

**Atlanta Center for Eating Disorders**  
**Patient Registration Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone# Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

May we leave you a message at home? \_\_\_\_\_ at work? \_\_\_\_\_ on cell? \_\_\_\_\_

Date of birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_ Gender: (F) (M)

Employed ( ) Unemployed ( ) Full-time Student ( ) Part-time Student ( )

Referred to ACE by? \_\_\_\_\_

May we thank this person for referring you? Yes No Phone# \_\_\_\_\_

**If patient is under 25 years of age, please provide information for reaching each parent.**

Mother's Name: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

**Responsible Party**  Self  Parent\*  Spouse  Other

Name: \_\_\_\_\_ SS# \_\_\_\_\_ D.O.B. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

**Insurance Information:**

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Assignment of Benefits, Financial Agreement and Consent to Communicate with Financially Responsible Party**

I hereby give lifetime authorization for payment of insurance benefits to be made directly to the Atlanta Center for Eating Disorders and any assisting practitioners, for services rendered at the Atlanta Center for Eating Disorders. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event that I default on payment of my bill, I agree to pay all costs of payment collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that this may include information from my chart. I further agree that a photocopy of this agreement shall be as valid as the original. I further authorize the Atlanta Center for Eating Disorders to communicate with the Financially Responsible Party named above regarding any billing issues.

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Responsible Party Signature: \_\_\_\_\_

\* - If divorce/custody decree states that both parents are financially responsible, please have both parents fill out separate forms and sign next to Responsible Party Signature.



[www.eatingdisorders.cc](http://www.eatingdisorders.cc)

4536 Barclay Drive, Suite A  
Atlanta, GA 30338

Phone: (770) 458-8711  
Fax: (770) 458-8640

Dear Client,

Welcome to the Atlanta Center for Eating Disorders. You are probably reading this because you have scheduled an assessment with us. We offer many different levels of care and the time you take to carefully fill out the following questionnaires will aid us in determining what level of care to recommend to you. You will also be asked to read and sign several pages of information and consents. We apologize that they are so lengthy. Some of these forms are required by the federal or state government and some have been written by us to help you understand ACE's own operating policies. We hope these forms will help you feel informed about treatment at ACE. After completing the paper work, a psychologist will meet with you to give you feedback about the results of the questionnaires and make recommendations about treatment. If you decide to participate in the program, you will also be given a Patient Handbook that describes the program and groups in more detail.

Your confidentiality and privacy is very important to ACE staff. The "Georgia Notice Form" attached, is based on the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protection and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). Health professionals are required to give you a copy of the Georgia Notice form and to get a signature from you that you were informed about the new law.

This form may be somewhat confusing but basically it is to let you know that any identifying information about you is "protected." The law states that psychotherapists are allowed to relate protected information about you only for very specific reasons and ACE always tries to operate on the "minimum disclosure necessary" rule. We will only relate information about you for the purposes of coordinating your treatment with our team, other professionals who you are seeing and for the purposes of collecting payments (see section I "notice"). If we need to relate information about you for any other purposes, we will do so only if you give us separate written authorization (see section II of "notice") or when required by law to do so (see section III). Finally, if a participant is under 18, the parent or guardian may obtain access to your PHI. For these participants, the issues of privacy should be discussed in individual and family sessions.

The other consents you will be asked to sign prior to beginning your treatment include information about billing procedures, emergency procedures and program policies.

We hope that you will ask us any questions you have about these forms and that your experience at ACE will be a rewarding one.

Sincerely,

ACE Staff

# Atlanta Center for Eating Disorders Patient Emergency Medical Treatment Form

It is important to us that your health and safety is maintained at all times you or your child or loved one is here at ACE. Should a medical emergency occur during treatment at ACE, and in order to help you, your child or loved one access appropriate emergency medical services, please complete the information below so that there is no delay in responding to an emergency. **This form is a required part of your clinical paperwork and allows us to remain compliant with CARF policies.**

**Date:** \_\_\_\_\_ **Patient's Full/LegalName:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **SS or License/ID #:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Significant medical problems AND HOW STAFF SHOULD REACT (eg. in case of seizure, use of Epi Pen or other responses to allergic reactions, etc):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name, address and phone number(s) of physician(s) to be called in the event of an emergency**

Name(s) and type of physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Other information about contacting this physician: \_\_\_\_\_

\_\_\_\_\_

**Name, address and telephone number of a relative or other person to notify:**

Name(s) and relationship: \_\_\_\_\_

\_\_\_\_\_

Phone numbers to call in order of preference: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

**Insurance Information:**

Medical Insurance Company: \_\_\_\_\_

Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_

**Please provide any information ACE staff or medical professionals would need to know in the event of an emergency:**

**Medication allergies:** \_\_\_\_\_

Current medications (prescription and over the counter, including names, strength, how and why they are taken):

\_\_\_\_\_

\_\_\_\_\_

Hospital preference, if any: \_\_\_\_\_

**Please note any other pertinent information on the back side of this form.**

**Atlanta Center for Eating Disorders**  
**4536 Barclay Drive, Suite A, Atlanta, GA 30338**  
**(770) 458-8711 fax (770) 458-8640**

**Consent for Release of Information**

Patient’s Full Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

To the Patient: We at ACE are very conscientious about maintaining patient confidentiality while coordinating your care with others. **Please list any physicians, psychiatrists, or mental health therapists that you have seen in the last two years.** Please also list any family members with whom you think we may need to be in contact.

