Michael S. Conley, M.D., P.C.
315 West Ponce de Leon Avenue, Suite 360
Decatur, GA 30030

Date: ____________________

PATIENT INFORMATION

Please fill out completely.

Last Name: ______________________________ **First Name:** ______________________ **MI:** ___

Address: ____

City: ______________________________________ **State:** ____________ **Zip:** ______________

Home Phone: _____________________________ **Cell Phone:** ________________________

Email Address: ____

Date of Birth: _____/_____/_______ **Social Security Number:** ______/_____/_________

Gender: ___________ **Language (circle one):** English / Spanish / Other: _________________

Marital Status (circle one): Single / Married / Divorced / Separated / Widowed / Partnered / Other

Employment Status (circle one): Employed Full Time / Employed Part Time / Retired / Unemployed / Student

Race (circle one): Decline to Specify / American Indian or Alaska Native / Asian / Black or African American
Native Hawaiian or Pacific Islander / White or Caucasian / Unknown / Other Race: ____________________

Ethnicity (circle one): Decline to Specify / Hispanic or Latino / Not Hispanic or Latino

Pharmacy: Name: ___________________________________ Phone: _______________________

Emergency Contact: Name: ____________________________ Phone: ______________________

Financially Responsible Party
(Please indicate who is responsible for payment, if other than yourself):

Name: ____ Phone: _________________________

Address: ____

Email Address: ____

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OFFICE POLICIES

Thank you for choosing our office for your behavioral health care needs. We look forward to working with you. Please read the following policies and sign acknowledging that you accept the terms. If there is any part that you do not understand or have questions about, please ask for clarification before signing.

INSURANCE: Your insurance policy is a contract between YOU and your insurance company. As a courtesy, we file the insurance claim for you. But please keep in mind that you are responsible for making sure that you are authorized for these visits, and that our office receives payments in a timely manner. Please note you are responsible for notifying us of any changes to your insurance prior to your appointment.

Finally, the co-payment or co-insurance that we collect at your visit is often an estimate. Final co-payment, co-insurance and deductible amounts are determined by your insurance carrier when your claim is processed.

PAYMENT: Payment for services is required at the time of service. This includes co-payments, co-insurance, deductible or past due amounts. We reserve the right to reschedule an appointment due to inability to pay. We accept cash, check, money order, VISA, MASTERCARD, and DISCOVER. There is a $35 charge for returned checks.

APPOINTMENTS: The time of your appointment is reserved for you alone. If you miss an appointment, or cancel less than 24 hours before the scheduled time, we cannot fill that appointment. Therefore, we reserve the right to charge a missed appointment fee of $50, for the doctor's time. This fee will be charged regardless of the reason for missing the appointment. This fee is not covered by your insurance company, and must be paid before your next office visit. Appointment reminders are a courtesy, and are not guaranteed. Please remember, it is YOUR responsibility to keep track of appointment dates and times.

PRIVACY: Privacy is a major priority for our office when dealing with patient's medical information. Therefore, unless we receive written consent from a patient, we will not be in contact with anyone associated with that patient, for any reason.

WAIT TIMES: Dr. Conley does his best to see you in a timely manner. If you are late for your appointment, we reserve the right to consider it a missed appointment and reschedule you for another time. If you come for your scheduled appointment time and find that Dr. Conley is running behind schedule, you may reschedule your appointment without incurring any fees. For the sake of space and privacy, we insist no children, infants, or large groups wait for patients while they receive treatment. Our office can recommend local restaurants and coffee shops where families can enjoy themselves while waiting.

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REFILLS: All medication matters must be handled during scheduled office appointments. It is your responsibility to inform Dr. Conley about what medications you need during your visit. OUR OFFICE WILL NOT CALL IN REFILLS. We make every effort to schedule appointments in a timely manner, to avoid any patient running out of medication before the next visit. Please pay attention to your medications and make sure that appointments are scheduled in the appropriate amount of time so that you don't risk that chance of running out. If you do run out, you will be required to come in to the office for an appointment to obtain a refill. We will make our best effort to work you in.

FORMS AND LETTERS: Thank you for understanding that Dr. Conley's first priority each day is to see the patients in the office. He will complete forms and letters within 10 business days. We charge a fee for all forms and letters, ranging from $25 - $75, depending on the time required for completion. Please note Dr. Conley DOES NOT COMPLETE DISABILITY PAPERWORK. If you are in need of a physician to support a disability claim, please ask us for a referral.

PRIOR AUTHORIZATIONS: Dr. Conley prescribes medications based on your condition and what he believes is your best treatment. Sometimes your insurance company limits your access to medications. These types of restrictions are part of the contract between you and your insurance company. Should your pharmacy advise you that you require a prior authorization for a prescription, please have them fax a request to our office. Once we receive the request, we will begin processing the prior authorization. Please allow 5 business days for this to be completed. Once we have received notification from your pharmacy regarding the outcome, our office will notify you by phone. No charge is required for the initial prior authorization, but if prior authorization is denied you have two options. One choice is that you can ask Dr Conley to prescribe a medication that is approved by your insurance. Your second choice is to pay our office a fee of $35 to handle the appeal process for you denied prior authorization. Please keep in mind that your insurance company is the final decision maker in what they will cover and even after filing for an appeal there is no guarantee of coverage.

