Health Management Services, P.C.

Confidential Information - Adult

Is this court related? Yes ❒ No ❒

Date _____

(Please Print)
If yes please explain _____

Name_____ SS#_____
first middle or maiden last

Age_____ Date of Birth _____ Sex: ❒ Male ❒ Female Education_____

Home Address_____
street city state zip

Home Phone_____ Cell Phone_____ Work Phone _____

Occupation_____ Employer_____

Work Address_____
street city state zip

Marital Status _____Spouse's name_____ Age_____ DOB_____

Spouse's Education_____ Occupation_____ Employer_____

Are you a veteran? Yes ❒ No ❒ Combat? Yes ❒ No ❒

Please list your Parents, Siblings, and Children

Name	Relationship	Age	Occupation/Grade

Please complete the following medical information:

Do you have any medical problems? Please explain: _____

If you are currently under the care of a physician or psychiatrist for a continuing Health Problem, please give your physician's name and phone number:

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Do you take regular medications? Yes ❒ No ❒ If so, what?

Name of medication Dose Frequency

Allergies to Medications: _____

Do you smoke? Yes ❒ No ❒ If so, how much? _____ How long? _____

Previous Mental Health Services:

Type of Services Provider Dates of Service

Referred by:_____ Relationship:_____

Emergency Contact:_____ Relationship:_____

Address:_____ Phone:_____ _____

street city state zip home or cell work

Religious Preferences (Optional): _____

Ethnicity & Race (Optional): _____

List your hobbies:

What do you consider to be your strengths?

Briefly describe the problems and reasons that brought you here:

Briefly list goals of your treatment here. What would you like to achieve and/or see happen by coming here?:

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Patient's Name:_____

Payment Information

Please provide the following information about the **Financially Responsible Person**.

Name:_____ DOB:_____ SS#_____

Relationship to patient:_____ Home phone:_____ Cell Phone:_____

Billing Address:_____

Employer:_____ Occupation:_____ Work Phone:_____

STOP: Please only fill out the insurance section if you are being seen for counseling only. Testing services are self-pay. However, the patient or guardian needs to sign at the bottom of the page in either case.

Please provide the **insured's information** regarding insurance(s) and/or health plans to be utilized:

Primary Insurance or EAP:_____ **Insured's Name & Relationship:**_____

Insured's ID#:_____ Insured's Group#:_____

Insurance Company Phone#:_____ Insured's SSN:_____ **Insured's DOB**:_____

Payment/Insurance Agreement & Authorization to Send Reimbursement Information

I accept responsibility for payment of charges for services rendered to the above mentioned patient. I understand that full payment and/or my copayment and/or deductibles are expected at the time services are rendered unless the doctor agrees otherwise. I understand that, unless the above mentioned patient has coverage under a managed health plan or medicaid to which I subscribe and to which the doctor is a participating provider, I am personally responsible for the payment of all charges. Payment for any charges denied or not covered by my insurance company become my responsibility and I agree to pay these charges. I also understand that any court order I have is an agreement between myself and the courts not the doctor, and I am still responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. In addition, if I have requested that the doctor file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that the doctor provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the doctor to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above mentioned patient. This consent shall remain in effect until all claims h ave been fully processed and all review procedures completed.

_____ _____

Signature of adult patient or parent/legal guardian of patient less than 18 years of age Date

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Patient Agreement with the Policies and Procedures

Welcome to Health Management Services, P.C.

The following information is provided to patients to assist them in understanding policies and procedures at our office. We strive to provide you care which is both comfortable and of the highest quality. Please do not hesitate to ask your HMS Clinician or the administrative staff questions at any time about these matters.

Appointments:

Clerical staff schedule appointments for patients and will call or text the opened business day before to remind of appointments.

