PATIENT INFORMATION

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☐ Teresa Fleming, LPC-MHSP ☐ Eve M. Giesey, LPC- MHSP ☐ Robert Hughes, PhD
☐ Eliza Kiernan, LPC-MHSP ☐ John Lawson, LMFT

Date: _____

Full Name: _____ Preferred Name:_____
DOB: ____ /_____/ _____ Age: _____ Sex: _____
Guardian Name (if under 18): _____ Relation to Patient: _____
Mailing Address: _____
_____
Phone: (___) _____ (Home)___ (Mobile)____
May we leave a Voicemail? ___ Text? ____ (please see top of next page)
E-Mail Address: _____
Employer/School: _____

Emergency Contact: _____
Phone #: (___) _____ Relation to Patient: _____

Primary Care Physician: _____
PCP Phone #: (___) _____ PCP Fax #: (___) _____
PCP Address: _____
_____

Insurance/Payment Information

☐ Self-Pay (please check if you are not using insurance)

☐ Primary Insurance Company: _____
Subscriber Name: _____ Subscriber DOB: ____/____/____
Subscriber ID: _____ Group Number: _____

☐ Secondary Insurance Company: _____
Subscriber Name: _____ Subscriber DOB: ____/____/____
Subscriber ID: _____ Group Number: _____

Guarantor (the person responsible for making payments on the patient account)
Guarantor Name: _____ DOB: ____/____/____
Phone #: (___) _____
Mailing Address: _____
_____

Client Information and Office Policy Statement

PRIVACY ACKNOWLEDGEMENT

May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? ☐ Yes ☐ No
May we text the number you provided? ☐ Yes ☐ No
If no, is there another number at which we may try to reach you? _____
May we mail to your address information regarding your appointment? ☐ Yes ☐ No
If no, is there another address at which we may send you information? ☐ Yes ☐ No
Please provide the address: _____
Do you wish us to share health/mental information regarding you with a family member or friend? ☐ Yes ☐ No
If yes, please provide name of person(s): _____
May we email billing invoices to the email address provided? ☐ Yes ☐ No

EMERGENCY CONTACT RELEASE OF INFORMATION

By signing I authorize Grace Pointe Counseling Center to release information to my emergency contact, designated on page one of the Patient Information Packet, in the event of a serious and imminent safety concern as determined by my provider. I have been informed that, in order to protect the limited confidentiality of records, my agreement to release information is necessary.

_____ _____
Signature **Date**

CONFIDENTIALITY

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person or a disabled person, 2) if your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3) if you report that you intend to physically injure someone, the law requires your therapist to inform that person as well as the legal authorities, 4) if your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc. 5) when your insurance company is involved (i.e. filing a claim, insurance audits, case review or appeals, etc.) 6) when otherwise required by law. With the exceptions of the above situations, your consent must be obtained prior to releasing any information about you. In situations where exchange of information is necessary, you may be asked to sign a Release of Information. By signing, I acknowledge that I have been offered a copy of the Practice's "Notice of Privacy Practices for Protected Health Information" as required by HIPPA.

_____ _____
Signature Date

AUTHORIZATION

Patient and/or guarantor is responsible for charges incurred. It is a courtesy of our office to file your insurance, however you are responsible for your co-pay/percentage, and deductible which the insurance company is not liable for on the day of your visit. It is also the patient's responsibility to obtain referrals from your primary care physician when required. If the referral is not obtained before your visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. By signing, I acknowledge that I have read and understand the above statement of the payment policy. I hereby request any benefits on my behalf be paid to the physician/clinician(s) that has provided services for me. I also authorize the release of any information acquired during my treatment to my insurance company as needed to issue benefits. I authorize the physician/clinician(s) to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician/clinician(s) and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____
Signature Date

Client Information and Office Policy Statement (Continued)

CANCELLATION/NO-SHOW POLICY

In order to accommodate the growing list of clients waiting to get an appointment, we ask that you call at least 24 hours prior to an appointment if cancellation is necessary. If you give less than 24 hours' notice for a cancellation or you do not show for your scheduled appointment you will be charged a $85.00 fee for the missed appointment. You will be required to pay this fee before being seen again by a provider. This fee is not paid for by insurance companies. Three (3) missed scheduled appointments without a 24-hour notice may result in dismissal from this practice. If a dismissal occurs, you will be given a list of three (3) providers in the area that you may contact for further services. I have read the cancellation / no show policy for Grace Pointe Counseling Center and I understand that a 24-hour notice is required for cancellation of appointments.

_____ _____

Signature Date

DISABILITY CLAIMS

The providers in this facility do not assist patients in filing for disability. Records can be requested for disability claims or to your primary care doctor to allow him/her to determine your disability status but are done so at the provider's discretion.

COPIES OF RECORDS

To obtain a copy of your medical records, it is required that you do so in writing. Pursuant to T.C.A. 63-2-102 law there will be a $20.00 charge for the first five (5) pages and a charge of $0.50 for each additional page after the first five. A $20.00 charge will apply to filling out forms as well. By signing below, you also understand there is a five to seven business day turn around for all records requests.

RETURNED CHECKS

A fee of $25.00, plus any additional bank fees and the original amount of the check will need to be paid in cash prior to the next appointment.

