric treatment and/or hospitalization, I will see to it that Dr. Fortuchang is notified within 24 hours. Afterward, I will follow-up with the office on the next business day to schedule an appointment. I will also inform Dr. Fortuchang of any medication changes made at the hospital.
4. I will take my medication as prescribed. If I want to increase, decrease, or discontinue my medication, I will discuss with Dr. Fortuchang first. I understand that changes made without Dr. Fortuchang's permission is strictly prohibited, potentially dangerous and will negatively affect my standing as a patient at The Fort Christian Psychiatric Center.
5. I understand that it is extremely important not to share my medication with anyone else, as well as not to take any medication that has been prescribed to someone else. I understand that such actions are strictly prohibited.
6. I understand that obtaining psychiatric medications from any doctor(s) other than Dr. Fortuchang violates the trust and open communication essential to a healthy therapeutic relationship. Therefore, such actions are strictly prohibited and may result in termination from The Fort Christian Psychiatric Center.
7. I understand that it is strongly advised to not drink alcohol or use illegal drugs— especially while taking psychiatric medications. I understand that substance abuse/dependence may result in termination of treatment and referral to an addictions specialist. I am aware that Dr. Fortuchang is NOT an addictions specialist.
8. I will notify Dr. Fortuchang if there are any changes to my home address, phone number or e-mail address.
9. I fully understand that The Fort Christian Psychiatric Center does not engage in email 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 my treatment.
10. Because safety is paramount, I will strictly adhere to the treatment plan (medication, frequency of appointments, etc.) prescribed by Dr. Fortuchang, and I will ask questions when I do not understand something regarding my psychiatric treatment.
11. I understand that it is fully my responsibility to keep track of my medication and request medication refills during my appointment. I am fully aware that requests made between appointments are subject to a \$25 fee.
12. I have read the office policies for The Fort Christian Psychiatric Center in their entirety. I understand them, I agree with them, and I understand that failure to adhere to them may result in termination of my treatment.
13. I agree not to take any over-the-counter supplements (diet pills, herbal supplements, etc)—especially if I'm being prescribed medication, without first discussing it with Dr. Fortuchang. Such supplements may have adverse effects and may worsen certain psychiatric disorders. I understand that failure to adhere to this pearl could jeopardize my status as a patient at The Fort Christian Psychiatric Center.
14. I understand that failure to adhere to these pearls of wisdom could result in my termination from The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C.

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

Patient's Signature _____

Date _____

Patient's Printed Name _____

Date _____

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