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: _____

Psychiatric Evaluation Intake Form

1. Patient Contact Information

Patient Name_____ Preferred Name _____
Last First MI

Address_____

Best contact phone number: _____Email address: _____

Primary Care Physician _____Tel _____Fax_____

Pharmacy _____ Phone #_____

2. Date of Birth ☐☐/☐☐/☐☐☐☐ **3. Age** ☐☐ **Years**
M M D D Y Y Y Y

4. Race/Ethnicity (Check one or more):

☐ American Indian/ Alaskan Native ☐Asian ☐ AfricanAmerican ☐ Hispanic ☐ Caucasian ☐ Other_____

5. Current marital status (Check one):

☐ Single,never married ☐ Married,living together ☐ Separated ☐ Widowed ☐ Cohabiting with partner ☐ Divorced
☐ Married,not living together

6. If you are married or cohabitating with partner, how long has this been? ☐☐ ☐☐
Years Months

7. Total number of marriages? ☐☐ **How many children do you have?** ☐☐

8. Spouse's/Partner's Name_____

9. Who else lives with you? _____

10. How many years of formal education have you completed? ☐☐
Years

11. Highest degree obtained: (Check only one)

☐ High school graduate ☐ G.E.D. ☐ 4 year college degree ☐ M.B.A./M.A./M.S./M.P.H. ☐ M.D.
☐ Junior college degree or technical school diploma ☐ J.D./LL.B. ☐ Ph.D ☐ Other_____

12. What best describes your current employment status? (Check one from each category a, b, & c)

a. Employment Status	b. Student Status	c. Volunteer Status
☐ Unemployed, not looking for employment	☐ Part-time	☐ Volunteer Part-time
☐ Unemployed, looking for employment	☐ Full-time	☐ Volunteer Full-time
☐ Full-time employed ☐ Part-time employed	☐ Not a student	☐ No Volunteer Work
☐ Retired ☐ Self-employed		
☐ On welfare ☐ Social security disability		

14. What is your occupation? _____

15. Current Residence

☐ Own my house/ condo ☐ Retirement Complex/Senior Housing ☐ RENTING ☐ Apartment /Condominium

16. What is your spouse's occupation? _____

Are you currently seeing a therapist? (Name/contact #)_____

Have you ever seen a psychiatrist/psychotherapist before? If yes, please list:_____

Previous history: Have you ever been treated for any of the following (check all that apply):

____ Depression	_____ADHD	_____ Bipolar (Manic / Depressive) Disorder
_____ Anxiety	_____OCD	____ Schizophrenia
____ Panic Attacks	_____PTSD	____ Alcohol Problems (including AA)
____Anorexia/ Bulimia	_____Binge-eating	____ Drug Problems _____ECT treatment

Please list in chronological order all prior psychiatric hospitalizations (if any) below: None

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below: Never

Approximate date of attempt	How did you attempt (method)?

Please List *all* current medications below(include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort etc)

Name of Medication	Dosage(Mg)	How many times a day?	On this for how long?	Side effects (if any)	Prescribing physician

Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

Brand Name	Generic Name	√ if yes	How long did you take it?	What Dosage did you take? Mg/d	Did it help? √ if yes	How often In a day? Write 1, 2 or 3 times a day	Any Side effects
Selective Serotonin Reuptake Inhibitors(SSRIs)							
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Paxil CR	Paroxetine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Zoloft	Sertaline						
Prozac	Fluoxetine						
Serotonin-Norepinephrine Reuptake Inhibitors(SNRIs)							
Effexor	Venlafaxine						
EffexorXR	Venlafaxine						
Pristiq	desvenlafaxin						
Cymbalta	Duloxetine						
Other Antidepressants							
Desyrel	Trazadone						
Serzone	Nefazodine						
Wellbutrin XL / SR	Bupropion XL/ SR						
Remeron	Mirtazapine						
Viibryd	vilazodone						
Tricyclic Antidepressants							
Adapin	Doxepin						
Anafranil	Clomipramine						
Asendin	Amoxapine						
Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortriptyline						
Sinequan	Doxepin						
Surmontil	Trimipramine						
Tofranil	Imipramine						
Vivactil	Protriptyline						
Other Psychotropics (Have you taken any of these?)							
Abilify	Buprenorphin	Dexedrine	Ambien	Klonopin	Emsam	Provigil	Thorazine
Risperidal	Campral	Adderall	Buspar	Ativan	Nardil	Depakote	Dalmane
Invega	Antabuse	Vyvanse	Restoril	Xanax	Parnate	Lithium	Orap
Geodon	Suboxone	Strattera	Sonata	hydroxyzine	Halcion	Lamictal	Navane
Zyprexa	Naltrexone	Concerta	Buspar	Valium	Niravam	Phentermine	Trilafon
Seroquel	Ambien CR	Dexedrine	Halcion	vistaril	Tranxene	Tegretol	Mobane
Symbyax	Valproic Acid	Focalin	Atarax	Methadone	Cylert	Topamax	Stelazine
Clozapine	Adderall XR	Ritalin	Librium	Synthoid	Viibryd	Mellaril	Haldol
Rozerem	Metadate	Daytrana	Lunesta	Meridia	Saphris	Loxitane	Prolixin

