Piedmont Psychiatric Services

2094 Woodruff Rd. Greenville, SC 29607

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Welcome to Piedmont Psychiatric Services. _____has an appointment with Julie Stokes on_____ at _____. Julie is a Licensed Professional Counselor with over 13+ years specializing in individual and family therapy for children, adolescents, and adults with mood, personality, ADHD, adjustment disorders, anxiety, OCD and Autism Spectrums. If medication management is needed, a referral can be made to one of our psychiatrists in our office for an evaluation. We understand that your decision to seek treatment for yourself or a family member may have not been an easy one and you may have questions about our practice. Below, we have tried to address some of the most commonly asked questions by new patients and provide important information regarding our office policies and procedures.

OFFICE HOURS

**Julie's office hours are 8:20-6:00 pm Mon-Thurs. and on Fridays from 8:20.m.-11:40 a.m. Please note that our office closes early on Fridays at 12:00 p.m.*

FIRST VISIT

**Please plan to arrive 15 minutes before your scheduled appointment, bringing the completed new patient packet and insurance card(s) in order to process this information.*

***The first appointment is an initial assessment and evaluation. Julie will obtain a brief history and overview of presenting problem(s). If seeing a child or adolescent, she will meet with the parents and patient together and separately. She will then discuss her findings and recommendations regarding diagnosis and return visits.*

APPOINTMENTS

*******Appointments may be scheduled by calling our appointment line at* ***864-676-9211 ext. 125 or therapists@piedmontpsych.com between the hours of 8 am-4 pm M-Thurs., and 8 am-12pm on Friday.***

** Recommended follow up appointments can be made after each visit at the front desk. You will be given an appointment card with the time and date, as well as a courtesy reminder call the day before your next scheduled appointment.*

*******If you are unable to keep a scheduled appointment, please call 24hrs in advance to cancel or reschedule. Late cancellations or "no shows" are subject to charges.*

**Excuses for missed time at school or work due to appointment can be given during check out at the front desk.*

PATIENT CONCERNS/QUESTIONS

For any patient questions or concerns contact Julie's assistant at **676-9211 ext. 125 or by email at therapists@piedmontpsych.com M-Thurs. 8am-4pm and Friday from 8am-12pm. These will be forwarded to Julie for review.*

Calls made during evenings, weekends, holidays, and after noon Fridays, should be for **emergencies only. In this case, calls are taken by the answering service and then forwarded to the physician on call. There is a $15 charge for after hour calls.*

CORRESPONDENCES/FORMS

**Requests for Medical Records, dictated letters, and completion of forms (i.e., disability, return to work statements, etc.) can be obtained for a charge. The charge varies by form needed and the length and complexity of the request. Fees must be paid when the form is presented. Please contact Medical Records at 676-9211 ext. 126 or medicalrecords@piedmontpsych.com*

BILLING/INSURANCE

As a courtesy to our patients, we submit claims for up to 2 insurances. **It is the patient's ultimate responsibility to pay any deductible amounts or any other balance not paid by your insurance company. It is recommended that the insurance company be contacted so that the limits of coverage are fully understood.*

**Co-pays, co-insurances or deductibles that are not made at the time of service, will incur a $15 non-payment fee and follow up appointments cannot be scheduled.*

**Billing personnel are available M-Fri. 9:00am-4:00 pm at 1-855-558-4649.*

I have read the information stated above and agree with the policies and procedures as presented.

*Signed*_____ *Date*_____

Mental Health Benefits- Insurance Form

Patient Name: _____DOB: _____

Physician/Therapist Name: _____

Insurance:

Name of Insurance: _____ Effective Date: _____

Insurance ID: _____ Group #: _____

Mailing Address: _____ Employer: _____

Benefit period: _____ Max # of visits per year: _____

Co-pay: _____ Co-Insurance: _____

Individual Deductible: _____Family Deductible : _____

OOP MAX (Individual): _____ OOP MAX (family):_____

Prior Authorization:

Date Requested_____ Authorization #: _____

Number of visits:_____ Start Date: _____ End date: _____

This information was verified by _____ on _____.
(Name of person you spoke with) (Date)

Policy Holder's Information:

Name: _____ Date of Birth: _____

Social Security Number: _____Relationship to patient: _____

Piedmont Psychiatric Services has called and verified mental health benefits for the above patient. I understand that the information provided to PPS by my insurance carrier is not a guarantee of benefits or payment, but is an attempt to determine and validate proper coverage. I understand that I am responsible for any amount not covered by my insurance carrier and that if payment is not made at time of service, I will be charged $15.00 for non-payment. Appointments cannot be rescheduled until patient's account is current.

