Lilyfield Psychiatry of Atlanta, P.C.
Child, Adolescent and Adult **Psychiatry**
and **Psychotherapy**

800 Old Roswell Lakes Pkwy, Suites 250/ 260
Roswell, GA 30076
Phone(770)545-8799/ Fax(770)545-8797

Patient Information Form

Patient

Name _____

Date of Birth _____ SSN _____

Email _____

Do you consent to use this email for appointment reminders/correspondence: Yes ☐ No ☐

Street Address _____

City _____ State _____ Zip_____

Home Phone_____ I consent for staff to leave a voicemail at:

Cell Phone _____ Home Phone ☐ Cell Phone ☐

Pharmacy _____ Phone/Fax _____

Primary Care Physician _____ Phone/Fax _____

Emergency Contact _____

Relationship _____ Phone _____

Parents/Guardian (if minor)

Name_____ Name_____

Relationship _____ Relationship _____

Address _____ Address _____

Home Phone _____ Home Phone_____

Cell Phone_____ Cell Phone _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Insurance Information

Insurance Carrier _____ Policy# _____

Name of Guarantor _____ Guarantor's DOB _____

Responsible Party

I have received and read the Lilyfield Psychiatry of Atlanta, P.C. General Office Policies and Credit Card Policy. I understand and agree to all the policies. I understand I am financially responsible for all charges incurred, including those not paid by my insurance company. I understand the policies regarding missed appointment fees. I understand that these policies are subject to change, and these changes will be posted in the front office as well as on the Lilyfield website. I understand it is my responsibility to keep abreast of all policy changes. I consent to treatment including psychotherapy and/or medication management. Any questions I have asked have been answered to my satisfaction. My signature serves as acknowledgement and agreement to the above.

_____ _____

Signature of patient or guardian **Date**

Lilyfield Psychiatry of Atlanta, P.C.
Child, Adolescent and Adult **Psychiatry**
and **Psychotherapy**

800 Old Roswell Lakes Pkwy, Suites 250/ 260
Roswell, GA 30076
Phone(770)545-8799/ Fax(770)545-8797

1) I have been provided with a copy of the Lilyfield Psychiatry of Atlanta, P.C. Privacy Practices and HIPAA Notice regarding the use and disclosure of PHI (protected health information) for treatment, payment, and healthcare operations. I understand these policies.

Print Name of Patient:_____ **DOB:**_____

Print Name of Legal Guardian:_____

Signature of Patient/Legal Guardian:_____ **Date:**_____

2) Important Points to Remember:
   a. If you/your child are an imminent threat to self or others, call 911 or go to your nearest emergency room.
   b. Notify your provider if there are any significant changes to your/your child's psychiatric or medical health
   c. Please do not email Lilyfield Psychiatry of Atlanta with any urgent clinical matters. Patients should discuss any clinical concerns directly with their provider. Emails may be sent for administrative purposes after providing advanced verbal notice to front staff.
   d. Please discuss with you provider before increasing, decreasing, or discontinuing any psychiatric medication. Medication changes without consultation can be dangerous
   e. It is your responsibility to notify your provider if you are pregnant or plan to become pregnant.
   f. Refrain from driving if your medication makes you feel drowsy or otherwise impaired and notify your provider.
   g. It is advised not to drink alcohol or use illicit substances while taking psychiatric medication.

I have read, understand, and agree to the above important points to remember.

Signature of Patient/Legal Guardian:_____ **Date:**_____

3) For Parents/ Legal guardians of Minors:
   a. To provide consent for psychiatric treatment for a minor, you must have either sole custody or shared legal custody of the child. If you share legal custody, and your legal arrangement requires that you notify the other parent of health appointments, it is your responsibility to do so. Please note that any clinical matter discussed during an appointment with one parent present may be discussed with the other parent as well.
   b. By signing below, you are certifying that you are the legal guardian of (Child's Name) _____ and that you have legal authority to consent to treatment for your child. You also agree to notify Lilyfield Psychiatry of Atlanta if your custody arrangement changes.

Signature of Patient/Legal Guardian:_____ **Date:**_____

4) Every patient has the option to either pay $75 upfront annually for any forms that will need to be completed that year OR to pay per form. Please indicate your preference below by checking one option: ☐$75 annually OR ☐ Pay per form

Signature of Patient/Legal Guardian:_____ **Date:**_____