Since patients are seen by appointment only, we ask that you give at least a **24-hour notice** to cancel your reserved time and **48 hours** if you are scheduled for a two-hour block. In the absence of life threatening emergencies, you will be charged the following fee:

- **Late Cancelling a Routine Appointment** without a 24-hour notice: **$30/hr.**
- **Late Cancelling a Testing Appointment** without a 24-hour notice: **$50/hr.**
- **No Call, No Show** for a **Routine Appointment: $50/hr. scheduled**
- **No Call, No Show** for a **Testing Appointment**: **$75/hr. scheduled**

Please understand that insurance companies will not be billed for missed appointments, and you are fully responsible for any charge due to a missed appointment. If you fail to make two appointments without calling, it is our office policy not to reschedule.

Emergencies and Telephone Calls:

There may arise occasions where you need to talk to your HMS Clinician between appointments, in which you can call during normal office hours. If your call is an emergency, you should declare your call to be an emergency and let the receptionist know of your needs. HMS has 24-hour emergency coverage; clinicians can be paged through our 24-hour answering service. However, for an immediate response, HMS does advise for you to go to the local emergency room or call the TN State Crisis Line at: 1-855-274-7471.

Fees and Payments:

Copayments, deductibles, coinsurance, and past due balances (including missed appointment fees) are due upon arrival at each appointment when applicable. If your insurance does not pay and you are the responsible party, you are responsible for payment and applicable fees will be discussed at that time. Special fee structures for certain specified tasks such as psychological testing, consulting, or court-ordered appearances will be discussed with you and agreed upon before any actions are taken.

Insurance Usage and Coordination of Benefits:

It is standard practice for insurance companies to periodically request “Coordination of Benefits” information from you to see if you have other insurance coverage. It is your responsibility to comply with this request promptly in order to receive benefits and coverage. Failure to do so will result in delayed claims processing by the insurance company. HMS reserves the right to postpone visits until the necessary information has been completed.

_____ _____

Signature of adult patient or parent/legal guardian of patient less than 18 years of age — Date

_____ _____

Witness — Date

Health Management Services, P.C.

Confidential Information - Adult

Patient Agreement with the Policies and Procedures

Issues of Confidentiality and Privileged Communication:

Psychologists, psychological examiners, and mental health therapists have a strong privileged communication law in Tennessee which carries the same legal status as that of attorney-client privilege. What you talk about in your established relationship with your HMS Clinician is protected by privileged communication laws and confidentiality principles, with the exception of certain specific actions (i.e., clear and imminent danger to self and/or others, child abuse, suspected child abuse, elder abuse, worker's compensation related cases, if your psychiatric or psychological health becomes an issue in a lawsuit, utilization review reports for authorization of care, and chart audits by your insurance carrier). With these exceptions, unless you specifically sign a release of information authorizing HMS to talk to someone, all communications are kept private, confidential and privileged. We strive to maintain the sacredness and privacy of your confidential communications with us.

Authorization for Release of Information:

If you would like for a spouse, relative, or friend to coordinate appointments for you or have access to your personal health information, please inform the front desk so that you may fill out and sign an authorization form. You may also fill out a release of information if you would like to coordinate care between your HMS Clinician and your doctor, lawyer, etc. as needed.

Cellular or Recording Devices:

As a patient of HMS, you willingly agree not to record any session or contact with the clinician or staff. You also agree to inform anyone involved in your case (i.e., attorney, relative, case worker, advisor, etc.) that they do not have permission to record any session or contact (i.e., phone conversations) with the clinician at any time and agree to turn off all cellular phones during session.

Your Informed Consent to Care:

HMS has provided this information to you in the hope of fully informing you about the policies of the HMS office and some of the parameters of care you will receive here, such as the importance of confidentiality. Psychiatric and psychological care, like other things in life, offers no absolute guarantee of success and there are limitations to any form of care offered to a patient. After you have met with your HMS Clinician, your concerns will be reviewed and your HMS Clinician will construct an individualized treatment plan for you and share it with you so that identified problems can be resolved.

Please feel free to discuss any of these matters with your HMS Clinician in greater detail. By signing below, you acknowledge having read, understood and agree to these policies and procedures. Your signature below acknowledges your informed consent for care.

