



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 MALE 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: _____ 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 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: 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: _____

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, 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):** _____

****Full name and title of person prescribing your current medication:** _____

Have you ever been **hospitalized for psychiatric reasons (including drug 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

In the past 12 months, have you taken ANY pills to calm you down, help you relax or to help you sleep? Yes No

During the past 12 months, have you found that once you start drinking you ended up drinking much more than intended to? Yes No What about drinking for a much longer time than intended? Yes No

In the past 12 months, check all that you have you used: marijuana, speed, methamphetamine, crystal meth, "crank", prescription stimulants, Prescription pain killers (Percocet, Percodan, Oxycontin, Tylox, Vicodin, Lortab, Lorcet, Suboxone, buprenorphine), PCP, angel dust, "special K", "Vitamin K", LSD, mushrooms, inhalants, Cocaine

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

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

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

Suicide History

Are you having 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 having a negative impact on your life:

- | | | | |
|--|---|--|---|
| Recently engaged <input type="checkbox"/> | Recently married <input type="checkbox"/> | Difficult family members <input type="checkbox"/> | Financial issues <input type="checkbox"/> |
| Recently divorced <input type="checkbox"/> | Work-related changes or difficulties <input type="checkbox"/> | Slander/gossip <input type="checkbox"/> | Scandal <input type="checkbox"/> |
| Marital discord <input type="checkbox"/> | School-related changes or difficulties <input type="checkbox"/> | Extramarital affair <input type="checkbox"/> | |
| Restraining order <input type="checkbox"/> | Personal injury <input type="checkbox"/> | Un-repented sin <input type="checkbox"/> | |
| Recent breakup <input type="checkbox"/> | Sexual difficulties <input type="checkbox"/> | Un-forgiveness <input type="checkbox"/> | |
| Special needs child <input type="checkbox"/> | Personal illness <input type="checkbox"/> | Retired <input type="checkbox"/> | |
| Birth of a child <input type="checkbox"/> | Recent move <input type="checkbox"/> | Death of a loved one <input type="checkbox"/> | |
| Legal difficulties <input type="checkbox"/> | Custody Battle <input type="checkbox"/> | Serious health issues of a loved one <input type="checkbox"/> | |
| Lost job <input type="checkbox"/> | Fired <input type="checkbox"/> | Let Go <input type="checkbox"/> | Bullied <input type="checkbox"/> |
| Rape/sexual assault <input type="checkbox"/> | Caring for an elderly relative <input type="checkbox"/> | Robbery/burglary/mugging <input type="checkbox"/> | |
| Other: _____ | | I have not experienced any major life stressors <input type="checkbox"/> | |

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 LSD Hallucinogens
 Amphetamines Speed Meth Ecstasy Opiates (pain pills) Barbiturates
 Bath salts Cocaine Crack Kratom K-2 Spice PCP Synthetic drugs Triple Cs
 Sedatives Benzodiazepines (Valium, Xanax, Klonopin, etc) Other NONE

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

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

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

Your Birth History & Childhood

Mother's pregnancy with you: normal abnormal Mother's delivery of you: normal abnormal
If abnormal, please explain: _____ I do not have this information

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

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

- Afraid to go to school
- Anxiety
- Fear
- Moodiness
- Inattention
- Hyperactive
- Destruction of property
- Ran away from home
- Bullied by others
- Bullied others
- No friends/loner
- Gang involvement
- Cruelty to animals
- Lying
- Disrespectful
- Stealing
- Disturbed sleep
- Nightmares
- Night terrors
- Fire-setting
- Frequent accidents
- Fear of the dark
- Bedwetting after age 5
- Rebellious
- Truant from school
- Expelled from School
- Poor grades in school
- Oppositional to authority
- Cruelty to others
- Cigarettes
- Alcohol
- Drugs
- Promiscuity
- Sexually active
- Abuse
- Incest
- Frequent transitions (moves, school changes, etc)
- Divorced parents
- Step-parents
- Difficulty with: Reading Writing Mathematics IEP 504 Plan Socially awkward
- Psychological testing
- Failed a grade(s)
- Repeated a grade(s)
- Diagnosed Learning disorder(s)
- School detentions
- Arrests
- Juvenile detention
- Mispronounced words/Lisp/Stuttered/Stammered
- Spiritual issues
- Voodoo
- Witchcraft
- Occult
- Dabbling in other religions
- Astrology/horoscopes
- Chronic medical problems
- Seizures
- Tics
- 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 Attended church

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, Medical and Substance Abuse History Please list all **BIOLOGICAL family members affected by the conditions below. Write N/A if none.**

Depression _____ Bipolar Disorder _____
ADHD _____ Anxiety Disorder _____
PTSD _____ Obsessive Compulsive Disorder _____
Panic Disorder _____ Substance Use _____
Schizophrenia and other Psychotic Disorders _____
Learning Disorders _____ Eating Disorders _____
List other Psychiatric / Medical Problems _____

Psychiatric Hospitalizations? _____

Have there been ANY suicide attempts or completions on either side of the family? Yes No

If YES, please explain: _____

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

Legal History Have you ever been arrested for ANY reason? Yes No

If YES, please indicate the year(s), the charge(s): _____
If YES, any jail time? Yes No Prison? Yes No Parole? Yes No Probation? Yes No

