PATIENT INFORMATION PACKET *(PLEASE PRINT)*

FIRST NAME:_____MI:_____LAST NAME:_____
Preferred name:_____
If the patient is under 18 years old: parent or guardian name and phone #
_____

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

Mailing address:_____
City:_____State:_____Zip code:_____ Initials:_____

Birthdate:_____ Sex: Male_____ Female_____

Cell phone:_____ Initials:_____
Is it OK to text the above cell phone number? Initials:_____
Email:_____ Initials:_____
Home phone:_____ Initials:_____
Work phone:_____ Initials:_____

Emergency contact:_____Phone:_____
Next of kin:_____Phone:_____

Responsible Party (if other than the Patient)
Name:_____Phone:_____
Email address_____
Mailing address:_____
City:_____State:_____Zip code:_____

It is our office policy that a copy of a credit/debt card or blank check must be kept on file for all missed appointments, unpaid balances, and correspondence. By signing below you agree to these terms. Failure to do so shall result in the cancellation of any appointments.

Name on card:_____
Card #_____
Expiration Date:_____CVV (3 digit code)_____Zip code:_____

_____ _____
Signature Date

Use of insurance - Read and review carefully

Providers who are in-network and/or participate in insurance contractual agreements are obligated to verify a patient's insurance status and benefits prior to providing services. A patient does have the right to opt of utilizing their coverage for any reason. ***However, the patient is require to document their decision.***

-I have insurance and intend to use it. Therefore, I authorize the release of all information necessary to secure payments from my insurance company. **For in-network services,** I assign the provider of my services direct payment for myself and my dependents. **For out-of-network services,** I will receive payments directly from my insurance company if applicable. I understand that my insurance company will only estimate benefits in advance of my services and will not guarantee the estimate until after claims are processed. I understand that I am financially responsible for payments should my insurance company deny a claim for any reason. I understand that I am ultimately responsible for all charges incurred regardless of insurance coverage. I understand that as a courtesy, my provider will bill my insurance company. I understand that should payment not be made by the insurance company ninety days from the date of service, I will be financially liable. Failure to do so, will result in disclosure to a collection agency or attorney and shall not be deemed a breech of confidentiality.

Medicare: I authorize any holder of medical or other information to be released to the Center for Medicare and Medicaid Services (CMS) or its agents any information needed to determine benefits payable for services. Regulations pertaining to Medicare assignment of benefits apply.

Patient signature:_____ Date:_____

Primary Insurance:_____Yes

Name of Insured:_____ DOB:_____

Insurance company name:_____

Policy ID#:_____Group#:_____

Insurance company address:_____Phone #:_____

Employer of Insured:_____

Patient Relation to Insured:_____Self _____Spouse _____Parent _____ Dependent _____Other

Secondary Insurance:_____Yes _____No

Name of Insured:_____ DOB:_____

Insurance company name:_____

Policy ID#:_____Group#:_____

Insurance company address:_____Phone #:_____

Employer of Insured:_____

Patient Relation to Insured:_____Self _____Spouse _____Parent _____ Dependent _____Other

-I have in-network insurance and DO NOT wish to use it or am aware services are not covered by my policy. *** I am aware that EMDR, Brainspotting, and Anger Management are not typically covered services by most insurance companies, plans, and policies. I will pay for services and waive my rights to reimbursement. I cannot request retroactive billing to my insurance company should I change my mind in the future.

Patient signature:_____ Date:_____

-I have out-of network insurance and do not want to file out-of-network claims. I cannot request retroactive billing to my insurance company should I change my mind in the future.

Patient signature:_____ Date:_____

-I DO NOT have insurance coverage and understand I am responsible for my provider's self-pay rates.

Patient signature:_____ Date:_____

Insurance policy

Provider Andréa McInnis, Pre-Licensed Masters Level Therapist DOES NOT accept insurance plans. All other providers may or may not be in contract with your insurance company. A patient is able to request and receive a superbIll to submit to an insurance company for possible reimbursement.

Patient signature:_____ Date:_____

CONSENT TO TREAT

I, _____ do hereby consent for an independent provider at Hendrick Counseling Services, Inc to provide me or my dependent care. I understand that all services are voluntary. I affirm that I am willing participant. I understand that I have the right to withdraw consent at anytime.

****Note:** Without your signature in this area, services will not be provided.

Patient signature:_____ Date:_____

INFORMED CONSENT FOR TELEHEALTH

I,_____do hereby consent to participate in online Telehealth counseling services for myself or my dependent with an independent provider at Hendrick Counseling Services, Inc. I understand that all services are voluntary. I affirm that I am willing participant. I understand that I have the right to withdraw consent at anytime.