_____ _____

Signature of adult patient or parent/legal guardian of patient less than 18 years of age Date

_____ _____

Witness Date

Health Management Services, P.C.

Confidential Information - Adult

HIPAA Notice of Privacy Practices

Patient Name (print)_____ Patient Signature _____ Date_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice was published and became effective on/or before January 1, 2006. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition, and related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the clinician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes coordination with a third party. For example, your PHI could be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval from your insurance carrier or employee assistance program for treatment may require that your relevant PHI be disclosed to the health plan.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your clinician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of undergraduate and graduate students, licensing, and conducting or arranging for other business activities. For example, we may call you by your first or last name in the waiting room.

We may use or disclose your PHI in the following situations without your authorization: As required by law; public health issues as required by law; communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; research; criminal activity; military activity and national security; and worker's compensation.

The following is a statement of your rights with respect to your protected health information: You have the right to inspect and copy your PHI. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members of, or friends who may be involved in your care, or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your clinician is not required to agree to a restriction that you may request. If your clinician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another mental healthcare professional.

If you refuse to allow disclosure necessary for your clinician to be paid by your insurance carrier or employee assistance program, you agree to pay, in full, for all services provided by your clinician on the date services are provided.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively.

You may have the right to have your clinician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please feel free to speak to your clinician or with our HIPAA Compliance Officer, Dr. Owen (Tom) A. Biller, Ed.D. at Health Management Services.

You may revoke this authorization, at any time, in writing, except to the extent that your clinician or the clinician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

HIPAA2006

_____ _____

Witness Date

Health Management Services, P.C.

Confidential Information - Adult

AUTHORIZATION TO RELEASE PSYCHOTHERAPY NOTES

I, _____, _____
(Print name) (DOB)

SPECIFICALLY AUTHORIZE Health Management Services, P.C. to release progress notes, treatment summaries, and results of a psychological assessment from dates:

_____ to _____.

The clinical information is to be sent to the following agency:

---

for the designated purpose of:

I acknowledge Health Management Services, P.C. Clinician has fully informed me that the Health Insurance Portability and Accountability Act (HIPAA) affords special privacy protections regarding "Psychotherapy Notes" in an effort to preserve/protect the confidentiality parameters of the therapeutic relationship. I have also given permission to release progress notes, treatment summaries, and psychological evaluation reports to the above person(s) or agency. I understand HIPAA forbids payors from requiring disclosure of psychotherapy notes as a condition for payment. Psychotherapy notes differ from progress notes. I have discussed this matter with my HMS Clinician and any questions I had are answered.

_____ _____
Patient Signature or Parent of Minor/Legal Charge Date
If legal charge, describe representative relationship

Representative Relationship: _____

_____ _____
Witness Signature Date

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Developmental History – Adult

GENERAL INFORMATION

Client's Full Name: _____ Age: _____ DOB: _____
Preferred Name: _____ Preferred Pronouns: _____
Current Address: _____ How long at this address: _____
_____ Primary language at home: _____

Please share any other information related to the client's personal identity that you feel is pertinent (some examples may include ethnic/racial/cultural identity, gender identity, sexual orientation, religious/spiritual identity, etc.):

_____

_____

DEMOGRAPHIC / FAMILY HISTORY

With whom does the client live? Please list all other persons who currently live in the household:

Name	Relationship to client	How long has this person lived in the household?

Have any of the client's family members had any of the following?	*If yes, please specify family member's relationship to client* (parent, sister/brother, aunt/uncle, grandparent, etc.)
☐ Learning difficulties (reading, math, writing)	
☐ Speech/language problems (articulation, stutter, etc.)	
☐ Developmental disorder (Autism, Asperger's, etc.)	
☐ Emotional problems (depression, anxiety, etc.)	
☐ Mental disability (schizophrenia, etc.)	
☐ School failure (failing grades, dropout, etc.)	
☐ Drug or alcohol addiction (specify)	
☐ Attention Difficulties and/or ADHD	

Has the client experienced any significant changes over the *last few years*? (e.g., new marriages, deaths, births, address changes, homelessness, family separations/divorce, job change, money problems)

☐ Yes ☐ No If yes, please specify: _____

_____

_____

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HEALTH AND DEVELOPMENT

Pregnancy and Birth

Please complete the following information regarding the client's birth to the best of your ability. If unknown or unable to be obtained, leave blank.

