Bearden Behavioral Health
New Patient Form

Full Name First:_____**Last:**_____**Middle:**_____

DOB: _____ **SSN**: _____ **Male / Female**

Address: _____ **City**:_____

State: _____ **Zip**: _____ **Marital Status:** _____

Phone #: _____ **Alternate Phone #**: _____

Email Address:_____ **Employer:** _____

Do you have access to a computer? Yes / No

May we contact you at the above phone numbers and email address? ☐ Yes ☐ No

May we leave a voice mail message at the above phone numbers? ☐ Yes ☐ No

May we leave a message with anyone besides you at the above numbers? ☐ Yes ☐ No

If yes, please list the name(s) of the individuals we may leave a message with: _____

Emergency Contact: Please list who we may contact in case of emergency

Name: _____ **Phone**: _____

Relationship: _____ **Address:** _____

If under 18, legal guardian(s): _____

(If client is in custody of DCS- DCS is the emergency contact)

Self- Pay? ☐ Yes ☐ No **Self-Pay** **$150 for Initial Evaluation**

$100 per Follow-up Session

Insurance? ☐ Yes ☐ No

Primary Insurance Company: _____

Insured/Policy Holder's Name: _____

Insured/Policy Holder's DOB: _____ **Insured/Policy Holder's SSN:** _____

Insured/Policy Holder's Phone Number: _____

ID / Policy Number:_____ **Group Number:** _____

Secondary Insurance Company: _____

Insured/Policy Holder's Name: _____

Insured/Policy Holder's DOB: _____ **Insured/Policy Holder's SSN:** _____

Insured/Policy Holder's Phone Number: _____

ID / Policy Number:_____ **Group Number:** _____

BEARDEN BEHAVIORAL HEALTH NOTICE OF OFFICE / FINANCIAL INFORMATION

Appointments with each clinician of Bearden Behavioral Health are set by mutual agreement between the clinician and the client. Except for the Initial Evaluation, sessions last 45-50 minutes. Clients must call to inform the office of appointment cancellations at least 24 hours in advance in order to avoid charges for missed sessions.

Insurance co-pays are due at the beginning of each session. All fees and copays **must** be paid at the time of the appointment. Should your insurance claim be denied, you are responsible for payment of your treatment including all deductibles and in-network and out-of-network co-insurances. **Payments for sessions should be made by cash or credit card (Visa, MasterCard and American Express are accepted). Personal checks will not be accepted.**

Any amount owed by a client will be sent in a statement at the end of each month. Should payment or payment arrangements not be made within thirty (30) days of invoice date, all unpaid balances will be sent to a collection agency for non-payment. At this time, you understand and agree that the money owed to Bearden Behavioral Health will be collected by the collection agency plus a forty (40) percent collection fee.

Bearden Behavioral Health & its providers **will not** complete forms or provide specialized records for clients to obtain or maintain disability income, work or school leave, FMLA, or for court or legal cases. Bearden Behavioral Health and associates will not bill disability/worker's compensation insurance companies or client's attorneys, or get involved in disability or legal/court cases. Should any therapist at Bearden Behavioral Health be subpoenaed or required to participate in any sort of legal matters (such as correspondence, consultations with attorneys, expert opinions, or creation of any documents which will be used for legal purposes), the client (not the insurance company) will be billed at a rate of $350 per hour and a NON-REFUNDABLE minimum of one hour fee must be deposited one week prior to services. This is a per scheduled date fee and will be billed for each date the therapist has to block their schedule for legal services. Any non-legal document preparation which therapist agrees to complete will be billed at the rate of $75 per hour.

Bearden Behavioral Health & its providers are not able to accept some insurance plans; these include but are not limited to, TennCare products or any form of Medicaid insurance.

If client is using health insurance to pay for sessions:

I authorize the release of any of my records, or other information necessary, to the insurance company for processing of my claims. I authorize the payment of my medical benefits to the treatment professional for services provided to me.

_____ _____

Signature of Client or Parent/Guardian Date

I acknowledge that I have read and understand this Notice of Office/Financial Information offered by Bearden Behavioral Health and Associates. I acknowledge that I may have a copy of this information sheet at any time upon request.

_____ _____

Printed Name of Client Signature of Client or Parent/Guardian Financially Responsible

