Dr. Sambunaris & associates

5755 North Point Parkway
Suite 256
Alpharetta, GA 30022
770-817-9200

Institute for Advanced Medical Research

Personal/Contact Information

Last Name:		First Name:	Middle Initial:
SSN:	Gender:	DOB:	Age:
Race: ☐ Caucasian ☐ Black ☐ Asian ☐ Indian ☐ Other _____			
Ethnicity: ☐ Hispanic ☐ Non-Hispanic			
Full name of spouse:		Children: ☐Yes ☐ No	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated			
Home address: Street: City: State: Zip:			
please check preferred contact number ☐ Cell phone:		☐ Work phone:	
☐ Home phone:		May we contact you by e-mail? ☐ Yes ☐ No	
E-mail:		**EDUCATION** High School ☐ Yes ☐ No Year _____ College/Tech: ☐ Yes ☐ No Year _____ Degree/Cert. Obtained: _____ School Attended: _____	
Occupation:_____ ☐Full Time ☐ Part Time ☐ Unemployed ☐ Retired			
Employer: Address: City: Telephone #: Length of Employment: _____yrs _____mos		**EMERGENCY CONTACT** Name: Relationship: Telephone #: Address: City:	
PHYSICIAN Name: Telephone #: Address: City:		**MILITARY** Branch: Years of Service: Combat: Yes No Discharge:	
Have you ever participated in a clinical trial before? ☐Yes ☐ No If yes, when? _____ Where? _____ **If yes, what diagnosis/condition? _____Which drug/device? _____** **Have you applied for or are you receiving any pension or compensation for an existing disability? ☐Yes ☐ No**			
_____ **Signature**		_____ **Date**	
_____ **Staff Review**			

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Report of Medical History

Name:	Initials:	Date:
DOB:	Gender: ☐ M ☐ F	Are you : ☐ Right handed ☐ Left handed
Statement of your present Health: ☐ Excellent ☐ Good ☐ Poor Explain:		

Current Medical Conditions (Please list all medical conditions you have that are currently ongoing)

Med Illness	Date of Onset	Intensity	Treatment	Comment

Surgical History (Please list any surgeries that you have had)

Surgical Procedure	Date of Procedure	Reason for Surgery	Comment

Past Major Medical Conditions (Please list any previous major medical problems that are no longer active)

Med Illness	Date of Onset	Intensity	Treatment	Comment

Prescription medications taken within the past 90 days: ☐ None

Medication Name	Total Daily Dose	Reason	Dates of Use	Prescribing Physician

Over-the-counter medications taken within the past 90 days: ☐ **None**

Medication Name	Total Daily Dose	Reason	Dates of Use	Comments

Patient's Name (printed)	Signature	Date

Allergies: ☐ None ☐ Medications ☐ Environmental ☐ Dietary

Allergy Source	Reaction	Treatment	Date Diagnosed

Have you had or have you now (please check at left of each item, **X = current, / = past**)

Y	N	?	*(check each item)*	Y	N	?	*(check each item)*	Y	N	?	*(check each item)*
			Adverse reaction to serum, drug or medicine				Chronic or frequent colds				Heart trouble
											Nervous Bowels
			Epilepsy, Seizures, or Fits				Frequent or severe headaches				Shortness of breath
			Tumor, growth, cyst, cancer								Migraine headaches
			Head injury				Rupture/hernia				Eye trouble
			Periods of unconsciousness				Muscle tension & aches				Hearing loss
			Tuberculosis				Swollen or painful joints				Seasonal Allergies
			Jaundice or hepatitis				Arthritis or Bursitis				Dizziness or fainting spells
			Palpitation or pounding heart				Bone, joint or other deformity				Loss of memory or amnesia
			High blood pressure				Recurrent back pain				Asthma
			Diabetes / Sugar or albumin in urine				Indigestion, Heartburn/Reflux, or Acid Stomach				Gall bladder trouble or gallstones
			Thyroid trouble				Recent gain or loss of weight				Ear, nose, throat trouble
			Skin diseases				Rheumatic fever				Fatigue
			Motion sickness				Sleeping too Much				Frequent trouble sleeping

Females Only:

Are you: ☐Fertile ☐Infertile, due to: (☐sterile ☐tubal ligation ☐hysterectomy ☐oophorectomy ☐post-menopausal ☐Other:_____)

Y N ?
☐ ☐ ☐ Do you menstruate? Is it: ☐regular ☐irregular
☐ ☐ ☐ Recent change in menstrual cycle/status?
☐ ☐ Sexually active
☐ ☐ ☐ Inability to achieve orgasm

