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 - CHILD/ADOLESCENT

Date of Initial appointment: ______________________________ Date of Birth ________________

Patient's Full Name: ______________________________ Age: ________________

Parent(s) / Guardian(s) Name: ______________________________ Relation to child: ________________

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:

Current Symptoms: (Check All That Apply)

- ❑ Long Periods of Sadness
- ❑ Loss of interest
- ❑ Fatigue
- ❑ Change in sleeping or eating
- ❑ Nightmares
- ❑ Loss of time
- ❑ Feeling disconnect from body
- ❑ Difficulty feeling emotions
- ❑ Difficulty concentrating
- ❑ Physical aggression
- ❑ Hyperactivity
- ❑ Separation Anxiety
- ❑ Other Symptoms:
- ❑ Intrusive memories
- ❑ Racing thoughts
- ❑ Physical pain
- ❑ Memory challenges
- ❑ Thoughts of suicide
- ❑ Self-harm behavior
- ❑ Substance Abuse
- ❑ Feeling disconnect from self, others or body
- ❑ Panic Attacks
- ❑ Change in Toileting Habits
- ❑ Destruction of Property
- ❑ Learning Disability
- ❑ Peer difficulties
- ❑ Mood swings
- ❑ Startle easily
- ❑ Hearing voices
- ❑ Spacing out/blacking out
- ❑ Anger
- ❑ Seeing things others don't
- ❑ Defiant Behavior
- ❑ Change in Academics
- ❑ Developmental Delays

What does the child (the patient) hope to accomplish?

Student: ❑ Y ❑ N Current grade: ______________________

Highest level of education: ______________________

Current School: ______________________ Phone#: ______________________

Special Education Service | 504 plan | IEP:

Are there any concerns in the school setting? ❑ Y ❑ N

If yes, please describe:

Is the child employed? ❑ Y ❑ N

Employer: ______________________

Length of employment: ____________

Any work related stressors: ❑ Y ❑ N

If yes, please describe:

Is the child disabled? ❑ Y ❑ N ❑ N/A

If yes, date of disability approval: ______________________

Disability approval based upon:

With whom does the child live:

Name:	Relationship to child:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Does the child participate in any leisure, extracurricular activities or community programs?

Marital status of child's biological parents: ❑ M ❑ S ❑ D ❑ W

If biological parents are divorced, please answer the following:

Year of Divorce: ________________________

Visitation arrangements:

Please check all that applies to your child's biological parents:

Mother:
- ❑ Involved with child
- ❑ Deceased
- ❑ Married # __________
- ❑ Divorced
- ❑ Employed

Father:
- ❑ Involved with child
- ❑ Deceased
- ❑ Married # __________
- ❑ Divorced
- ❑ Employed

Is there a parenting plan in place; ❑ Y ❑ N

If yes, please provide us with the documentation.

Has the child ever experienced any type of abuse or neglect?

Age:	Experience:

Has the child 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 the child's biological family have any history of mental health treatment (outpatient, inpatient, or medication management)?

Relationship to child: ______________________ Type of care: ______________________

______________________ ______________________

Does the child currently use/abuse or has the child used/abused alcohol or drugs?

Name: ______________________ Last use: ______________________

______________________ ______________________

______________________ ______________________

Has the child ever received any type of treatment for alcohol or drug misuse/abuse?

Where: ______________________ When: ______________________

______________________ ______________________

______________________ ______________________

Does anyone in the child's biological family have any history of alcohol or drug misuse (including treatment)?

Relationship to child: ______________________ Type of care: ______________________

______________________ ______________________

______________________ ______________________

Has the child ever attempted to take his or her own life or someone else's life?

When: ______________ Means: ______________ Stressor: ______________

______________ ______________ ______________

Does the child currently feel suicidal or homicidal? ❑ Y ❑ N

If yes, do you have a plan?

Does the child have any present or past legal charges? ❑ Y ❑ N

If yes, please explain:

Date: ______________________ Charge: ______________________

______________________ ______________________

______________________ ______________________

Pediatrician or 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

______________________________ ______________

Parent / Guardian signature Date

THIS PAGE FOR PROVIDER USE ONLY

Initial plan of care: ______________________________

____

____

Frequency: ______________________________

Referral made: ______________________________

____

____

Recommendations made: ______________________________

____

____

____

____

____

____

____

Diagnosis: ______________________________

____

____

____

Provider’s signature: ______________________________

Date: ______________________________

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Additional Information/Comments:

Please email this completed form to: counseling4you@bellsouth.net