SHEPHERD'S HILL
ACADEMY

Psychiatry Services at Shepherd's Hill Academy

Shepherd's Hill Academy partners with Atlanta Specialized Care to provide medication management and psychiatry services while your child is enrolled at SHA.

Katie Butler, APRN-BC specializes in evaluating and managing medication needs for clients with anxiety, depression, mood disorders, ADHD, and substance abuse. Katie holds a degree in psychology from Southern Methodist University. She is also a graduate of the Medical College of Georgia School of Nursing and received a master's degree in Family Nurse Practitioner from Georgia State University. Katie worked in August Veteran's Hospital in nursing school and used her nursing degree in med-surg, home health, home health, and pediatric oncology.

For Shepherd's Hill Academy, Katie will provide monthly comprehensive assessments and medication rechecks for those in need of starting or maintaining psychotropic medications. Under the designation of Bradley Johns, MD, and her many years of professional experience, Katie will provide premium care for the students, while also coordinating with their families and the staff of Shepherd's Hill Academy.

The fees for service are as follows:

Initial Consult: $517 ($500 with cash or check). This is an hour long appointment to gather a thorough history with the student and evaluate them.

Med Checks: $206.80 ($200 with cash or check). These are 20 minutes appointments that are done monthly or quarterly depending on the need of the child.

Atlanta Specialized Care does not bill insurance, but can provide an invoice to submit to your insurance in order to receive out-of-network reimbursement when applicable. Your credit card information will be placed on file and charged following each appointment.

Coordination of Care Form

Patient Name

Please provide us with your current care providers.

*** We will not contact any individual on this list without a document of informed consent being completed in addition to this form.**

Primary Care Physician:

_____

OB-GYN:

_____

Pediatrician:

_____

Psychiatrist:

_____

Other Counselors Involved with Family/Members Treatment:

_____

School Counselor:

_____

Other Specialists:

_____

Professional Disclosure Statement

Kathryn Butler, FNP-BC

Psychiatric Nurse Practitioner

Education and Licensure

Bachelor of Arts in Psychology from Southern Methodist University-May 1993

Bachelor of Science in Nursing from Medical College of Georgia-May 1996

Masters in Family Nurse Practitioner from Georgia State University-2014

Georgia State Board of Nursing Nurse Practitioner License-2014

Georgia State Board of Nursing Registered Nurse License-1996

Certification through Advanced Association of Nurse Practitioners-2014

Experience

After graduating from nursing school, Kathryn (Katie) worked as a medical-surgical nurse. After that, she did home health nursing and worked as the nurse at her children's elementary school. She then worked on a pediatric hematology-oncology unit at CHOA. Upon graduating with a nurse practitioner degree, she worked as a psychiatric NP with Dr. Barry Jones from 2014 until 2021 before joining Atlanta Specialized Care.

Session Fees

Twenty-to-thirty-minute Medication checks are $206.80 by credit card or $200 for cash or check.

Sixty-minute new patient appointments are $517 by credit card or $500 for cash or check.

Confidentiality

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our therapeutic relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to

disclose information. I am a mandated reporter of abuse in the state of Georgia.

Code of Ethics

Katie abides by the confidentiality and ethics regulations and licensing requirements set forth by the Georgia Board of Nursing.

Emergencies

Please call office during business hours Monday through Friday and I will return your call within 24 hours. If your situation is urgent, please contact your primary care doctor or call 911. You can also go to the Emergency Department of the nearest hospital. If you are having an allergic reaction to medications such as skin rash, hives, itching, swelling, or difficulty breathing or swallowing, stop taking the medication and seek medication attention immediately.

Complaints

If you are unsatisfied with the care provided, please discuss with Katie. If not resolved, you may contact Tatiana Matthews. As a last resort, you can call the Georgia Board of Nursing to make a complaint.

Social Media

Social Media/Internet Policy • I not accept invitations from clients to personally network on social media sites. This is a common practice in my field and this policy helps to protect your privacy. If you have questions or concerns about this, please let me know. • It is my policy not to conduct Internet searches on my clients. I rely exclusively on the information clients have provided to me directly in our counseling work. However, in matters that could involve significant safety issues (both mental and physical), I reserve the right to use this source of public information.