I understand that telehealth services can include, but may not be limited to, consultation, diagnostic assessment, treatment, education, and telephone and video conversations using interactive audio and/ or video communications. I understand that telehealth services also involves the communication of information both orally and visually. I understand that I may benefit from telehealth services, but no results are guaranteed as telehealth based care man or may not be as complete as face-to-face care. I understand that I am responsible for providing the necessary telecommunications equipment and internet access for my telehealth sessions. I understand that I am responsible for arranging a location that allows myself privacy and is free from disruptions or distractions during my telehealth appointments.

****Note:** Without your signature in this area, services will not be provided.

Patient signature:_____ Date:_____

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:_____
Phone number:_____ Email:_____

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 provider to inform them of the services that you will be receiving in our office. By providing this information and your signature, this gives us authorization to make contact regarding care. **If you do not have a Primary Care Physician or you do not want us to make contact, please initial and date.**

Initial_____Date_____

Physician's name:_____
Phone #:_____Fax #:_____
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 so, please leave this area blank.

Name of individual referring you:_____
Address:_____
Phone #:_____ Fax #:_____

Patient signature:_____ Date:_____

CHARGES TO PATIENT

$5.00 card processing fee
$120.00 for patients who NO SHOW or do not give 24 hour notice when cancelling
$25.00 returned check charge
$20.00 copying of records
$5.00 per page for correspondence
$1,500.00 court appearance per day

CANCELLATION POLICY

A patient will be billed the provider's full self pay rate/amount for any missed appointment (No show) or for any appointment not cancelled by the patient 24 hours prior to the appointment. The charge will be the patient's responsibility, as insurance will not pay for nor can insurance be billed.

RESCHEDULIiNG

Patients with an outstanding 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 be taken out of school on a routine basis, each child will be asked to take an appointment after 3 pm and then take an appointment before 2:30 pm. Each appointment thereafter will be rotated on this schedule.

EMAILS/TEXTS/VOICEMAILS

Please email us through our website email link or through our secure patient portal. Our website is www.hendrickcounseling.com. These two avenues are the only **SECURE** means of providing us with any sensitive or confidential information. Please **DO NOT** leave or provide sensitive information on our voicemail or via text. These means of communication with us are **NOT SECURE.**

SNOW POLICY

If the Lebanon City Schools are closed due to weather, our office will be closed as well. You and your provider might determine that telehealth would be a better alternative to cancelling. That coordination will be up to each individual provider.

CONFIDENTIALITY POLICY

This is to inform you that all services received in our 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. This applies to in-office care and telehealth.

BILL OF RIGHTS & NOTICE OF PRIVACY PRACTICES

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

I HAVE READ AND UNDERSTAND ALL CHARGES, POLICIES, PRACTICES, & THE BILL OF RIGHTS.

Patient signature:_____ Date;_____

DIRECTIONS TO HENDRICK COUNSELING SERVICES
440 PARK AVE, LEBANON, TN 37087 (615) 449-9611

From Nashville- Take I-40 east to exit 239B Lebanon/Watertown exit. Veer right off the exit. Go to the 1st red light turn left. This is Tennessee Blvd. Go to 4 way stop turn right onto Park Ave. Hendrick Counseling is on the left, a tan two story building. The awning on the left side of the building has Hendrick Counseling. That is our main entrance.

From Cookeville- Take I-40 west go to exit 239 Lebanon/Watertown, veer right at end of exit then follow directions at top of this page.

From Gallatin- Take 109 to Hwy 70/109 intersection, go straight until you come to I-40. Take I-40 east to exit 239B veer right off exit then follow directions at the top of this page.

From Hartsville- take 231 to Lebanon. Follow 231 into Lebanon, to the square. Go around the square to Lowery, Lowery,and Cherry and to right (east). Go to the 3rd red light and veer right onto Park Ave. Hendrick Counseling is a ½ mile on your right.

From Lavergne and Smyrna- Take 840 toward Lebanon. Take the Lebanon/Knoxville exit I-40 east. Then go to exit 239B and follow directions at the top of this page.

From Murfreesboro,Lavergne, and Smyrna and taking 231- Take 231 into Lebanon to I-40 east and go to exit 239B and follow directions at the top of this page.

From Carthage- Take Hwy 70. You will then come to a traffic light go straight through the light. Go to the next traffic light and turn left. You are turning onto Park Ave. We are ½ mile on the right.

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 base 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?

_____

_____

_____

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
April Bowen Harrison, MA, LSPE, HSP
Suzanne Prince, MA, LPC
Andréa McInnis, Pre-Licensed Masters Level Therapist

Additional Information/Comments:

Please bring this completed form with you to your appointment.