Today's Date _____

PATIENT INFORMATION

Patient Name _____

Address _____

City, State, Zip _____

Area Code / Phone No. _____

Social Security No. _____

Patient Sex M F
(Please Circle)

27. MARITAL STATUS	
1. MARRIED	3. DIVORCED
2. SINGLE	4. WIDOWED
	5. SEPARATED

Birthdate _____ Age _____

Student (Y/N) _____ Part _____ Full _____

School Child Attends _____

Occupation _____

Employer _____

Address _____

_____ Tel. _____

Spouse's Name _____

Birthdate _____ Social Sec. # _____

Occupation _____

Employer _____

Address _____

_____ Tel. _____

Person to Contact Regard Appointments _____ Tel. _____

Relationship to Patient _____ May we leave messages with anyone else at this #? ____

Person to Contact in Case of Emergency _____ Tel. _____

Relationship to Patient _____

GUARANTOR INFORMATION (Party Responsible for Payment of Personal Balance)

Same as Above ☐

Guarantor Name _____

Address _____

City, State & Zip _____

Guarantor Area Code/ Phone No. _____

Birthdate _____ Sex _____

Employer Area Code/Phone No. _____

Guarantor Employer _____

Address _____

City, State & Zip _____

Guarantor Social Security No. _____

REFERRAL INFORMATION

Were you referred by: Physician ____ EAP Program ____ Managed Care Co. ____ Other _____

Name Referral Source _____

Address _____ Tel. _____

CURRENT MEDICATIONS (Please list current medications and prescribing physician)

I hereby consent to treatment for myself, my child, or the above named minor, for whom I accept responsibility. I authorize the release of information to any insurance carrier and direct payment to this office for treatment rendered. I hereby acknowledge and accept final responsiblity for payment of charges for services rendered. I acknowledge to be responsible for appointments not cancelled within 24 hours that will be charged at the basic hourly rate (only with the exception of emergencies).

(Signature) PATIENT OR PATIENT/GUARDIAN _____ Date _____

PCP Communication Form

☐ I **do authorize** communication with my Primary Care Physician MD.

Physician: _____ Phone #: _____

☐ I **refuse to authorize** communication with my Primary Care Physician MD.
I understand that my not authorizing providers to communicate regarding my care may be potentially dangerous in my treatment and may be a barrier to my receiving the best possible care.

I request that an information form* **NOT** be sent to my Primary Care Physician (PCP) MD because:

- ☐ I do not have a Primary Care Physician MD.
- ☐ I do not know who my Primary Care Physician MD is.
- ☐ I do not plan to continue care with my current Primary Care Physician MD.

I understand that open communication between providers is very important and can enhance the quality of my care. I understand by signing this statement below I acknowledge that I have read and understand this information.

_____ _____

Patient Signature (guardian) Date

_____ _____

Provider or Other Witness Date

* Some Insurance Companies request that an information form is sent to the PCP.

The Family Therapy Center, PLC

INFORMATION CONCERNING INSURANCE AND COLLECTIONS

Professional Services are rendered and charged to the patient. We will file your insurance claims, but we cannot accept responsibility for collecting your claim or negotiating a settlement for a disputed claim.

In order for us to file your insurance claims, we often have to release a significant amount of information regarding your case. You need to be aware that we are releasing this information to your insurance company and cannot be responsible for the insurance company's use of or redisclosure of this information.

Your insurance company may further "manage" your care. This means that sessions may have to be approved in advance in order to be paid. It is your responsibility to have your initial session approved. We will assist in this process, if we can. Insurance companies may further have their own definition of medical need for treatment, which may differ with our opinion or your opinion of the situation. In the event that you continue treatment beyond that approved by your insurance, you will be responsible for the charges.

In the event we have to place this account for collection, you hereby agree to pay all collection fees, attorney fees, and court costs associated with the collection of this account. You also hereby grant us permission to release account information to a collection agency necessary to collect this account.

.....

.....

PLEASE BE ADVISED THAT WE DO NOT ACCEPT OR FILE THE FOLLOWING INSURANCE PLANS IN THIS OFFICE (as primary or secondary insurance plans):

- **AmeriChoice/ AmeriGroup**
- **CoverTN**
- **TennCare**
- **Medicaid**
- **Medicare**

If at any time during your treatment here your insurance changes to one of these, it is your responsibility to inform us of this change so that we can discuss other payment options.

