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

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

Patient Information Form

Patient

Name _____

Date of Birth _____ SSN _____

I consent to use the provided email for appointment reminders & administrative correspondence:
Email _____
Initial: _____

I consent for staff to leave a voicemail at the provided phone numbers:
Home Phone_____ Cell Phone_____
Initial:_____

Street Address _____
City _____ State _____ Zip_____
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. 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 (www.lilyfieldpsychiatry.com). 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**

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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. It is your responsibility to notify your provider if there are any significant changes to your/your child's psychiatric or medical health or medication regimen
c. Please discuss with you provider before increasing, decreasing, or discontinuing any psychiatric medication. Medication changes without consultation can be dangerous
d. It is your responsibility to notify your provider if you are pregnant or plan to become pregnant.
e. Refrain from driving if your medication makes you feel drowsy or otherwise impaired and notify your provider.
f. It is advised not to drink alcohol or use illicit substances while taking psychiatric medication.
g. 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. Please refer to the "Communicating via Email" section in our general office policies for further information regarding the risks of communicating via email.

I have read, understand, and agree to comply with 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:**_____