Patient/Guardian: _____ Date: _____

If you have questions please call 676-9211 ext 125 or email therapists@piedmontpsych.com or you may call our billing department at 1-855-558-4649.

Directions to Piedmont Psychiatric Services

From Greenville or locations West of South of Greenville.
From Interstate 85

*** Exit onto Woodruff Road. Go approximately two and a half miles toward the town of Woodruff (not toward Greenville)*
*** Cross the bridge over 1-385. You will go past Walmart on your left, pass Goodwill and BB&T on your right.*
*** Immediately after BB&T, look for a sign on your right that says Woodruff Road Professional Park. (You should see Pizza Inn and Culvers on your left) Turn right into Woodruff Road Professional Park.*
*** We are the second to last building on the left—Piedmont Psychiatric Services Building #2094*

From Interstate 385

*** Exit onto Woodruff Road. Go approximately two miles toward the town of Woodruff (not toward Greenville)*
*** Go past Walmart on your left, and Goodwill and BB&T on your right.*
*** Immediately after BB&T, look for a sign on your right that says Woodruff Road Professional Park. (You should see Pizza Inn and Culvers on your left) Turn right into Woodruff Road Professional Park.*
*** We are the second to last building on the left—Piedmont Psychiatric Services Building #2094*

From Greer

*** Drive South on Highway 14. Cross the bridge over I-85. Stay on Highway 14 for approximately five miles to the intersection of Highway 14 and Woodruff Road. A landmark at that intersection is McDonalds on your right.*
*** Turn right onto Woodruff Road. You will see an Allstate Insurance Company on your left and a sign that says Woodruff Road Professional Park. (You should see Pizza Inn and Culvers on your left) Turn left into the Park. We are the second to last building on the left-- Piedmont Psychiatric Services Building #2094*

From Spartanburg-- and other locations East of Greenville

*** Go South on Interstate-85 (toward Greenville)*
*** Take Exit 56, Which is Highway 14. Exit 56 is the exit immediately following the Greenville/Spartanburg Airport. At the top of the ramp at Exit 56, turn left onto Highway 14.*
***Go across the I-85 bridge and continue on Highway 14 approximately five miles to the intersection of Highway 14 and Woodruff Road. There will be a McDonalds on your right.*
*** Turn right onto Woodruff Road. There will be an Allstate Insurance Company on your left and a sign that says Woodruff Road Professional Park. (You should see Pizza Inn and Culvers on your left) Turn left into Woodruff Road Professional Park.*
*** We are the second to last building on the left-- Piedmont Psychiatric Services. Building #2094*

IF YOU GET LOST PLEASE CALL 864-676-9211 PRESS OPTION 2

PIEDMONT PSYCHIATRIC SERVICES

Section A. Patient Information

Patient name: Last_____ First_____Middle_____

Sex M or F S.S#_____ Marital Status S M D W D.O.B_____

Race_____ Ethnic Group_____ Preferred Language_____

Address_____Zip_____ City_____State_____

Home#(_____) _____Cell # (_____)_____Preferred Contact Method: Home or Cell

E-mail:_____

Are You Employed: Full Time Part Time Are You a Student: Yes No If Yes, School Attended _____

Patients Employer_____ Telephone(____)_____

Employers Address _____ City, State Zip Code _____

Section B. Responsible Party Information (Parent, Guardian, Power of Attorney) if any information is the same as above, please indicate by writing "same" in appropriate section