Date of LMP (last menstrual period) _____(1st day)
Average duration of your menstrual period: _____days
Average cycle is every:_____days
Flow is: ☐heavy light ☐spotty ☐Other:_____

Contraceptive method:
☐None ☐Injectable ☐Condoms ☐Spermicides ☐Diaphragm ☐Tubal ligation ☐Other_____
☐BC pills BC Pill Name: _____Dates of Use: _____

Males Only:

Y N ?
☐ ☐ Sexually active
☐ ☐ ☐ History of Prostate problems
☐ ☐ ☐ Erectile Difficulty

Y N ?
☐ ☐ ☐ Ejaculatory Difficulty
☐ ☐ ☐ Inability to achieve orgasm
☐ ☐ Vasectomy; if yes list year _____

All:

In order to protect the safety of our research subjects and those close to them we require that all research subjects use a medically acceptable form of birth control during, and for 30 days following, participation in a research program.
Would you and your partner be able to abide by these requirements? YES / NO

If No, please explain: _____

I certify that I have reviewed the foregoing information supplied by me and that it is true to the best of my knowledge

Patient's Name (printed)	Signature	Date

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Report of Mental Health History

Name:	Date:

Please record any psychiatric conditions with which you have been diagnosed:_____

The three symptoms that bother you the most are: 1) _____

2) _____

3) _____

Are you currently in treatment for your mental health?: ☐ Medication ☐ Counseling ☐ None
Do you plan on starting or stopping Counseling at any point in the next three months? ☐ Yes ☐ No

Psychiatric Medications Used:

(Begin with most recent)

Drug Name	Dose	Approximate Start Date	Length of Treatment	Reason for use	Reason you stopped	What did you think of the medication?

Have you ever been treated using the following methods? (If yes list dates of treatment)

☐ Electro-convulsive Therapy (ECT) _____
☐ Vagal Nerve Stimulation (VNS) _____
☐ Transcranial Magnetic Stimulation (TMS) _____

Any suicidal thoughts or thoughts of self-harm at this time? ☐ Yes ☐ No
Any homicidal thoughts or thoughts of harm to others at this time? ☐ Yes ☐ No
Comments:_____

_____

_____

Y	N	
☐	☐	**Alcohol Use:** Average number of alcoholic beverages consumed each week __Beer _____Wine _____Liquor (Alcoholic beverage = 1 oz. Liquor, 5 oz. Wine, 12 oz. Beer)
☐	☐	**Tobacco Use:** Do you currently smoke cigarettes? (circle) Yes No Have you ever smoked? Yes No If yes to either, how many packs do/did you smoke per day? _____; # of years smoking?_____; ☐ Cigars ☐ Smokeless ☐ Chew
☐	☐	**Caffeine Use:** Average number of caffeinated beverages consumed per day. Coffee:_/day Tea:___/day Cola:___/day (Caffeinated beverage = cup of coffee/tea, can of soda, etc.)
☐	☐	**Drug Use:** Recreational drug use: _____ ☐ Cocaine ☐ Amphetamine ☐ Narcotics/Opiates/Pain Pills ☐ Marijuana ☐ Other: _____

Have you ever had or been:

Y	N		Y	N	
		history of self injurious behavior			arrested for harming others
		molested			suicidal ideation or thinking
		history of impulsive behavior			abused
		suicide attempt			history of alcohol abuse
		traumatized			homicidal ideation or thinking
		history of drug abuse			psychiatric hospitalization

Please provide additional information to any affirmative or yes answers:

Family Psychiatric History

Have any family members (blood-line only) had or have now:

Y	N	?		Y	N	?	
☐	☐	☐	Depression	☐	☐	☐	Anxiety
☐	☐	☐	Manic-Depressive/Bipolar	☐	☐	☐	Panic
☐	☐	☐	ADD / ADHD	☐	☐	☐	Obsessive-Compulsive Disorder
☐	☐	☐	Schizophrenia	☐	☐	☐	Drug Abuse
☐	☐	☐	Alcoholism	☐	☐	☐	Attempted Suicide
☐	☐	☐	Other:_____	☐	☐	☐	Committed Suicide
☐	☐	☐	Been under a psychiatrist's care	☐	☐	☐	Alzheimer's Disease
☐	☐	☐	Died in an institution	☐	☐	☐	Been hospitalized in a psychiatric hospital/institution
				☐	☐	☐	Been prescribed medicines for a psychiatric or emotional condition

Please provide additional information to any yes answers:

I certify that I have reviewed the foregoing information supplied by me and that it is true to the best of my knowledge.