Medical History

When was your last physical exam? _____ With whom? _____

Sleep: Check all 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? _____

Caffeine: Coffee? Yes No Tea? Yes No Soda? Yes No Energy drinks? Yes No

Smoking: Do you vape, smoke cigarettes, cigars or use other forms of tobacco? Yes No What? _____

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 _____

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"/> 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 |

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 Why? _____
2. Have you ever had a head CT scan or MRI (brain)? Yes No Why? _____
3. Have you ever had an EKG (heart)? Yes No Why? _____
4. Have you ever had an EEG (brain)? Yes No Why? _____
5. Have you ever had a seizure? Yes No
If yes, explain: _____

Your Children

List your children's ages, gender, whether or not they have EVER been diagnosed with any major medical and/or psychiatric illnesses, and what medication they take.

Name _____ Age _____ Gender _____ Diagnosis / Medication _____
Name _____ Age _____ Gender _____ Diagnosis / Medication _____

Abuse/Trauma History

1. Have you ever been a victim of verbal/emotional abuse? Yes No Perpetrator? Yes No
2. Have you ever been a victim of physical abuse? Yes No Perpetrator? Yes No
3. Have you ever been a victim of sexual abuse? Yes No Perpetrator? Yes No

****If yes to any of the above, please explain:** _____

Have you ever been in a situation where you feared that your life, or someone else's life, was in imminent danger? Yes No

If "yes," please explain _____

DISCLAIMER: Completing these forms does NOT guarantee an appointment. A doctor-patient, provider-patient, or therapist-patient relationship is NOT established until the decision is made to create such a relationship at the conclusion of your initial psychiatric diagnostic appointment. Therefore, you will NOT be considered a patient of Shaw Wendi Fortuchang, M.D., PC / The Fort Christian Psychiatric Center or its associates until then. If we determine our services are not adequate to meet the level of care required, we will notify you within a reasonable time frame.

GUARANTOR INFORMATION (if not patient):

Full Name:

_____ (First) _____ (MI) _____ (Last)
Relationship to patient: _____ Gender: M ___ F ___

Address: _____ City: _____ State: _____

Zip Code: _____ DOB: _____ SSN _____

Phone number: _____ Email Address: _____

Employer's Name & Address: _____

Phone number: _____

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

Patient / POA Signature: _____ Date: _____

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

GUARANTOR AGREEMENT:

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

CONSENT FOR TREATMENT AT A CHRISTIAN PSYCHIATRIC FACILITY:

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

Patient's Signature _____ Date: _____

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

Signature of POA: _____ Date: _____



The Fort Christian Psychiatric Center
 Shaw Wendi Fortuchang, MD, FAPA
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 (Phone) 770-376-6726 (Fax) 770-376-6727

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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 services rendered. We reserve the right to charge additional administrative fees related to insurance claims, when appropriate. X_____

Appointments

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

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

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

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

Appointment Reminders for Established Patients

It is always your responsibility to remember the date and time of your appointment. However, as a courtesy (and only after you have provided consent to receive them), an unencrypted appointment reminder will be sent via email from our business email address (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 Only

Initial Diagnostic Evaluations and Consultations are conducted typically conducted in the morning on Tuesdays, Wednesdays and Thursdays. If you choose to cancel your appointment, then you must do so at least **48 business hours** prior to the exact date and time of the appointment in order to avoid being charged. **A cancellation made after 48 business hours to the exact date and time of the appointment will be charged the full fee for the missed session.** *Tuesday appointments must be cancelled by the previous Thursday. All no-shows are charged the full fee for the session and are not granted a future appointment. X_____

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

Cancellations and No-Shows for Established Patients Only

Your appointment time is reserved specifically for you. Therefore, The Fort Christian Psychiatric Center adheres to a strict cancellation and no-show policy. **Missed appointments not cancelled within 24 business-hours to the exact date and time of the scheduled appointment will be charged the full rate for the session.** No-shows occur when a patient does not call to cancel their appointment and does not show up for it. **No-shows are ALWAYS charged the full fee for the missed session.** Please note that insurance companies DO NOT reimburse these fees. X_____ To cancel an appointment, you may call and speak with a representative of TFCPC or leave a voice message. To reschedule an appointment, you must speak directly with a representative of TFCPC. Patients with outstanding balances may NOT schedule a follow-up appointment until after the balance is paid in full. When possible, patients are asked to please cancel appointments during business hours. X_____

Telephone Policy

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

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

Extensive Phone Call Policy

For more extensive phone calls please schedule a phone appointment with Dr. Fortuchang. There will be a routine charge for these phone sessions based on the time spent per call. (Please see fee schedule outlined above). This includes phone calls lasting longer than 10 minutes. X_____

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

After Hours, Urgencies and Emergencies

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

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

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

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

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

Medication Refill Policy

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

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

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

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

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

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

Photocopies

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

Policy Changes

The Fort Christian Psychiatric Center reserves the right to change/modify/amend/update our office policies at any time. You will be notified of any changes. The updated version will always be available on our website and at our front desk for your review.

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.

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.

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: _____)



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.