Health Management Services

2292 Chambliss Ave NW, Suite C-2
Cleveland, TN 37311
P: (423) 479-5672 | F: (423) 479-5679

ADULT NEW PATIENT PACKET

Is this court related? Yes ❒ No ❒

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: (___)_____

Ethnicity & Race: _____ Religious Preference: _____
*Optional *Optional

Occupation: _____ Employer: _____

Work Address: _____
street city state zip

Marital Status: Choose One Spouse's name: _____ Age: ___ DOB: _____

Spouse's Education: _____ 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:

_____

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

MEDICATION NAME	DOSE	FREQUENCY

Allergies to Medications: _____

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

Previous Mental Health Services:

TYPE OF SERVICE	PROVIDER	DATE(S) OF SERVICE

Referred by: _____ Relationship:_____

Emergency Contact: _____ Relationship:_____

Address:_____ Phone:_____
street city state zip

Briefly describe the reason(s) that brought you here:

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

What do you consider to be your strengths?

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

_____ _____

Signature of Office Staff Member Date

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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:

sharing psychological report for vocational purposes

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 Date

_____ _____
Signature of Office Staff Member (Witness) Date