Patient's Name (printed)	Signature	Date

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Name:	Screen #:
Date:	Patient #:

SCREENING SELF REPORT

		0	1	2	3	4	Total
1.	How often do you have a drink containing alcohol? (One drink is a beer, glass of wine, or mixed drink)	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2.	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3.	How often do you have six or more drinks on one occasions?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4.	How often during the past year have you been unable to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5.	How often during the past year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6.	How often during the past year have you needed a drink in the morning to get going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7.	How often during the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8.	How often during the past year have you been unable to remember what happened the night before because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9.	Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the past year		Yes, during the past year	
10.	Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year	
						Total Score ⇒	

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Financial Policies

We strive for your experience at our clinic to be an excellent one. In order to achieve that goal, we want you to be fully informed on our policies.

In order to keep our fees reasonable, we required full payment at the time of service for all office visits, supplemental testing, clinical supplies, medications, and any treatment performed at our clinic.

Our providers do not participate with and are not affiliated with any insurance company.

Dr. Sambunaris & Associates operates on a fee-for-service basis. This policy protects your privacy to the highest possible degree, allows greater flexibility in developing a plan of treatment with you, allows our physicians to spend more time with each patient, and optimizes accessibility to our staff and appointments. Many of our patients find this approach preferable. Payment by cash or credit card is required prior to receiving services. For credit cards, the owner of the account must be present in the office at the time of use or have a verified card on file and authorized use form. The office does not accept checks.

No refunds will be given for rendered services. Accounts need to remain current in order to maintain ongoing treatment or formal termination with be pursued.

Some patients who do have insurance are able to obtain partial "out-of-network" reimbursement for fees paid particularly those with PPOs. After your appointment, you will receive a receipt for your visit, containing procedure and diagnostic codes. You then submit this receipt yourself to your insurance for possible reimbursement. Every company and plan has different policies and reimbursement rates.

We strongly advise that you call your insurance company in advance of your appointment to verify your coverage and/or obtain approval for services.

We reserve the right to change fees and/or policies without notice.

Fees

Fees vary according to the time you have spent with the provider and what kind of treatment or medications you receive and the complexity of your needs. *Effective February 01, 2024:*

- New Adult Patient Evaluation: $575.00
- Adult follow up appointment / medication management: $200.00
- Adult follow up appointment / medication management every 3 months: $250.00
- Adult follow up appointment/ medication management every 6 months: $300.00
- Appointments cancelled with 24 hour or more notice: No charge.
- Appointments cancelled with less than 24 hours-notice: $75.00
- Same day appointment requests: Additional $100.00
- Emergency refill (weekday due to No Show or Missed Visit): $75.00
- WEEKEND & HOLIDAY EMERGENCY CALLS: $350.00
- Ketamine: Varies depending on the treatment plan, please call the office directly for information.
- Same day ketamine appointment requests: Additional $100.00
- Saturday Ketamine Appointment: $500.00
- Suboxone / Buprenorphine induction: $750.00
- Suboxone / Buprenorphine medication management: $200.00 per visit
- Suboxone / Buprenorphine lost meds or early refills: $100.00

**All new patients MUST complete an evaluation appointment to become a patient of our office unless you have completed one of our research studies.*

Above fees are only for office visits and does not include other treatments, supplements, labs, or any other supply or service. In order to keep our fees reasonable, we required full payment at the time of service for all office visits, supplemental testing, clinical supplies, medications, and any treatment performed at our clinic.

Otherpolicies

Primary Care

Patients should maintain a primary care physician for any non-psychiatric medical emergencies and for their routine medical needs. All patients should have a primary care physician.

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Our clinic does provide an on-call after hour service, but we do not provide emergency medical service or admit or care for patients in the hospital.

Phone inquiries

All phone inquiries, including medication refill requests, will be responded to within 48 hours. If you need immediate response or medical attention, email is not the right communication tool. We suggest that you call the office directly for urgent needs.

Please note that to protect confidentiality, we do not provide or exchange clinical information by email. Please call the clinic to discuss any clinical or administrative needs.

Phone calls and telehealth

Phone calls with the physician requested by patients are considered telehealth visits and they are charged to patients at regular Office Visit fees. Credit card information will be required at the time of scheduling and will be charged for any services. Our cancellation policy applies to telehealth appointments.