TERMINATION OF CARE: Dr. Conley's goal is to provide you medical care until you feel treatment goals have been accomplished, however, you may wish to terminate your care at any time. If you have not been seen for a period of one year, Dr. Conley will consider you self-terminated. Dr. Conley reserves the right to terminate patients for non-payment of services, missed appointments, dishonest use of prescriptions, or for inappropriate behavior or conduct towards staff or himself. This termination may be verbal or in writing.

AFTER HOURS CARE / EMERGENCY ACCESS: For any medical emergency, please call 911 immediately. If you are experiencing a medical crisis and need to go to the emergency room, you can go to the nearest one, or you can go to the Atlanta Medical Center and identify yourself as a patient of Dr. Conley. They will notify him that you are there. Our voice-mail system is available after hours for other concerns. Please allow 2 business days to return calls.

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ACKOWLEDGEMENT OF OFFICE POLICIES

I have read and understand Dr. Conley's policies.

I have read and understand Dr. Conley's privacy practices.

My Signature below authorizes Michael S. Conley, MD to bill my insurance company for charges incurred during the course of my treatment. I further authorize Dr. Conley's office to release any information necessary to process such claims.

Print Name: ______________________________

Signature: ______________________________ **Date:** ______________

Witness: ______________________________ **Date:** ______________

Michael S. Conley, M.D., P.C.

315 West Ponce de Leon Avenue, Suite 360, Decatur, Georgia 30030

Phone (404) 681-4100 / Fax (404) 681-2300

michaelconleymd.com

CONSENT TO RELEASE AND RECEIVE CONFIDENTIAL INFORMATION

Patient Name: ____________________

Patient's DOB: ____________________

I authorize Michael S. Conley, M.D. to:

[] Receive my medical history information

[] Release my medical history information

to the following physician, therapist or individual:

Name: ____

Address: ____

Phone: ______________________ Fax: ______________________

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for my condition by Dr. Michael S. Conley, unless I withdraw my consent, and it will expire 365 days after I complete my treatment.

I understand the records to be released may contain information pertaining to psychiatric treatment, and/or treatment for alcohol or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illnesses.

I understand that these records are protected by the Code of Federal Regulations Title 43 Part 3 (42CRF Part 2) which prohibits the receipt of the records from making any further disclosures to third parties with the express written consent of the patient.

______________________________ ______________________

Patient's Signature Date

______________________________ ______________________

Witness Date

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name____________________ Age_____ Sex: ☐ Female ☐ Male Today's Date________

1. **During the last 4 weeks, how much have you been bothered by any of the following problems?**	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods	☐	☐	☐
e. Pain or problems during sexual intercourse	☐	☐	☐
f. Headaches	☐	☐	☐
g. Chest pain	☐	☐	☐
h. Dizziness	☐	☐	☐
i. Fainting spells	☐	☐	☐
j. Feeling your heart pound or race	☐	☐	☐
k. Shortness of breath	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐

2. **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

3. **Questions about anxiety.**	**NO**	**YES**
a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question #5.		
b. Has this ever happened before?	☐	☐
c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

4. **Think about your last bad anxiety attack.**	**NO**	**YES**
a. Were you short of breath?	☐	☐
b. Did your heart race, pound, or skip?	☐	☐
c. Did you have chest pain or pressure?	☐	☐
d. Did you sweat?	☐	☐
e. Did you feel as if you were choking?	☐	☐
f. Did you have hot flashes or chills?	☐	☐
g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h. Did you feel dizzy, unsteady, or faint?	☐	☐
i. Did you have tingling or numbness in parts of your body?...	☐	☐
j. Did you tremble or shake?	☐	☐
k. Were you afraid you were dying?	☐	☐

5. **Over the last 4 weeks, how often have you been bothered by any of the following problems?**	**Not at all**	**Several days**	**More than half the days**
a. Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐
If you checked "Not at all", go to question #6.			
b. Feeling restless so that it is hard to sit still.	☐	☐	☐
c. Getting tired very easily.	☐	☐	☐
d. Muscle tension, aches, or soreness.	☐	☐	☐
e. Trouble falling asleep or staying asleep.	☐	☐	☐
f. Trouble concentrating on things, such as reading a book or watching TV.	☐	☐	☐
g. Becoming easily annoyed or irritable.	☐	☐	☐

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'. Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

		NO	YES
6. Questions about eating.			
a.	Do you often feel that you can't control what or how much you eat?	☐	☐
b.	Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked "NO" to either #a or #b, go to question #9.			
c.	Has this been as often, on average, as twice a week for the last 3 months?	☐	☐

		NO	YES
7. In the last 3 months have you often done any of the following in order to avoid gaining weight?			
a.	Made yourself vomit?	☐	☐
b.	Took more than twice the recommended dose of laxatives?	☐	☐
c.	Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d.	Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

	NO	YES
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

	NO	YES
9. Do you ever drink alcohol (including beer or wine)?	☐	☐
If you checked "NO," go to question #11.		

		NO	YES
10. Have any of the following happened to you more than once in the last 6 months?			
a.	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b.	You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c.	You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d.	You had a problem getting along with other people while you were drinking.	☐	☐
e.	You drove a car after having several drinks or after drinking too much.	☐	☐

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank. Alc Abu if any of #10a-e is 'YES'.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.