Did the client's mother receive prenatal care from a physician? ☐Yes ☐No

Pregnancy lasted _____ weeks/months Client's birth weight: ____ pounds ____ ounces

Please specify any medications used by the client's mother during pregnancy:

Name of medication	Purpose

Please check the conditions below that describe the client's health and the health of his/her/their mother during:

Mother's Pregnancy	Delivery	Condition at Birth
☐ No complications	☐ Normal	☐ Normal / no problems
☐ Excessive bleeding	☐ Induced labor	☐ Lack of oxygen
☐ Physical Injury	☐ C-Section	☐ Breathing problem
☐ Gestational Diabetes	☐ Breech birth	☐ Birth injury/defect: _____
☐ Emotional stress	☐ Forceps used	☐ Lengthy hospital stay:
☐ Toxemia	☐ Other problems (specify)	Duration _____
☐ High blood pressure	_____	☐ Low Apgar Score _____
☐ Alcohol/drug use	_____	☐ Other problems (specify)
☐ Tobacco use		_____
☐ Other problems (specify)		_____
_____		
_____		

Development

Please rate the client's functioning as an infant and toddler in the following areas:

Milestone:	Advanced	Average	Delayed	Age when milestone was met?
Rolled over	☐	☐	☐	
Sat unassisted	☐	☐	☐	
Pulled up to stand	☐	☐	☐	
Walked unassisted	☐	☐	☐	
Toilet trained during day	☐	☐	☐	
Toilet trained during night	☐	☐	☐	
Speaking first words	☐	☐	☐	
Speaking in phrases/sentences	☐	☐	☐	

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During the client's *first few years of life*, were any of the following present to a *significant* degree?*

☐ Difficult to comfort	☐ Failure to thrive
☐ Difficulty separating from parents	☐ Underweight
☐ Colicky	☐ Difficulty feeding
☐ Excessive crying/irritability	☐ Fascination with certain objects
☐ Difficulty sleeping	☐ Temper tantrums

*If checked, please describe and list at what age(s) it occurred: _____

_____

Health

Describe the state of the client's current health: ☐ Excellent ☐ Good ☐Fair ☐ Poor

Primary Care Physician: _____ Telephone: _____

How often does the client see a physician? _____ Date of last visit? _____

Medical Diagnoses (including chronic health issues):

Diagnosis _____ Medication ☐ Yes ☐ No Type and dosage: _____
Diagnosis _____ Medication ☐ Yes ☐ No Type and dosage: _____
Diagnosis _____ Medication ☐ Yes ☐ No Type and dosage: _____
Diagnosis _____ Medication ☐ Yes ☐ No Type and dosage: _____

Has the client experienced any of the following?	Age of onset	Currently a problem?		Details
☐ Serious Illness		☐ Yes	☐ No	
☐ Head Injuries		☐ Yes	☐ No	
☐ Seizures or convulsions		☐ Yes	☐ No	
☐ History of ear infections		☐ Yes	☐ No	
☐ Allergies and/or Asthma		☐ Yes	☐ No	
☐ Vision problems		☐ Yes	☐ No	
☐ Hearing problems		☐ Yes	☐ No	
☐ Speech or language problems		☐ Yes	☐ No	
☐ Drug and/or alcohol use		☐ Yes	☐ No	
☐ Self-harm		☐ Yes	☐ No	
☐ Suicidal ideation or attempts		☐ Yes	☐ No	
☐ Significant trauma		☐ Yes	☐ No	
☐ Other health problems		☐ Yes	☐ No	

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Has the client had frequent ER visits? ☐ Yes ☐ No Reasons: _____