Professionals Seen	City	State	Phone Number	Reason

Family Members	City	State	Phone Number	Relationship

**PURPOSE FOR CONSENT:** To assist the ACE clinical staff in the evaluation and/or treatment of the patient’s presenting concerns, to be informed of or to coordinate treatment with other health care or mental health professionals, and to facilitate continuity of care during discharge planning.

**SPECIFIC INFORMATION TO BE RELEASED OR RECEIVED:** The information exchanged with other health care or mental health professionals could include the following: results of psychological testing, results of medical examination or testing, diagnoses, names of other mental health care or health care providers, treatment plans, recommendations for current treatment, statement of progress in treatment, prognosis, discharge summary, and discharge recommendations.

*I hereby request and/or consent for the clinical staff at ACE to release and obtain the above information regarding my dependent, or myself. I understand that this information may include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as regarding mental health treatment, mental retardation, privileged communications, communicable or infectious diseases, alcohol/drug abuse, AIDS (acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus). I also understand that I may cancel this consent at any time in writing. However, the revocation will not be effective to the extent that ACE has taken action in reliance on the consent. Unless I specify otherwise, this authorization is in effect for the duration of my treatment at ACE and it automatically expires six months after my termination of services.*

*The following are clinicians I have seen in the past two years or family members whom I do not give my consent for you to contact. (Please note that ACE may deny treatment in some cases when not given permission to contact other clinicians who have been or are involved in your care.)*

Name	City	State	Phone Number	Reason Seen/Relationship

_____ Patient Signature	_____ Date	_____ Witness	_____ Date
_____ Parent/Guardian Signature	_____ Date	_____ Relationship to Patient	

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**Billing Procedures**

- You will be asked to pay for your first visit at the time of your appointment. If you are admitted to the ACE program, we may submit claims for you after the first visit.
- We file insurance to your primary insurance company as a courtesy to you. If you have a secondary insurance company, it will be your responsibility to file with them. You are responsible for your bill regardless of the amount that insurance pays and you are ultimately responsible for following up with your insurance company if ACE has difficulty collecting payments. You also may choose to file your own claims. You will be expected to make payment on any deductibles or copayments at the time services are rendered.
- Some insurance companies only reimburse certain procedures or providers (i.e., may not pay for nutrition counseling or unkept appointments). If we know of limitations set by your insurance company, we will not submit claims for these particular program components. Nevertheless, you will be responsible for these charges. If your account has not been paid for more than 60 days and a payment plan has not been agreed on, ACE has the option of using legal means to secure payment.

Attendance:

- You will be given a schedule of your program which will include the time and type of session. It is very important that you attend all of your scheduled meetings. Interruptions in your treatment may slow your progress. Additionally, it is important to other group members that all scheduled members attend in order to establish trust and safety.
- You will be charged for all groups on your schedule.
- If you cannot attend, contact your individual therapist or case manager to discuss a planned absence. You will not be charged if you and your individual therapist or case manager, decide that the absence is of therapeutic benefit.
- Give a note to your individual therapist, case manager or the front office regarding the date of absence (to be posted).
- *Missed sessions with less than 24 hours notice will be **billed** as a late cancellation or unkept appointment.* Insurance companies will not pay for unkept appointments, therefore you are responsible for the fees. We will send you a statement at the time of a missed appointment. Payment is expected for missed appointments in addition to any other payment arrangements. No scholarship or patient courtesy discounts will be given for missed appointments. However, charges for an absence may be reversed if you and your case manager decide that the absence was an unforeseeable emergency.
- If, at any time, you believe that it is time to reduce or rearrange your program schedule, meet with your case manager/individual therapist to discuss your wishes. The changes will then be brought to the treatment team for consideration.