Relationship to patient: Self Spouse Parent Other

Name: Last_____ First _____Middle_____

Mailing Address _____ City, State, Zip Code_____

Home Telephone (_____)_____Driver's license number _____

Social Security Number _____ Date of Birth_____

Employer_____ Telephone (_____)_____

Employer's Address_____ Occupation _____

E-mail:_____

Section C: Please complete if the patient is under the age of 18

Father's Name: _____ M.I. ____ Last_____DOB_____

Father's place of employment: _____ Telephone (____)_____

Mother's Name: _____ M.I. ____ Last _____DOB_____

Mother's Place of employment: _____ Telephone (_____)_____

Father's SSN_____ Mother's SSN_____Legal Guardian_____

Medical Consent: I hereby give my consent for the physician and or therapist to treat my child (or minor) as determined medically necessary. The parent or guardian will be advised of all treatment plans

_____

Signature

Assignment of Insurance Release

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and is not a substitute for payment. Some companies will pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's ultimate responsibility to pay any deductible amount, co-insurance, or any other balances not paid for by your insurance company. If we are filing your claim we will allow forty-five days from the billing date for the carrier to process your claim and make payment accordingly. If payment from your insurance company is not received within the time frame specified above we will notify you to clear your account. Filing to the insurance company is only done as a courtesy to the patient. I certify that I have read and understand fully the provider's billing policy, and agree to make payment in full and /or satisfactory arrangements when asked to do so as specified above.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and other health plans. This assignment applies to all charges outstanding as of the date of signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by the insurance carrier. I hereby authorize said assignee to release all information necessary to secure payment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

Our patient "Bill of Rights" and "Notice of Privacy Policies" are posted in the lobby of the office. We strongly encourage you to review these notices completely and ask any questions on areas that you do not understand. It is your responsibility to know and abide by both policies.

Signature_____ Date_____

Parent (if minor)_____Date_____

Consent to Examination and Treatment

I consent to have Piedmont Psychiatric Services including its professional staff perform/ order examination(s), psychotherapy, related mental health treatments, and order/refill medications when deemed necessary.

Signature_____ Date_____

Release of Confidential Information:

I hereby authorize Piedmont Psychiatric Services, P.A. to release confidential information to:

Physician : _____

Name of doctor/or practice name ***Phone/Fax#***

AND/OR THE FOLLOWING INDIVIDUALS: (FAMILY MEMBER, SPOUSE, ETC.)

_____

Name ***Relationship to patient***

_____

Name ***Relationship to patient***

_____

Name ***Relationship to patient***

The following information may be released:

____ ***Insurance & Billing***
____ ***Appointment Date & Time***
____ ***Discuss Treatment Plans (ex: medication)***
____ ***I do not wish to release any of my medical information***
____ ***Current Treatment Notes***
____ ***All of the above***

I understand that I may revoke this consent at any time except to the extent that action has been taken based on this authorization. I also understand that this authorization shall not expire unless I revoke it in writing.

_____ _____

Signature of patient or Legal Guardian ***Date***

NEW PATIENT QUESTIONNAIRE

Name _____ ***Age*** _____ ***Marital Status*** _____

Educational Level _____

Employment Status/Occupation _____

Name of Referring Physician or Therapist _____

	Yes	***No***
Cannot Sleep		
Sleeping Too Much		
Loss of Appetite		
Recent Weight Loss		
Increased Appetite		
Recent Weight Gain		
Loss of Energy		
Loss of Motivation		
Loss of Interest in Pleasurable Activities		
Decreased Interest in Sex		
Difficulty Concentrating		
Feelings of Hopelessness		
Suicidal Thoughts		
Frequent Crying Spells		
Too Much Energy		
Racing Thoughts		
Periods of Quick Anger or Agitation		
Periods of Excitement of Elation		
Overspending Money		
Anxiety Attacks		
Recurrent of Repetitive Thoughts or Worries		
Repetitive Behaviors or Rituals		
Hearing Voices		
Seeing Things that Others Do Not See		
Paranoid Feelings of Suspiciousness		

Areas of Stress

Problems with Primary Family_____

Educational Problems_____

Occupational/Work Problems_____

Financial Problems_____

How Much Alcohol do you Drink?_____

Is There Anyone in Your Family With a History of Psychiatric Problems or Treatment?

_____

General Information

Have you previously received psychiatric treatment? _____

_____

Please list all Current Medications _____

_____

_____

Please list any allergic and/or adverse reactions to medications _____

_____

_____

Please list active medical problems _____

_____

_____