PATIENT INFORMATION SHEET
PLEASE PRINT

FIRST NAME:__________________ MI :_____ LAST NAME:________________________
If patient is under 18 years old: parent/guardian/DCS name and phone number:
____

If we may contact you via mail, phone,text or e-mail,please initial by all applicable information provided indicating your permission.

Address:____
City:___________ State:________ Zip Code:___________ **Initials:**________

Home Phone:__________________________ **Initials:**_____
Work Phone:__________________________ **Initials:**_____
Cell Phone:___________________________ **Initials:**_____
Is it OK to text the above cell phone number? **Initials:**_____
E-Mail Address:______________________ **Initials:**_____

Birthdate:________ Sex: Male _______ Female ________
Social Security Number of Patient: ____________________
Marital Status : S____ M_____ Sep____ D_____W______
Place of Employment:_______________________________

Emergency Contact:____________________ Phone # __________________
Next of Kin: ___________________________ Phone # __________________

Responsible Party (if other than the Patient)
Name:_______________________ Home Phone # ______________________
Address:_____________________ Work Phone # ______________________
City:____________________ State:____________ Zip Code:____________

It is our office policy that a credit or debit card must be kept on file for all missed appointments, unpaid balances and correspondence. By signing below you agree to these terms.

Name on Card:_________________________________
Card # ____
Exp. Date: __________ **CVV(3 digit code)** ______ **Zip Code:**________

__________________________ ________________________
Signature **Date**

Insurance Co. Information:

Primary Insurance : ____Yes ____No
Name of Insurance Company:___________________
Name of Insured:_____________________________
Employer of Insured:_____________________ Date of Birth of Insured: ____________
Relation to insured :___ self ___spouse___dependent___other

Secondary Insurance : ____Yes ____No
Name of Insurance Company:___________________
Name of Insured:_____________________________
Employer of Insured:_____________________ Date of Birth of Insured: ____________
Relation to insured :___ self ___spouse___dependent___other

Psychiatric Advance Directive

In the event that I, _______________ have a psychiatric emergency and am incapable/incompetent to make a decision for myself regarding my psychiatric care,I designate the following person

Name: ____________________ Relationship to self ______________________
Address:_____________________________ Phone #:______________________
Signature :_________________________________ Date:__________________

<u>CHARGES TO PATIENT</u>

$5.00 PER PAGE FOR CORRESPONDENCE
$20.00 COPYING OF CHART
$80.00 FOR PATIENTS WHO NO SHOW
OR DO NOT GIVE 24 HOUR NOTICE
$25.00 RETURNED CHECK CHARGE
$15.00 RETURNED PHONE CALL
$3.00 CREDIT CARD PROCESSING FEE

HENDRICK COUNSELING SERVICES

Kim Stroud-Hendrick, L.C.S.W.
Frieda Whitt, L.P.C
April C. Bowen, S.L.P.E.
Suzanne Prince, L.P.C.
Lori L. Ball , APN,PMHCHS,FNP
P.O. Box 2623/440 Park Ave
Lebanon, TN 37088

CONSENT TO TREAT

I, ______________________ do hereby consent for the staff at Hendrick Counseling Services to provide me services. I understand that all services are voluntary. I affirm that I am a willing participant.

- **Note** : Without your signature in this area, we will not be able to provide services.

Patient Signature:______________________________ Date:______________________________

PRIMARY CARE PHYSICIAN

For coordination of care, we ask that you provide us the name of your primary care physician. We will make contact with your physician to inform them of our services that you will be receiving in our office. By providing this information and your signature, this gives us authorization to make contact, as required , regarding your treatment. **If you do not have a Primary Care Physician or you do not want us to make contact,**
Initial __________ and Date__________

Physician Name:______________________________ Phone:______________________________

Address:____

Patient Signature:______________________________________ Date:_________________________

REFERRAL SOURCE

We would like to thank whomever referred you to our office. By providing the following information and your signature, this gives us authorization to send a "Thank You " letter on behalf of our office. If you do not wish for us to do this, please leave this area blank.

Name of individual referring you: ______________________________ Phone:___________________

Address:____

Patient Signature:__________________________________ Date:____________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Kim Stroud-Hendrick, L.C.S.W./Frieda Whitt,L.P.C./April C. Bowen, S.L.P.E./Suzanne Prince, L.P.C., Lori L. Ball, APN,PMHCHS,FNP to furnish information to insurance carriers concerning my illness and treatment and assign to the practitioner all payments for medical services rendered to myself or my dependents.

I understand that I am ultimately responsible for all charges incurred regardless of insurance coverage. I understand that as a courtesy, Hendrick Counseling Services will bill my insurance company. Should payment not be made by the insurance company ninety days from the date of service received I will be financially liable. Failure to make payment indicates my account will be turned over to a collection agency and at such time, I shall then be liable for any fees and/or attorney's fees, incurred through the process of collections.

_________________________ _________________________

DATE **RESPONSIBLE PARTY**

MEDICARE/MEDICAID/CHAMPUS

I authorize any holder of medical or other information about me to be released to the social security administration and health care financing administration or its intermediaries or carrier any information needed for related Medicare/Medicaid/Champus claim. I permit a copy of this authorization to be used in place of the original, and request payments of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_________________________ _________________________

DATE **RESPONSIBLE PARTY**

All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGMENTS HAVE BEEN MADE PRIOR TO APPOINTMENT.

CONFIDENTIALY POLICY

This is to inform you that all services received in this office are confidential. Without your written consent for release of information, your participation in services provided by this office will at no time be released to anyone,confirmed or denied.

BILL OF RIGHTS

In our lobby is a copy of a Patient's Bills of Rights. Please take a moment to read and familiarize yourself with this information. For your convenience and at your request, a copy can be provided to you.

SNOW POLICY

If the Lebanon City Schools are closed due to weather,our office will be closed as well.

NOTICE OF PRIVACY PRACTICES

In our lobby is a copy of Notice of Privacy Practices. Please take a moment to read and familiarize yourself with this information. For your convenience and at your request, a copy can be provided to you.

CANCELLATION POLICY

In order to keep down the number of missed or "no show" appointments,the Patient will be billed the full amount for any missed appointment that was not given 24 hour cancellation notice. This will be the patient's responsibility, as insurance will not pay for this charge.

RESCHEDULING

Patients with an account balance will not be allowed to schedule future appointments until the balance is paid in full.

CHILDREN'S APPOINTMENTS

In an effort to be fair and keep any one child from having to taken out of school on a routine basis, each child will be asked to take an appointment after 3pm and then take an appointment before 2:30pm . Each appointment thereafter will be rotated on this schedule.

NO SHOW FOR MEDICATION MANAGEMENT

Patients that do not show for their scheduled medication follow-up appoinemtn will be charged a no show fee. A patient will not be allowed to reschedule with the medication provider until the fee is paid in advance. The patient will be given 15-30 days supply (at the providers discrestion) and the patient will have to seek medication management elseswhere.

I HAVE READ AND UNDERSTAND ALL POLICIES AND THE BILL OF RIGHTS.

PATIENT SIGNATURE: ____

DATE: ____