*I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event that I default on payment of my bill, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that this may include information from my chart. I further agree that a photocopy of this agreement shall be as valid as the original. I give ACE my consent to release public health information requested by my insurance company for payment*

Patient Signature	Date	Witness	Date
Financially Responsible Party	Date	Relationship to Patient	

# Atlanta Center for Eating Disorders

4536 Barclay Drive, Suite A  
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(770) 458-8711 fax (770) 458-8640

## In Case of Emergency

ACE is not a medical facility. Therefore, we only admit participants that are physically safe. For this reason, we ask that you see a physician for blood work (Biochemical Profile and CBC) and that you consent to the following policy. During treatment, some patients have suicidal, self-harm or homicidal thoughts. These generally pass within hours or days if discussed in sessions. You may call ACE (770-458-8711) at any time during working hours and leave a message for your primary therapist who will make every effort to call you back before the end of the day. If you have an emergency after hours (5:30 pm - 9:30 am) or on the weekend, you may leave a message with our Answering Service (770-928-5051) for Dr. Buchanan or Dr. Kilmer.

Please read the following contract, which is required of all individuals being treated on an outpatient basis at the Atlanta Center for Eating Disorders:

- 1. *I promise to talk with my individual therapist if I should have any thoughts of harming myself or someone else. I understand that for some individuals, these thoughts may be a natural part of the therapy process and are likely to pass if I talk about them.*
- 2. *I understand that the ultimate responsibility for my health and therapy is my own. Therefore, I agree to give my therapist **24 hours to respond to my emergency call** before acting on any harmful impulses to myself or someone else. In the interim, I may phone a hotline for support or go to an emergency room if unable to keep myself safe.*
- 3. *I understand that if I break this contract, it may result in ACE asking me to leave the program.*

*I have read and understand the emergency policies and promise to abide by them.*

_____ Signature of Patient	_____ Date	_____ Witness	_____ Date
_____ Parent/Guardian Signature	_____ Date	_____ Relationship	

### Emergency Mental Health Numbers

Dekalb	404-892-4646
Cobb	770-422-0202
Fulton	404-730-1600
Gwinnett	770-985-2494

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**Procedure for Discontinuing Groups**

It is very important to other group members that you do not stop coming to a group abruptly. We recommend the following procedure:

1. Make at least a one month commitment to any group that you begin. This increases group comfort and feelings of trust and helps you make a fully informed decision.
2. Mention to the group at least one week in advance, if not earlier, that you are planning to discontinue the group. Talk with the group about how you have arrived at your decision (i.e., “my eating is improved and I am reducing my schedule,” or “I have decided to discontinue this particular group for the following reason...”).
3. If your reason for discontinuing a group is not due to improvement, but to some problem you are having in the group, you will be asked to share your problem with the group, then the team will be able to support your decision to discontinue. This will certainly be beneficial to you in improving assertiveness and may improve the group as a whole. It will also prevent misunderstanding, which may be worked through with appropriate communication. If the problem cannot be solved, then you may bring up discontinuing the group. Therefore, this would involve two sessions; one to problem solve and, if ineffective, the second to wrap up and say good-bye.

These procedures are important to increase group safety and help the group adjust to a change in group structure, to help you learn how to have closure on relationships (since people come and go throughout your life), and to help you improve your assertiveness and problem-solving skills. Additionally, endings can stir up feeling of loss for other members, and these are important to work through.

**Procedure for Discontinuing the Program**

Following discontinuation of individual groups, you will be asked to fill out some questionnaires before leaving the program. These allow you to evaluate and give us feedback on the program. Your feedback is very important and can help strengthen the program. You will also be asked to take three short assessments so that we can identify improvements you have made in the areas of eating disorder symptoms, depression, and anxiety. Your case manager will give these to you before your last week. These assessments are the same ones you filled out in your initial assessment. If you would like, you can ask your therapist to go over these assessments with you and compare your results before and after treatment at ACE.

*I understand and agree to the above policies.*

_____	_____	_____	_____
Patient Signature	Date	Witness	Date
_____	_____	_____	
Parent/Guardian Signature	Date	Relationship to Patient	

### Atlanta Center for Eating Disorders Medical History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Please use a checkmark to indicate whether or not you have had medical problems in any of the following areas. Also, please indicate if the condition is currently active or present.

Do you have a history of:	Yes	No	Current
Heart disease	_____	_____	_____
High blood pressure	_____	_____	_____
Abnormal EKG	_____	_____	_____
Pulmonary (lung)	_____	_____	_____
Tuberculosis	_____	_____	_____
Positive TB test	_____	_____	_____
Hepatitis/liver disease	_____	_____	_____
Ulcer	_____	_____	_____
Hernia	_____	_____	_____
Gall bladder problems	_____	_____	_____
Kidney/bladder disease	_____	_____	_____
Sexually transmitted disease	_____	_____	_____
Chronic infections	_____	_____	_____
HIV positive	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid disease	_____	_____	_____
Arthritis	_____	_____	_____
Back problems	_____	_____	_____
Blood disorders	_____	_____	_____
Cancer	_____	_____	_____
Disease of the colon	_____	_____	_____
Frequent headaches	_____	_____	_____
Disease of testes/ovaries	_____	_____	_____
Seizures	_____	_____	_____
Hearing problems	_____	_____	_____

Past surgery (describe): \_\_\_\_\_  
\_\_\_\_\_

History of Drug/Alcohol abuse: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Treatment: \_\_\_\_\_

History of psychiatric disorder: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Describe: \_\_\_\_\_

Treatment \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reviewed by Intake Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

# Atlanta Center For Eating Disorders Confidential Parent Questionnaire

Information requested on this questionnaire will be helpful in the diagnostic process. Please feel free to add as much information as you want on the back of these pages. This information is strictly confidential.

