REGISTRATION (please print)

BARRY K. HULL, M.D., F.A.A.F.P.
A New Start Medical Center, Inc.
115 Habersham Drive, Fayetteville, GA 30214 / 678-788-7500 phone / 678-788-7501 fax

Patient Information

DATE: _____ Preferred Contact number:_____ OK to leave message? ☐YES / ☐NO

Patient Name: _____ Date of Birth: _____ Age: _____

Parent / Guardian Names: _____ Relationship: _____

Address:_____ Insurance: _____

City: _____ State: _____ Zip: _____ Email: _____

Phones: Cell _____ Home _____ Work _____

Occupation / Grade in school: _____ Place of Employment / School: _____

Whom may we thank for referring you? _____

POLICIES AND PROCEDURES

_____ Payment must be made at the time services are rendered. You may pay with cash, check ($30.00 charge on all
Initial returned checks), HSA/FSA card, credit card (Visa, MasterCard, or Discover).

_____ **The charge for a new patient appointment is $595; follow-up appointments are $150.**
Initial *(you may request extended appointment times and the charges will be applied accordingly)*

_____ Because the time has been reserved for you, **PAYMENT IN FULL IS REQUIRED IF YOU FAIL TO SHOW *Initial***
Initial **FOR A SCHEDULED APPOINTMENT WITHOUT A 24- HOUR PRIOR NOTICE.**

_____ I am aware that I may not file a reimbursement claim with Medicare or Medicaid.
Initial

_____ The patient (or parent) is responsible for fees related to letters, forms, anything court-related, etc. The usual
Initial charge for letters and forms is $50; it may be more if it's more involved (depending upon time / complexity).

_____ All aspects of a patient's care are confidential. The patient's records may only be released when the requesting
Initial provider obtains the patient's written permission. However, as required by law, confidentiality must be broken under the following circumstances:

1. Evidence of child or elder abuse. The law requires that the healthcare provider report this to the appropriate authorities immediately.
2. Evidence of endangerment to self or others requires that appropriate action must be taken.
3. Receipt of a court subpoena requires release of records.

_____ I am aware that Dr. Hull is not a psychiatrist, but he will be providing psychiatric medical
Initial services. He is Board Certified in Family Medicine. Dr. Hull is, additionally, board certified in Clinical Lipidology, and he has received a certification as a Master Clinician in Psychopharmacology by the Neuroscience Education Institute.

_____ Patient has received access to this office's Privacy Policy, and a paper copy is available upon request.
Initial

Your signature below signifies you have read, understand, and agree to all of the above stated policies and procedures.

_____ _____ _____
PATIENT PRINTED NAME SIGNATURE DATE

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PSYCHIATRIC / MEDICAL HISTORY

Have you ever been hospitalized for a psychiatric condition and / or substance abuse treatment? ☐YES / ☐NO

Please list any psychiatric conditions you have been **DIAGNOSED** with in the past:

_____

_____

Please list **all** current medications, dosages, etc.: _____

_____

_____

In the past, have you ever been the victim of or witnessed any type of traumatic incident? ☐YES / ☐NO

Do you have any other non-psychiatric medical diagnoses? ☐YES / ☐NO (if yes, please explain):

_____

_____

Primary Care Physician Name / Phone:_____

Most Recent Psychiatrist Name / Phone:_____

Current Therapist's Name / Phone:_____

THIS SECTION FOR FEMALES ONLY (please do not leave blank)

Please check any of the following that apply:

☐ I am pregnant (or trying to become pregnant) ☐ I have had a hysterectomy ☐ I have regular menstrual periods

☐ I have never been sexually active in my life ☐ I am perimenopausal ☐ I am menopausal

☐ I have been sexually active in the past, but currently I am not sexually active

☐ I am currently sexually active, and I use the following method of birth control:

☐ I do not use any form of birth control ☐ Birth control pills ☐ IUD

☐ My husband/other has had a vasectomy ☐ Other (specify)_____

☐ I have experienced variations in mood or anxiety level related to my menstrual period ☐ I have experienced post-partum depression

CLINICAL CONCERNS

Briefly describe what prompted you to seek care from Dr. Hull at this time: _____

_____

_____

Problem Areas: Place a check mark next to each item that identifies an area of concern to you (two checks by the most important)

____ Stress / Worry
____ Anger/ Temper
____ Depression / Unhappy
____ Education / School / Work
____ Marital Problems
____ Physical Problems
____ Other: Specify _____

____ Thoughts of Suicide
____ Sexual Concerns
____ Trouble making decisions
____ Fearfulness
____ Use of alcohol
____ Religious/ Spiritual Concerns

____ Family Problems
____ Rape
____ Incest
____ Problem with children
____ Use of drugs
____ Problems with Social Relationships

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Questionnaire

Patient Name: _____ Date of Birth: _____ Age: _____ Today's Date:_____

1. Most of all I want _____
2. I'm different from others because_____
3. People are always_____
4. It would be funny if_____
5. Girls / Women think I_____
6. Guys / Men think I_____
7. My family_____
8. I worry about_____
9. I wish I could stop_____
10. When I grow up (or when I'm older) _____
11. I just can't_____
12. People shouldn't_____
13. I want to know_____
14. It hurts when_____
15. If I were the opposite sex_____
16. All my life I_____
17. My father (or spouse) thinks I_____
18. I get mad when_____
19. When I get mad, I_____
20. If I were older_____
21. If I were younger_____
22. I'm afraid of (or I fear)_____
23. When I'm afraid, I_____
24. I often wonder_____
25. Other children (or other people)_____
26. Nobody knows_____