Acceptance of Terms We agree to the above terms and will abide by these guidelines. Client: _____
Date: _____ Nurse Practitioner:
_____ Date: _____

6782 Jamestown Dr., Alpharetta, GA 30005
1730 Mount Vernon Road. Suite G, Atlanta, GA 30338
PH: 770-815-6853

Admitting Form **Date: _____**

Name: _____ Date of Birth: _____

Preferred Pronouns: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work phone: _____

Can we leave messages at this number?: _____

E-mail Address: _____

Employer/School: _____

Marital Status: _____ Spouse/Parent's Name: _____

Person to Contact in Case of Emergency: _____

Phone Number for Emergency Contact: _____

How were you referred to our office?: _____

Person responsible for billing if different than above:

Name: _____Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

ASC has a 48 hour cancellation policy. Regardless of the reason, any appointments that are not canceled at least 48 hours in advance of the appointment time will be billed at the rate of the full fee. Cancellations may be made by voicemail at (770) 815-6853.

Patient/Guardian 1 Signature: _____Date:

_____

Guardian 2 Signature: _____

Date:_____

ASC Consent Form

I, _____ , hereby grant permission to ASC to provide any therapy, testing, or diagnostic evaluation that may be deemed pertinent in the treatment of myself, my marriage, or my family (including my minor children). I willingly and voluntarily agree to mental health treatment and release any and all other providers and support/clerical contractors from liability claims. I understand that all fees are due at the time of service. In other words, the full fee must be paid at the end of each session.

I understand that there will be a $25.00 service charge for all returned checks and that all additional collection expenses are my financial responsibility if the amount of the returned check plus $25.00 is not paid in cash within 30 days. Outstanding accounts will be forwarded to our collection agency. I realize that my insurance policy is an agreement between me and my insurance company – not ASC.

Confidentiality

ASC's confidentiality policy is highly regarded and followed. All communications between client and therapist are kept strictly confidential. ASC will respond to any request for release of information regarding all our clients by indicating that a signed written release must be obtained prior to any information being released or discussed. Otherwise we will not even acknowledge that the undersigned is a client of ASC. Exceptions to this rule are where state law requires the reporting of threats of violence, harm, or child/elder abuse and neglect (from evidence or suspicion), and when information is subpoenaed by the courts.

Waiver of Legal Testimony

ASC considers all communication, either with you or with anyone the therapist speaks with for case coordination to be privileged information. Any trip to court or discussion with a lawyer can put the therapist in an extremely dangerous ethical and legal position. If your goal in entering counseling is to find someone to be your advocate in a legal situation, please let your therapist know and they will assist you to the best of their ability to find the right person to help with your legal testimony.

ASC will never release their individual therapy notes without a direct court order. ASC is asking for your agreement at this time that you will never request a subpoena for any partner or employee ASC or for any therapy records other than dates of treatment, a five Axis diagnosis, a synopsis of therapy goals and an evaluation of your general progress. Therapists will not go to

court and prefer not to speak with your lawyer. By signing this form you are stating that you understand and accept these conditions of treatment.

Emergency Services

In the event that I become ill or I am injured while on the premises, I authorize ASC to provide or obtain emergency medical services (i.e. call an ambulance).

Credit Card on File

Your credit card will be charged for the following services:
1. All missed appointment fees (regardless of the reason for cancellation).
2. Paperwork and Form completions.
3. Services not paid for at the time of the appointment.
4. Phone calls of a clinical nature exceeding 10 minutes or frequently placed phone calls or e-mail exchanges will be charged at our normal rate.

Signature consenting to the payment of all charges:

_____

Date of above signature:

_____

Print name:

_____

My signature acknowledges agreement to conditions as a patient/guardian of ASC set forth above. *Medical decision documentation must be provided without two signatures.

Patient/Parent/Guardian Signature:

_____**Date of signature:**_____

Print name:

_____

Parent/Guardian 2 Signature:

_____**Date of signature:**_____

Print name:

_____

Atlanta Specialized Care

Communication Addendum to the Informed Consent Agreement

Secure and private communication cannot be fully assured utilizing cell/smart phone or regular email technologies. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Use of any non-secure technologies to contact ACSC will be considered to imply consent to return messages to clients via the same non-secure technology, pending further clarification from client. Please check the area below which modes of communication are permitted and which are not permitted. This consent may be altered at any time should circumstances or preferences change. In the event that client chooses not to allow non-secure modes of communication, contact will only be made via wire to wire phone, wire to wire fax, or mail.