Name of person completing form/relationship to child \_\_\_\_\_  
Date \_\_\_\_\_

### **Background Information**

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_

Describe the reasons you are requesting this treatment for your child. If possible, list specific questions for which answers are sought.

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### **Pregnancy and Birth History**

Was the pregnancy with this child a planned pregnancy? \_\_\_\_\_

Where was your child born? \_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ Mother's age when child was born: \_\_\_\_\_

Prenatal exposure to drugs, alcohol, nicotine, other (eg. falls, traumas)? Yes\_\_\_\_ No\_\_\_\_ If yes, please describe: \_\_\_\_\_

Describe any complications that occurred during pregnancy (excessive vomiting, toxemia, medications, alcohol or drug consumption, infections, etc.).

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Describe any complications that occurred during delivery (prematurity, postmaturity, length of labor, special procedures, etc.).

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Birth weight \_\_\_\_\_ Apgar score \_\_\_\_\_ Length of labor \_\_\_\_\_

Were there any complications after delivery (jaundice, weak sucking instinct, birth defects, respiratory problems, vomiting, infection, etc.)?

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### **Early Temperament**

Describe the child's temperament during the first six months (i.e., sleep patterns, colic, eating patterns, did not enjoy cuddling, "easy baby," etc.).

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Did your child experience any developmental delays (rolling over, sitting up, language development, etc.)? Explain. \_\_\_\_\_

Is your child under the care of any specialist? For what? Are any future medical procedures planned? \_\_\_\_\_

Have there been any previous psychological, psychiatric, or neurological evaluations? If so, please list names, addresses, and dates of contact. Please attach any pertinent reports. \_\_\_\_\_

**Social/Emotional/Behavioral History**

List your child’s personality characteristics, both positive and negative. \_\_\_\_\_

Note any particular behavior concerns (i.e., eating habits, sleeping patterns, level of activity, sibling relationships, peer relationships, moodiness, attending difficulties, destructiveness, picking at hair or skin, unusual habits, fears, bizarre ideas, sex related issues, tenseness, etc.). \_\_\_\_\_

Current discipline techniques: \_\_\_\_\_

Who disciplines? \_\_\_\_\_

Has your child been in treatment for any mental health issue in the past? Please describe. \_\_\_\_\_

Has your child experienced any academic difficulties? Please describe. \_\_\_\_\_

**Family Information**

Mother’s name \_\_\_\_\_ Home phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell phone \_\_\_\_\_

Occupation \_\_\_\_\_ Work phone \_\_\_\_\_

Any history of emotional/mental problems? If so, please explain: \_\_\_\_\_

Any history of substance use/abuse/dependence? If so, please explain: \_\_\_\_\_

Any previous marriages? Children from previous marriages? \_\_\_\_\_

Father's name \_\_\_\_\_ Home phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell phone \_\_\_\_\_

Occupation \_\_\_\_\_ Work phone \_\_\_\_\_

Any history of emotional/mental problems? If so, please explain: \_\_\_\_\_

Any history of substance use/abuse/dependence? If so, please explain: \_\_\_\_\_

Any previous marriages? Children from previous marriages? \_\_\_\_\_

Marital status: Mother: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Remarried \_\_\_\_\_ Widowed \_\_\_\_\_  
Father: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Remarried \_\_\_\_\_ Widowed \_\_\_\_\_

Please list the other children in the family and any emotional or physical problems.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does anyone other than the parents and children live at home? Who?

\_\_\_\_\_  
\_\_\_\_\_

What activities are you involved in as a family. What things do you enjoy doing together?

\_\_\_\_\_  
\_\_\_\_\_

What activities are you involved in after school and in the evenings (and on which days?).

\_\_\_\_\_  
\_\_\_\_\_

If your child is admitted to our program and is under 18, it is mandatory that all parents be involved with the treatment. Are you willing to be involved in family therapy once a week? Yes \_\_\_\_\_ No \_\_\_\_\_.

What of the above activities could you give up if necessary to be involved in your child's recovery?

\_\_\_\_\_  
\_\_\_\_\_

Parents often need individual or couples' therapy as well. Are you willing to do this if recommended?

Individual? \_\_\_\_\_ Couples? \_\_\_\_\_

We very much appreciate the time and energy you spent in filling out this questionnaire. Please add any additional comments below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_