_____ _____

Client Signature (or Legal Guardian) **Date**

OFFICE POLICIES REGARDING APPOINTMENTS, PAPERWORK, PRESCRIPTIONS AND LEGAL TESTIMONY

POLICY REGARDING APPOINTMENTS

It is your responsibility to keep appointments you schedule. If you fail to cancel your appointment 24 hours in advance you will be charged $70.00 for late cancellation. **The first missed appointment will be a charge of $ 70.00. You will not be rescheduled until the $70.00 is paid in full. A person who fails to show two times in a row will not be rescheduled with that provider.**

We do make calls to confirm your appointment the night before as a courtesy. However, it is your responsibility to keep up with your appointments. If you are unsure when your appointment is call and ask. You will still be charged if you do not get a courtesy reminder.

Would you like a courtesy call? YES _____ NO _____

May we leave a message with someone at your home or your answering machine?
YES _____ NO _____

POLICY REGARDING PAPERWORK FEES AND PRESCRIPTION REQUESTS

If you require a letter, disability paperwork, FMLA paperwork or other time-consuming documents to be filled out by your doctor or therapist, please be advised that you will be charged a paperwork fee that must be paid in full before the paperwork can be provided to you. The charge will be determined based on the amount of time it takes the provider to complete the paperwork or forms. Please allow the provider sufficient time to complete the paperwork.

It is your responsibility to keep up with your medication and when you will need refills. Please allow **24 – 48 hours** upon your request for your doctor to provide a prescription. Our doctors are not in every day of the week. We do our best to get it to you in a timely manner, **but we do require advanced notice before the patient runs out of medication.**

POLICY REGARDING LEGAL & COURT ISSUES

We are **not** experts in issues that require testimony in our courts. If a client's primary reason for seeking these mentioned services involve legal issues that would require us to testify in court, we refer these clients to other agencies that better serve and deal with their legal issues.

Specifically, if a client is seeking counseling services for their child, for a custody evaluation, it is recommended that the family seek services elsewhere. Our providers are to support children and their families during the difficult period of adjustment. Likewise, our charting/documentation is in an effort to document progress and is not intended to be used as a support to legal proceedings.

However, in the course of providing mental health services, therapists are from time to time called upon to testify in court and/or give depositions. **The cost for our licensed counselors is $250/hr, and four hours of payment is to be remitted prior to court appearance.**

By signing this statement below you acknowledge that you have read and understand this information.

Client (Legal Guardian) **Date**

FAMILY THERAPY CENTER P.L.C.

Procedures in the Event of Behavioral Health Crisis

A mental health emergency is a life threatening situation in which an individual is imminently threatening harm to self or others, severely disoriented or out of touch with reality, has a severe inability to function, or is otherwise distraught and out of control.

Examples of a Mental Health Crisis include:

- Threatening Self-Harm
- Acting on a suicide threat
- Homicidal or threatening behavior
- Self-injury needing immediate medical attention
- Severely impaired by drugs or alcohol
- Highly erratic or unusual behavior that indicates very unpredictable behavior and/or an inability to care for themselves.

What to Do in Case of a Behavioral Health Emergency

- **Call 911**, or have a trusted person take you to a local Hospital's Emergency Department
- **Go to nearest Psychiatric hospital:**
  - **Rolling Hills Hospital**, 2014 Quail Hallow Road, Franklin TN 37067 / 615.628.5700
  - **Vanderbilt Psychiatric Hospital**, 1601 23rd Ave S, Nashville, TN 37212 / 615.327.7000
  - **Tristar Centinnial Parthenon Pavillion,** 2401 Parman Pl, Nashville, TN 37203 / 615.342.1450

Patient/Guaridan Signature Date

I acknowledge receipt of the Notice of Privacy Practices from The Family Therapy Center PLC.

_____

Signature

_____

Date

THE FAMILY THERAPY CENTER, PLC

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to obtain a paper copy of this Notice upon request.

If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We submit requests for payment to your health insurance company. The health insurance company or business associated helping us obtain payment requests information from us regarding your medical care given. We will provide information to them about you and the care given.

Health Care Operations: We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following reasons:

- Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

(Continued on reverse)

- Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement official.

- Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

- Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and d safety or the health and safety of the public or another person.

- Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. WE may also disclose information to correctional institutions or for national security purposes.

- Research: We may use or disclose information for approved medical research.

- Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any question, requests, or complaints, please contact

Regina Flippo
Office Manager
854 West James Campbell Blvd., Suite 201
Columbia, TN 38401
(931) 490-0999

Effective Date: The effective date of this Notice is April 9, 2003.