Voice communication TO client's cell/smart phone for:

Scheduling Appointments:	Permitted ☐	Not Permitted ☐
Appointment Reminders:	Permitted ☐	Not Permitted ☐
Between Session Contact:	Permitted ☐	Not Permitted ☐

Voice communication FROM client's cell/smart phone for:

Scheduling Appointments:	Permitted ☐	Not Permitted ☐
Appointment Reminders:	Permitted ☐	Not Permitted ☐
Between Session Contact:	Permitted ☐	Not Permitted ☐

Text communication TO client's cell/smart phone for:

Scheduling Appointments:	Permitted ☐	Not Permitted ☐
Appointment Reminders:	Permitted ☐	Not Permitted ☐

Between Session Contact:	Permitted ☐	Not Permitted ☐

Text communication FROM client's cell/smart phone for:

Scheduling Appointments:	Permitted ☐	Not Permitted ☐
Appointment Reminders:	Permitted ☐	Not Permitted ☐
Between Session Contact:	Permitted ☐	Not Permitted ☐

Contact via the client's email:

Scheduling Appointments:	Permitted ☐	Not Permitted ☐
Appointment Reminders:	Permitted ☐	Not Permitted ☐
Between Session Contact:	Permitted ☐	Not Permitted ☐

If permitted, please list email address(es):

_____

Fax communication to client's non-secure fax or E-fax:

Scheduling Appointments:	Permitted ☐	Not Permitted ☐
Appointment Reminders:	Permitted ☐	Not Permitted ☐
Between Session Contact:	Permitted ☐	Not Permitted ☐

If permitted, please list fax number(s):

_____

Statement of Validation

I have read this Statement of Services, it has been adequately explained to me, and I understand its contents.

Print name:

_____

Signature and Date:

_____

Atlanta Specialized Care

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

(Also known as Protected Health Information)

PATIENT NAME: _____ DATE OF BIRTH: _____

I authorize Atlanta Specialized Care to use or disclose information from my mental health record, which may include information about psychiatric diagnosis, treatment and substance abuse issues to:

Name: _____ Organization: _____

Contact Phone: _____ Fax: _____

Address:_____

Dates of Treatment: From_____ To_____

Information to be released: Copies of all medical records History and Reports Progress Notes
Other:_____

Purpose of Disclosure: _____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Atlanta Specialized Care at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the
4. recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit
5. the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
6. I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.
7. I acknowledge I have been provided a copy of ASC's Notice of Privacy Practices and any charges that may be associated with this release of information.
8. I acknowledge I have discussed any concerns I may have about the use, release, and disclosure of my health information with the appropriate office personnel at ASC.
9. I understand that I can request a copy of this form after completed and signed.
10. I release ASC from all legal liability that may arise from this authorization.

Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule.

By signing below, I acknowledge that I have read and understand this Authorization.

Patients Signature:_____ Date: _____

If not the patient, state reason for acting in place of patient. _____

Name: _____ Signature: _____

Relationship to patient: _____ Date: _____

Atlanta Specialized Care

PATIENT SELF-REPORT: CHILD/ADOLESCENT (18 AND UNDER ONLY)

Patient Name:_____Age:___ Date:____
Name of person completing this form (if not patient)_____
1. Briefly describe the problem which brought you here today:_____
_____
_____

2. Is the patient having thoughts of hurting themselves or someone else?
YES☐ NO☐ If yes, please explain:_____
_____
Has the patient ever had thoughts of hurting themselves or someone else?
YES☐ NO☐

THERAPIST COMMENTS

PAST AND CURRENT TREATMENT

3. Has the patient ever been treated for psychiatric, substance abuse, emotional, or behavioral problems in the past? YES☐ NO☐ If yes, when, where, and with whom?_____
Did you find past treatment helpful? YES☐ NO☐

4. Is the patient currently under the care of a psychiatrist, therapist, school counselor, or pediatrician for a psychiatric problem? ☐YES ☐NO

5. Has the patient ever taken psychiatric medications in the past? ☐YES ☐NO If yes, please list name(s) and dosage(s):_____
_____

6. Is the patient currently taking any psychiatric medications? ☐YES ☐NO
If yes, please list name(s) and dosage(s):_____
_____

FAMILY'S TREATMENT

7. Have any of the patient's family members currently or in the past been under the care of a psychiatrist or therapist? ☐YES ☐NO If yes, which family member and for what reason?_____