COMPLAINTS

You have a right to have your complaints heard and resolved in a timely matter. If you have a complaint about your treatment, your therapist, or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose.

I have read and understand the above polices for Grace Pointe Counseling Center and by signing below I agree to abide by the above policies.

_____ _____

Signature Date

Name:_____ DOB:_____ Date:_____

GracePointe Counseling Center

PATIENTS RIGHTS AND RESPONSIBILITIES

The following is a statement of rights and responsibilities of all patients eligible to use

Patients have the right to:

- Receive humane care and treatment, with respect and consideration
- Privacy and confidentiality when seeking or receiving care, except for life threatening situations or conditions
- Confidentiality of health records
- Be informed of and to exercise the option to refuse to participate in any research aspect of your care without compromising access to medical care and treatment
- Receive accurate information concerning diagnosis, treatment, risks involved, and prognosis of an illness or health-related condition
- Ask about reasonable alternatives to care at GracePointe Counseling Center or outside facilities
- A second professional opinion regarding diagnosis or treatment
- Participate actively in decisions regarding one's health care and treatment
- Access information regarding the scope and availability of services
- Be informed about any legal reporting requirements regarding any aspect of screening or care

Patients have a responsibility to:

- Provide complete information about one's illness/problem to enable proper evaluation and treatment.
- Ask questions so that an understanding of the condition or problem is ensured.
- Show respect to health personnel, GracePointe Counseling Center staff, and other patients.
- Reschedule/cancel an appointment so that another person may be given that time slot.
- Pay bills or file health claims in a timely manner.
- Inform the practitioner(s) if one's condition worsens, or an unexpected reaction occurs from a medication.
- Provide requests for permission to release health records in writing, to GracePointe Counseling Center.

_____ _____

Signature Date

Name:_____ DOB:_____ Date:_____

Medical History

Allergies (adverse reactions to medications/food/etc.) _____
_____
Date of Last Physical Exam_____
Findings from Exam _____
_____
Current Medications (include prescribed dosages, and name of doctor prescribing medications)
_____
_____
_____
Hospitalizations/Surgeries (include dates, complications, adverse reactions to anesthesia, outcomes, etc.)
_____
_____
Any relevant medical conditions (diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc)_____
_____
Past Psychiatric History (Mental Health and Chemical Dependency History)_____
_____
Hospilizations_____
_____
Prior Outpatient Therapy (include previous practitioners, dates of treatment, response to treatment)
_____
_____
Results of Recent Lab Test and Consultation Reports_____
_____
_____
Family Mental Health or Chemical Dependency History _____
_____

Psychosocial Information

Support Systems_____
School/Work Life_____
Marital History _____
Military History _____
Spiritual Beliefs _____
Church Name_____

Children and Adolescents

Developmental History (developmental milestones met early, late, normal)
_____
_____
Perinatal History (details of labor/delivery)
_____
_____
Prenatal History (medical problems during pregnancy, mother's use of medications)
_____
_____

PLEASE CHECK ANY OF THE FOLLOWING CONCERNS THAT APPLY TO YOU

- ☐ Feeling angry/frustrated
- ☐ Marital stress
- ☐ Family problems
- ☐ Relationship problems
- ☐ Financial problems
- ☐ Legal problems
- ☐ Problems at work/school
- ☐ Fear of public places
- ☐ Sadness/depression
- ☐ Withdraw from people
- ☐ Feeling worthless
- ☐ Lack of interest/enjoyment
- ☐ Hard time making new friends
- ☐ Feeling lonely
- ☐ Difficulty trusting others
- ☐ Dwell on problems
- ☐ Sexual problems
- ☐ See/hear strange things
- ☐ Decreased energy
- ☐ Feel used by people
- ☐ Thoughts of hurting self
- ☐ Thoughts of hurting others
- ☐ Feelings of people are out to get you
- ☐ Feelings of being watched
- ☐ Feelings of being talked about
- ☐ Unable to control anger/urges
- ☐ Panicky/anxious
- ☐ Restless/unable to sit still
- ☐ Very talkative
- ☐ Shaky/trembling
- ☐ Nervous/tense
- ☐ Hot/cold spells
- ☐ Difficulty sleeping
- ☐ Sweating
- ☐ Lightheaded/dizzy
- ☐ Many fears/phobias
- ☐ Problems breathing
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Drug use
- ☐ Quick change in mood
- ☐ Feeling negative towards the future
- ☐ Alcohol use
- ☐ Tobacco use
- ☐ Laugh without reason
- ☐ Nightmares
- ☐ Confused
- ☐ Memory problems
- ☐ Health problems
- ☐ Frequent stomachaches
- ☐ Excessive pain
- ☐ Headaches
- ☐ Chest pain
- ☐ Seizures
- ☐ Urinary frequency
- ☐ Skin rashes
- ☐ Bowel problems
- ☐ Hair loss
- ☐ Muscular pain
- ☐ Joint pain
- ☐ Thyroid problem
- ☐ Unable to control thoughts
- ☐ Trouble Concentrating
- ☐ Increased Energy

LIST ANY OTHER CONCERNS:_____

_____

_____

Name:_____ DOB:_____ Date:_____