Family History :Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate indicate paternal or maternal)

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression								
Anxiety								
Panic Attacks								
Post traumatic stress								
Bipolar/Manicdepression								
Schizophrenia								
Alcohol Problems								
Drug problems								
ADHD								
Suicide attempts								
Psychiatric hospital stay								

Medical History: Do you have, or have you ever had any of the following (please check all that apply)? **Please write in your medical problem in each category**

	Mark √		Mark √		Mark √
High Blood Pressure		Gastrointestinal Problems (ulcers, pancreatits, irritable bowel, colitis)		Viral Illness (herpes, Epstein-Barr, chronic hepatitis)	
Lung Disease		Arthritis or Rheumatoid Problems		Cancer	
Diabetes		Liver Damage or Hepatitis		Genital Problems	
Heart Disease		Other Endocrine/Hormone Problems		Eating Disorder	
Thyroid Disease		Neurological Problems (stroke, brain tumor, nerve damage)		Eye Problems	
Anemia		Gynecological / hysterectomy		Chronic pain	
Asthma		Urinary Tract or Kidney Problems		Fibromyalgia	
Skin Disease		Migraine or Cluster Headaches		HIV Positive or AIDS	
Seizures		Ear/Nose/Throat Problems		Head Injury	
Other medical issues		High Cholesterol		Sleep apnea	

Regarding alcohol, when was your last drink?_____
In the past 30 days, about how many of those days have you had at least one alcoholic drink?_____
What is the maximum number of drinks you have had in one day in the past month?_____drinks
DUI_____DWI_____Public Intoxication_____Seizures_____DT's_____

Please check the appropriate boxes that apply to you for the following substances:

	Never Used	Age first used	Last used on this approx date	Age peak use	Hx abuse?	Current use and frequency
Cocaine						
Amphetamine Or Speed						
Marijuana						
Diet Pills						
Hallucinogens (LSD,mushrooms, Mescaline)						
Ecstasy						
Diuretics						
Tranquilizers						
Pain Pills						
Inhalants						
Sleeping Pills						
Laxatives						
Cigarettes,cigars, Or tobacco						
PCP or Angel Dust						
IV Drug use						
Heroin						
GHB						
Anabolic Steroids						
Caffeine(coffee, Tea,cola's,iced tea						
Benzodiazepines (xanax,valium,ativan Restoril, Librium)						
Other:						

List all prior surgeries and hospitalizations for medical illnesses

_____
_____
_____

Are you allergic to any medication or food? If so, please list below

_____
_____

Last menstrual period (if applicable) _____
Contraceptive method: _____

Emergency contact: _____ **Phone #**_____

HENDRICK COUNSELING SERVICES, INC.
LORI L. BALL, APN,PMCNS,FNP
440 PARK AVE., LEBANON, TN 37087
615-449-9611 FAX 615-453-7051

CONTROLLED SUBSTANCES CONTRACT

NAME :_____ DOB:_____

I understand that there are strict laws which regulate controlled substances in the state of Tennessee. I agree to the following terms:

1. I will take these medications as directed. I will not exceed the dosage prescribed by my health care provider.

2. I understand that both the prescription(s) and medication(s) are my responsibility. If I lose them, or someone takes them, the medication(s) will not be refilled early.

3. I promise not to share or sell my medications. I am the only one who will take my medication(s).

4. I understand that there may be side effects associated with these medications, which include , but are not limited to, drowsiness, impaired coordination,confusion,memory problems,constipation,nausea,vomiting and withdrawal symptoms. I will use good judgment when taking these medications,and will not engage in activities which might put me or someone else in danger. I will discuss potential side effects with my health care provider, and inform him or her if I experience side effects which concern me.

5. I understand that controlled drugs are addictive. I will tell my health care provider about any history I have of addiction problems,to include prescription drugs,alcohol,or street drugs.

6. I understand that there are interactions between many controlled substances and other medications or drugs. I will not use alcohol or street drugs while I am taking these medications. I will check with my health care provider for many potential interactions with other medications which I take.

7. I understand that I must obtain these medications at the same office each time I get them. I will not obtain these medications from any other source, including other health care providers, emergency rooms, or off the street. I will inform my health care provider immediately if another doctor-for example , a specialist changes my dosage or prescribes additional medications for me.