MEDICAL PROBLEMS

8. Does the patient have any current medical problems? ☐YES ☐NO If yes, please explain:_____

9. Has the patient ever had any significant medical problems in the past? ☐YES ☐NO If yes, please explain:_____

THERAPIST COMMENTS

_____

10. Are immunizations up to date? ☐YES ☐NO

11. Are there any allergies or medication allergies? ☐YES ☐NO
If yes, please list:_____

12. Is the patient currently taking medication for medical problems?
YES☐ NO☐If yes, please list medication, dosage, and purpose:

_____

13. Does the patient have a history of head injury, seizures, loss of consciousness, or extended high fevers? ☐YES ☐NO If yes, please list:_____

14. Would you like information from today's visit communicated with your pediatrician or any other medical doctor? ☐YES ☐NO

DEVELOPMENTAL FACTORS

15. Were there problems with pregnancy or delivery? ☐YES ☐NO
If yes, please describe:_____

16. Was there any exposure to alcohol, tobacco, or other drugs during pregnancy? ☐YES ☐NO If yes, please describe:_____

_____

17. Did the patient have any problems with walking, talking, toilet-training, or other developmental milestones? ☐YES ☐NO If yes, please explain:

_____

SUBSTANCE ABUSE

18. Does the patient use (or do you suspect that the patient uses) any alcohol or drugs? ☐YES ☐NO

19. Does the patient currently attend support groups? ☐YES ☐NO

20. Does anyone in the patient's household have any substance abuse problems? ☐YES ☐NO

21. Circle any of the following that the patient has used in the past 30 days: alcohol, tobacco, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, methamphetamines/speed, LSD, PCP, Ecstasy, inhalants.

22. Have there been any problems related to substance abuse (school/legal/DUI)? ☐YES ☐NO

THERAPIST COMMENTS

LEGAL ISSUES

23. Does the patient have/had problems with school or the juvenile justice system? ☐YES ☐NO

24. Is the patient currently on probation or parole? ☐YES ☐NO

25. Are there any legal issues such as: (Please check)
☐Divorce in process ☐Possible custody battle
☐Going to court

26. Is a DFACS worker involved? ☐YES ☐NO

EDUCATIONAL/WORK CONCERNS

27. Are grades…☐average, ☐above average, or ☐below average?

28. Has there been a significant drop in grades recently? ☐YES ☐NO

29. Check all that apply: ☐learning disabilities, ☐developmental disabilities, ☐special education, ☐alternative school, ☐home school.

30. List grade and name of school:_____

31. Please circle current educational/job status: current student, GED, part-time job, full-time job.

32. List any problems related to hearing/speech/vision:_____
_____

33. Has the patient had a psychological evaluation/testing done in school?
YES NO

34. Does the patient have an IEP in effect? YES NO

FAMILY/RELATIONSHIPS

35. Please list anyone who lives in the home, his/her age, and relationship:
_____

36. List other extended family involved with the patient: _____
_____

THERAPIST COMMENTS

37. Are both biological mother/father in the home? YES NO
If no: divorced separated single parent family
stepfamily other

38. If divorced, what are the custody arrangements?_____
_____
Does the patient have contact with the parent they do not live with?
YES NO If yes, please describe how often_____
_____

39. Does anyone in the patient's immediate or extended family have psychiatric, emotional, substance abuse, or behavioral problems? YES NO
If yes, please describe:_____
_____

40. Has the patient survived any sexual or physical abuse? YES NO

41. Has the patient witnessed any domestic violence? YES NO

42. Is the patient's support network: Good Moderate Poor

43. What are the patient's hobbies/interests?_____
_____

44. Are there difficulties or concerns about how the patient gets along with other people? ☐YES ☐NO

45. Does the patient have any sexual orientation/gender issues or concerns? ☐YES ☐NO

46. Are there any transportation or financial concerns that would impact treatment? ☐YES ☐NO

_____

Patient (or person completing this form) signature Date

I have reviewed and discussed this information with the patient.

_____

Therapist Signature/Credentials Date

Atlanta Specialized Care

6740 Jamestown Dr., Alpharetta, GA 30005

1730 Mount Vernon Road. Suite G, Atlanta, GA 30338

PH: 770-815-6853

Telemedicine Informed Consent

I _____ hereby consent to engage in telemedicine (e.g., internet or telephone based therapy) with Atlanta Specialized Care. The main venue for my psychotherapy treatment will be at the office at the address listed above. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine based services and care may not yield the same results nor be as complete as face- to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with Georgia law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature:_____ Date:_____