

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 be 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?

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Primary Care Physician | <input type="checkbox"/> Website | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Family | <input type="checkbox"/> Google Search | |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Insurance Company | |
| <input type="checkbox"/> Other: _____ | | |

Reason for your appointment: _____

Current Symptoms: (Check All That Apply)

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

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

Student: Y N Current grade: _____

Highest level of education: _____

Current School: _____ Phone#: _____

Special Education Service I 504 plan I 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?

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: _____

- 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

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 yellow 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 Laverne 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, Laverne, 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.