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 Insured: _____
ID # _____ Group # _____
Employer of Insured: _____ Date of Birth of Insured: _____
Insurance Company Name: _____
Address: _____
Phone:_____
Policy Number:_____ Group Number _____
Patient Relation to Insured : Self_____ Spouse_____ Dependent_____ Other_____

Secondary Insurance :___ Yes ___No
Name of Insured: _____
Employer of Insured: _____ Date of Birth of Insured: _____
Insurance Company Name: _____
Address: _____
Phone:_____
Policy Number:_____ Group Number _____
Patient Relation to Insured : Self_____ Spouse_____ Dependent_____ Other_____

Charges to Patient

$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
$1000.00 Court Appearance
$3.00 Credit Card Processing Fee

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 Number:_____

Signature:_____ Date:_____

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.
Michele Ramey, MFT-A
Lauren Kelly,LPC,MHSP, NCC
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.,Michele Ramey ,MFT-A, Lauren Kelly,LPC,MHSP, 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 appointment 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 discretion) and the patient will have to seek medication management elsewhere.

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

PATIENT SIGNATURE: _____

DATE: _____

Hendrick
Counseling Services, Inc.

Office: 615-449-9611 • FAX: 615-453-7051 • 440 Park Avenue • Lebanon, TN 37087
www.HendrickCounseling.com • counseling4you@bellsouth.net

NEW PATIENT INTAKE - ADULT

Date of Initial appointment: _____ Date of Birth _____

Patient's Full Name: _____ Age: _____

Were you referred by anyone? ❑ Y ❑ N If yes, who? _____

How did you hear about our office?

- ❑ Primary Care Physician
- ❑ Family
- ❑ Friend
- ❑ Other: _____
- ❑ Website
- ❑ Google Search
- ❑ Insurance Company
- ❑ Social Media

Reason for your appointment:

Problem Areas - Stressors:

Goals you hope to accomplish:

Support system: Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Community support: (AA, Church, Senior Citizens, etc. ...)

Marital Status: ❑ M ❑ S ❑ D ❑ W

Spouse's Name (If married): _____ # of years: _____

Ever Divorced: ❑ Y ❑ N # of times: _____

Type of environment you live in: _____

With whom do you live?

Name:	Relationship to you:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any problem areas with any family member? ❑ Y ❑ N

If yes, describe. _____

Relationship description with your parents (past and present)

Mother:

Father:

Do you have any siblings? ❑ Y ❑ N

Name:	Describe Current Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever experienced any type of abuse or neglect?

Age:	Experience:

Have you ever had any previous mental health care?

Outpatient counseling or psychiatric medication management:

Where:	When:	Provider:

Inpatient psychiatric hospitalization:

Where:	When:	Reason:

Prior mental health diagnosis? _____

Does anyone in your biological family have any history of mental health treatment (outpatient, inpatient, or medication management)?

Relationship to you:	Type of care:

Do you currently use/abuse or have you used/abused alcohol or drugs?

Name:	Last use:

Have you ever received any type of treatment for alcohol or drug misuse/abuse?

Where:	When:

Does anyone in your biological family have any history of alcohol or drug misuse (including treatment)?

Relationship to you:	Type of care:
_____	_____
_____	_____
_____	_____

Have you ever attempted to take your life or someone else's life? ❑ Y ❑ N

When: _____ Means: _____ Stressor: _____

_____ _____ _____

_____ _____ _____

Do you currently feel suicidal or homicidal? ❑ Y ❑ N

If yes, do you have a plan?

Employed: ❑ Y ❑ N Retired: ❑ Y ❑ N

Place of employment: _____ Occupation: _____

Length of current employment: _____

Any work related stressors? ❑ Y ❑ N ❑ N/A

If yes, please describe:

Are you disabled? ❑ Y ❑ N ❑ N/A

If yes, date of disability approval: _____

Disability approval based on:

Do you have any present or past legal charges? ❑ Y ❑ N

If yes, please explain:

Date: _____ Charge: _____

_____ _____

_____ _____

Name of your primary care physician: _____

Address: _____

Phone Number: _____

Date of Last Visit: _____

Current medical conditions:

Current medications:

Medication:	Dose:	Frequency:	Prescriber:

Is there any additional information that you would like to share that was not asked previously?
(Please continue on last page.)

I hereby certify that the content disclosed within these pages is accurate and complete to the best of my knowledge.

_____ _____

Patient's signature Date

THIS PAGE FOR PROVIDER USE ONLY

Initial plan of care: _____

Frequency: _____

Referral made: _____

Recommendations made: _____

Diagnosis: _____

Provider's signature: _____

Date: _____

Kim Stroud-Hendrick, LCSW

Frieda G. Whitt, LPC, MHSP

Suzanne Prince, LPC

April C. Bowen, MA, SLPE

Michele Ramey, MFT-A

Lauren Kelly, LPC/MHSP, NCC

Additional Information/Comments: