

Piedmont Psychiatric Services

2094 Woodruff Rd. Greenville, SC 29607

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Welcome to Piedmont Psychiatric Services. _____ has an appointment with Carol Mitchell on _____ at _____. Carol has a Master of Science in Nursing and is a licensed professional counselor with over 16 years of specializing in individual counseling for mood and anxiety disorders, grief/loss issues, anger/stress management, gender identity issues and sex therapy. If medication management is needed a referral can be made to one of our psychiatrists here for evaluation. We understand that your decision to seek treatment for yourself or a family member may have not been an easy one and you have questions about our practice. Below, we have tried to address some of the most commonly asked questions by new patients and provided important information regarding our office policies and procedures.

OFFICE HOURS

**Carol's office hours vary. Please contact the office to schedule an appointment. Please note that our office does close early on Friday at 1 pm.*

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. Carol will obtain a brief history and overview of presenting problem(s) and 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, 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 Carol's assistant Terri at ext. 125 or by email at Terri@pedmontpsych.com M-Thurs. 8am-4pm and Friday from 8am-12pm. These will be forwarded to Carol 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.*

BILLING/INSURANCE

**As a courtesy to our patients, we submit claims for up to 2 insurances. It is the patients 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 can not be scheduled.*

**Billing personnel are available M-Fri. 9 :00am-4:00 pm at 1-800-599-7183.*

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

Signed _____ Date _____

PRIOR TO YOUR APPOINTMENT

You **MUST** call your insurance company prior to your appointment. Call the mental health number on the back of your card or the customer service number. Ask them if you need pre-authorization for outpatient mental health and obtain your outpatient mental health benefits. Be sure to ask them all of the following information:

Patient Name _____

Physician/Therapist you will see _____ Date of initial visit _____

PRIMARY INSURANCE

1. Name of Insurance carrier _____

2. Does your insurance carrier require prior authorization? Yes _____ complete questions 2-12
No _____ complete questions 6-12

3. Authorization Number _____

4. Number of visits authorized _____

5. Date authorization starts _____ Date authorization ends _____

6. Policy Holder's name _____ Group # _____

7. Policy Holder's Date of Birth _____ Policy Holder's SS # _____

8. You must provide us the outpatient mental health claims address for us to file your claim(s). **This address may be different than the medical claims address on your card.**

9. Insurance ID # _____ Policy Effective Date _____

10. Max # of visits per year _____ Deductible _____

11. Co-Pay _____ Co-Insurance _____

12. This information was verified by _____ on Date _____
(name of person you spoke with at insurance company)

I understand that by signing below that if this form is NOT FILLED OUT PRIOR to my appointment and if any of the information is incorrect my appointment will be RESCHEDULED or I will be a PRIVATE PAY PATIENT and will have to pay prior to my appointment and my insurance will not be refilled.

Patient/Guardian _____ Date _____

(If you have questions please call 676-9211 ext 125 or email me at terri@piedmontpsych.com or you may call our billing department at 1-800-599-7183)

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 I-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. (It's directly across the street from Pizza Inn.) 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. (It's directly across the street from Pizza Inn.) 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. (It's directly across the street from Pizza Inn.) 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. (It's directly across the street from Pizza Inn.) 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*

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 (Please Send Statements to) Parent or Guardian if patient is under 18 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 (____) _____ Occupation _____

Social Security Number _____ Date of Birth _____

Employer _____ Telephone (____) _____

Employer's Address _____ City, state, Zip Code _____

Driver's license number _____

Section C: Please Complete if the patient is a minor child 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

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*

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

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Employers Address _____ City, State Zip Code _____

Section B. Responsible Party Information (Please Send Statements to) Parent or Guardian if patient is under 18 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 (____) _____ Occupation _____

Social Security Number _____ Date of Birth _____

Employer _____ Telephone (____) _____

Employer's Address _____ City, state, Zip Code _____

Driver's license number _____

Section C: Please Complete if the patient is a minor child 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 and Release and Assignment

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. Billing is only done as a courtesy to the patient and is not to be done as to dismiss patient's responsibility. 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, Workman's Compensation 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 fess 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 and its professional staff perform or order examination, psychotherapy, and/or related mental health treatments and to order medications when deemed necessary or advisable by appropriate members of the professional staff.

Signature _____ Date _____

Authorization for Release of Confidential Information

Client Name: _____ SS # _____ Birth date _____

I hereby authorize Piedmont Psychiatric Services, PA to release confidential information to

the referring physician _____ and/or the following individuals(family members, spouse, ect.) _____

This information shall consist of the following: Evaluation and Progress Notes, or any information concerning patient's treatment. The above information is to be released for the Continuity of Care. This authorization shall remain valid until revoked in writing. I understand that this authorization may be revoked at any time except to the extent that action has already been taken in reliance on it

Signature _____ Date _____

NEW PATIENT QUESTIONNAIRE

Name _____ Age _____ Marital Status _____

Educational Level _____

Employment Status/Occupation _____

Name of Referring Physician or Therapist _____

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

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 _____