_____

Hospitalizations/Surgeries

Date: _____ Reasons: _____

Date: _____ Reasons: _____

Date: _____ Reasons: _____

Client's current Sleep Habits

☐Sound sleeper ☐Difficulty falling asleep ☐Bedwetting ☐Sleep apnea ☐Night Terrors
☐Sleep walking ☐Difficulty staying asleep ☐Difficulty waking ☐Other: _____
Client sleeps: ☐ Alone ☐ With partner ☐ With pets ☐ Other: _____
Average amount of sleep per night: _____

Therapies / Evaluation

Has the client ever received psychological counseling? ☐ Yes ☐ No
If yes, by whom and reason for counseling: _____

Has the client ever had a neurological or psychological evaluation? ☐ Yes ☐ No
If yes, by whom, date of evaluation, and reason for evaluation: _____

Is the client currently receiving private physical, occupational, speech, counseling services? ☐ Yes ☐ No
If yes, by whom and how often (e.g. once a week, twice a month, etc.): _____

Has the client ever been identified as having a disability? ☐ Yes ☐ No
If yes, by whom, at what age, and what disability? _____

BEHAVIOR

Please indicate whether the following describe the client.*

☐ Easily overstimulated	☐ Has poor self-esteem
☐ Has a short attention span	☐ Has test anxiety
☐ Hyperactive/Impulsive	☐ Perfectionistic
☐ Disorganized	☐ Has obsessive tendencies
☐ Does not listen to what is being said	☐ Has difficulty adapting to change in routines
☐ Easily frustrated	☐ Feels uncomfortable meeting new people
☐ Feels unhappy most of the time	☐ Physically aggressive
☐ Excessively worries	☐ Verbally aggressive
☐ Withdrawn/sullen	☐ Has frequent peer or family conflicts
☐ Withholds affection	☐ Steals or lies
☐ Hides feelings	☐ Lacks motivation
☐ Has fears	☐ Is destructive
☐ Frequently complains of aches and pains	☐ Is cruel to animals

*If checked, please describe, list at what age(s) this began, and if it is currently a problem: _____

_____

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What activities does the client enjoy (i.e., sports, hobbies, etc.)? _____

How would you describe the client's peer relationships/friends? _____

EDUCATIONAL AND VOCATIONAL HISTORY

Early Childhood

Did the client attend daycare? ☐ Yes ☐ No If so, at what age? _____

Any known problems in daycare? ☐ Yes ☐ No If yes, please describe _____

Did the client attend preschool? ☐ Yes ☐ No If so, at what age? _____

Any known problems in preschool? ☐ Yes ☐ No If yes, please describe _____

Elementary/Middle/High School

Please list all schools attended:

School _____ Grades _____

School _____ Grades _____

School _____ Grades _____

School _____ Grades _____

Was the client ever retained/held back in school? ☐ Yes ☐ No Grades retained: _____

Did the client receive a regular education diploma? ☐ Yes ☐ No If not, specify: _____

Did the client have difficulty with reading? ☐ Yes ☐ No If yes, please describe: _____

Did the client have difficulty with writing? ☐ Yes ☐ No If yes, please describe _____

Did the client have difficulty with math: ☐ Yes ☐ No If yes, please describe _____

Did the client ever receive special education services or supports in school? ☐ Yes ☐ No Specify: _____

Post-Secondary Education

Please list all education attained after high-school:

School _____ Level completed _____

School _____ Level completed _____

School _____ Level completed _____

School _____ Level completed _____

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Did the client fail or have to repeat any courses? ☐ Yes ☐ No If yes, specify: _____

Did the client receive academic accommodations? ☐ Yes ☐ No If yes, specify: _____

Employment History

Please list most recent employment history:

Position: _____ Duration at job: _____

Position: _____ Duration at job: _____

Position: _____ Duration at job: _____

Position: _____ Duration at job: _____

Did the client receive ADA/Section 504 supports? ☐ Yes ☐ No If yes, specify: _____

What are the client's strengths? _____

What are the client's weaknesses? _____

Briefly describe any additional concerns: _____

Name of person completing form: _____ Date: _____

Relation to client (if not self): _____