Letter and correspondence

At times, we are asked to fill out forms for work, insurance companies, other physicians, etc. In order to comply with these requests in a timely manner we charge a minimum of $150, although the price can vary depending on the reason for the request, chart review required, size of the chart or documentation to fill out.

Prescriptions

Any NEW prescription(s) and dose adjustments will require an office visit with no exceptions. Please make sure you schedule your routine appointments ahead of time to avoid a delay in getting your prescription renewed. You are responsible for ensuring continuity of treatment, and we ask you to be in charge of your prescription's schedule. We have many patients who need the same thing that you do so out of fairness we answer and refill in a first come first serve basis. Address refills at least a week before you need them.

If you leave a message on our answering machine after hours regarding a medication refill, please provide the following information:

– Your name and date of birth

– Exact medication name (including suffixes such as "ER" or "CR")

– Medication strength (mg)

– Medication frequency (how many tablets, how many times per day)

– Name and phone number of your pharmacy.

– Your phone number, in case of problems.

– The number of pills you currently have remaining

Cancellations

When you make an appointment with our clinic, we reserve that time exclusively for you. We do not double-book or over-book our schedules like many other medical and psychiatric offices. Because of this, we ask that you provide us with as much notice as possible should you need to change an appointment, by calling the main office number 770-817-9200.

Students and Fellows

Our clinic/facility is a teaching facility and is affiliated with several academic institutions. Fellows, residents, interns, medical, pharmacy, nursing, and/or other healthcare professional students may observe or assist in your care and treatment under the supervision of a physician. Student interns receive intensive ongoing guidance, evaluation, and education in providing excellence in clinical skills to you and your family members. By working with a student professional, you receive the benefit of a comprehensive and clinically-experienced team working together towards addressing your health concerns.

Refund policy

Please keep in mind that as with all mental health treatment, there is no guarantee in results or outcomes.

No refunds will be given for rendered services, with the exception of accounting errors. Accounts need to remain current in order to maintain ongoing treatment. While we stand by our policy as written above, we also want to understand how we can best serve you; please contact our team at 770-817-9200 with questions or concerns.

Dr. Sambunaris does not engage in psychotherapy and therefore does not participate in the "one-hour psychotherapy session" approach that you might expect with a therapist. You are not paying for time with the physician, but rather for access to their skill and experience. Should you require the help of a therapist, we can arrange a referral to one of our Associates.

Medical appointments with our physicians, both diagnostic evaluations and follow up visits, are performed with the utmost care to accurately diagnosis and treat patients. There may be a time when a patient is unhappy with the diagnosis provided or the treatment plan recommended, which should not be interpreted as a lack of skill or effort by the provider.

If you are unsure about the fit between you and any of our providers at Dr. Sambunaris & Associates, we encourage to access full complement of online resources we have created so insure you have found a good fit for your needs including our website, social media sites and public review platforms such as Google or Psychology Today.

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Termination

While we do not expect this to be the case, there are rare occasions when it is necessary to terminate the physician-patient relationship. Termination of treatment may occur at any time and may be initiated by either the patient or the doctor. Reasons for termination by the physician are generally due to patient non-compliance with treatment, missed appointments, and maltreatment or threats towards the physician or office staff. Our medical team will continue to provide refills and emergency care for 30 days as dictated by law after a notice of termination in order to allow sufficient time to find a new physician.

We trust that you understand the necessity for these policies and sincerely thank you for your cooperation. If you have any questions, please do not hesitate to ask.

Signature:_____

Date:_____

For minor / guarantor:

Signature:_____

Date:_____

If guarantor is not the patient:

I _____ hereby give permission for the team at Dr. Sambunaris & Associates permission to speak with _____.

Rev. 7/27/22

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DrSambunaris.com

Dr.Sambunaris
& associates

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date _____/_____
Cardholder ZIP Code (from credit card billing address): _____
Cardholder telephone number: Cell/Home (Circle one) (_____) - _____- _____
Security Code: _____

I,_____, authorize Dr. Sambunaris & Associates to charge my credit card above for agreed upon purchases and/or services for (first name) _____(middle initial) _____(last name) _____ (recipient of clinical services).

I understand that my information will be saved to file for future reference of transactions on my account.

It is our policy to hold a credit card or debit card on file. Unpaid balances will be charged on the provided card.

_____ _____

Cardholder Signature Date

_____

Printed Name

_____ _____

Cardholder Recipient of Services Date