8. I understand that if I take a high dose of narcotics on a regular basis, I may experience withdraw symptoms if I stop taking them abruptly. Withdrawal symptoms may include shaking,extreme nervousness , confusion,insomnia,or seizures. If I choose to go off one of my controlled drugs, I will taper off it gradually rather than stopping it abruptly.

9. I understand that I may be asked to take a urine drug test on a random basis to ensure that I am taking my medications properly. I understand the cost of these urine drug tests are my responsibility. By signing this agreement, I agree and consent to be tested at any time.

Name:_____ DOB:_____

10. I realize that my prescription will not be refilled over the phone. I must come in for my office visits as scheduled in order to keep receiving these medications.

11. I understand that the narcotic prescriptions written for me will not be routinely adjusted. The below medications and dosage(s) are considered to be maintenance for my condition: therefore , I will not frequently ask for increases of dosage(s). I understand that if my pain increases I will discuss this with my health care provider and treatment options will be discussed.

12. I understand that my health care provider may need to obtain certain tests in order to reach a diagnosis and provide me with the best possible care. If I am repeatedly non compliant with ordered tests or office visits, my health care provider will no longer be able to provide me with controlled drugs.

13. I understand that my health care provider may need to discuss certain aspects of my care with pharmacists or other health care providers in order to verify compliance with medication regiments and optimize my care, and I consent to this.

14. I understand that I may be referred to a pain clinic or other specialist(s) at any time for pain management or management of my condition.

15. I understand that I will make my follow up visits for my refills with the health care provider who initially began this narcotic treatment. I understand that in the best interest of my health,other providers at Hendrick Counseling Services, Inc. may not refill my medications. Having the same health care provider to refill my prescriptions is safer and provides more continuity in my care.

16. I will use only one pharmacy to obtain my medications.

17. I understand this is an agreement based upon trust. If I break any of the above,i understand that I may lose the ability to get narcotic medications at Hendrick Counseling Services, Inc. and I could be dismissed as a patient from Hendrick Counseling Services, Inc.

Drug and dosage :_____ # monthly:_____
Drug and dosage :_____ # monthly:_____

Pharmacy I will get these prescriptions filled at :_____

Diagnoses :_____

_____ _____
Patient Signature Date

_____ _____
Provider 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 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 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

440 Park Ave.,Lebanon, TN 37087
Phone 615-449-9611
Fax 615-453-7051

AUTHORIZATION FOR RELEASE

The undersigned hereby authorizes Lori L. Ball,APN,PMHCNS,FNP to release written and or oral psychiatric,psychological,medical,educational,alcohol and or drug information to Hendrick Counseling Services, INC.

Patient Name:_____ Date of Birth:_____
Social Security Number:_____ Maiden Name:_____
Address:_____

Purpose of release is for coordination/continuation of care:
Type of information to be released: Please initial next to all that apply

_____ Discharge Summary
_____ History/Physical
_____ Lab Reports
_____ X-ray Reports
_____ Educational Assessment
_____ Psychological Testing/Evaluation
_____ Psychiatric Evaluation
_____ Comprehensive Assessment
_____ Treatment/Progress Update
_____ Medication History

This is subject to written revocation at any time except to the extent that action has already been taken in reliance upon this consent. This consent will automatically expire 12 months from the date signed. A photocopy of this authorization is as authentic as the original.

It is further understood that the information released is for professional purposes only and may not be in whole or part provided to any other agency,organization,or person other than that stated above.

TO THE PARTY RECEVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. Further regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains,or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____
Signature of patient/legal guardian **Date**

_____ _____
Signature of Witness **Date**

HENDRICK COUNSELING SERVICES

440 Park Ave.,Lebanon, TN 37087
Phone 615-449-9611
Fax 615-453-7051

AUTHORIZATION FOR RELEASE

The undersigned hereby authorizes Hendrick Counseling Services, INC.
to release written and or oral psychiatric,psychological,medical,educational,alcohol and or drug information to Lori L. Ball,APN,PMHCNS,FNP .

Patient Name:_____ Date of Birth:_____
Social Security Number:_____ Maiden Name:_____
Address:_____

Purpose of release is for coordination/continuation of care:
Type of information to be released: Please initial next to all that apply

_____ Discharge Summary
_____ History/Physical
_____ Lab Reports
_____ X-ray Reports
_____ Educational Assessment
_____ Psychological Testing/Evaluation
_____ Psychiatric Evaluation
_____ Comprehensive Assessment
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_____ Medication History

This is subject to written revocation at any time except to the extent that action has already been taken in reliance upon this consent. This consent will automatically expire 12 months from the date signed. A photocopy of this authorization is as authentic as the original.

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_____ _____
Signature of patient/legal guardian **Date**

_____ _____
Signature of Witness **Date**