_____

Date

CONSENT FOR MENTAL HEALTH EVALUATION, THERAPY AND TREATMENT

Name of Client _____ DOB: _____

Name of Parent/Guardian (if client is child) _____

Psychotherapy is both a way of understanding human behavior and of helping people with their emotional difficulties and personal problems. Psychotherapy typically starts with an assessment of problematic symptoms and maladaptive behaviors that often intrude into a person's social life, personal relationships, school or work activities, and physical health. Specific psychotherapeutic strategies may be employed to alleviate specific problems causing distress such as depression, anxiety or relationship problems. Self-knowledge is seen as an important key to changing attitudes and behavior. Psychotherapy may involve the development of insight as to how our physical health may be compromised in many ways by emotional and relationship issues. Therapy is designed to help clients of all ages understand how their feelings and thoughts affect the ways they act, react, and relate to others. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Each client has a unique opportunity to view themselves more accurately, and to make connections between past and current conflicts that illuminate the way one relates to one's self and to others. Clients are encouraged to talk about thoughts and feelings that arise in therapy, especially feelings toward the therapist. These feelings are important because elements of one's history of important affections and hostilities toward parents and siblings or significant others are often shifted onto the therapist and the process of therapy. Psychotherapy can be relatively short term (8 to 16 weeks) when the focus is limited to resolve specific symptoms or problem areas, or longer term if the treatment focus targets more pervasive or long-standing difficulties. When the client feels she or he has accomplished the desired goals, then a termination date can be set. Psychotherapy aims to help people experience life more deeply, enjoy more satisfying relationships, resolve personal conflicts, and better integrate all the parts of their personalities.

I, the undersigned whose name appears above, wish to participate as a client in clinical interviews, therapy, counseling, and other mental health services to be performed by Bearden Behavioral Health and Associates. I (client or parent) request these services on my own accord.

Information about clients will not be shared by Bearden Behavioral Health without the client's permission, in accordance with HIPAA regulations. Bearden Behavioral Health and Associates will however release information about clients when clients threaten to harm themselves or others, or if such a threat is suspected. If the client is involved in legal or court-related issues, information will be shared if a valid subpoena is received. The clinicians of Bearden Behavioral Health retain the right to use client information, with identification hidden, for professional activities such as teaching or writing.

Professional skills will be provided in good faith, but there is not a guarantee of outcome. You are encouraged to ask questions about the professional process.

EMERGENCIES:

You may telephone or arrange for telepsych services with your therapist in an emergency. Your therapist is not always immediately available by phone and may not be available in the evening. If unavailable, your call will be returned as soon as possible. If your therapist is unavailable, or you have an emergency, you should call 911; telephone a crisis line; or proceed to a psychiatric emergency facility**. For emergencies/crisis team services call mobile crisis at 865-539-2409.**

ARBITRATION/MEDIATION:

I agree to address any grievances I may have directly with my therapist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated, which will be considered as a complete resolution and legally binding decision under state law. By signing tis contract you are agreeing to have any issue of medical or psychological malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. It is understood that any dispute as to medical malpractice, that is as to whether any medical series rendered under this contract were unnecessary or unauthorized or were improperly rendered, will be determined by submission to arbitration as provided by Tennessee law and in accordance with the rules of the American Arbitration Association, and not by lawsuit or resort to court process except as Tennessee law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above identified grievance procedures

I understand that I may end mental health services with Bearden Behavioral Health at any time of my choosing.

_____ _____

Signature of Client or Parent/Guardian Date

BEARDEN BEHAVIORAL HEALTH AND ASSOCIATES
Notice of Privacy Practices

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 office is required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about the privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI." This office will follow the privacy practices that are described in this Notice (which may be amended from time to time).

This office has a copy of the Notice of Privacy Practices which is available for viewing and will be given to you upon request.

I acknowledge that I have been made aware of the Notice of Privacy Practices offered by Bearden Behavioral Health.

I acknowledge that I may have a copy of the Notice at any time upon request.

_____

Name of Client

_____

Signature of Client or Parent/Guardian

_____

Date

BEARDEN BEHAVIORAL HEALTH / TRINITY MEDICAL
ADULT HISTORY FORM

NAME: _____ **DATE:** _____
DOB: _____ **SEX: MALE FEMALE**

SOCIAL HISTORY:

Please check one: __Single __Married __Divorced __Separated __Widowed __Significant Other

Employed? __Yes __No __Disabled **Employer:** _____

Do you have children: __Yes __No **If so, how many**? _____ **Ages**? _____

Who resides in the home with you? _____

Your occupation: _____ **Highest level of education completed**: _____

Do you drink alcohol? __Yes __No **If yes, how often**? __Seldom __Occasionally __Often

Illegal drug use? __Never __In the Past __Currently **Do you exercise**? __Yes __No

Do you smoke cigarettes? __Never __In the Past (date you quit: _____) __Yes, current smoker

Do you use other forms of tobacco? __Snuff __Pipe __Cigar __Chew

PERSONAL MEDICAL HISTORY:

Primary Care Physician: _____ **Phone Number**: _____

May we exchange information with your Primary Care Physician? __Yes __No

CURRENT MEDICATIONS (including Vitamins & OTC)	**DOSE**	**x PER DAY**	**PRESCRIBING DOCTOR**

ALLERGIES OR REACTIONS TO MEDICATIONS: __YES __NO, I AM NOT ALLERGIC TO ANY MEDICATIONS

If yes, please list the medication(s), as well as the reaction or side effect:

_____

_____

PERSONAL MEDICAL HISTORY, CONTINUED

PLEASE LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES YOU MAY HAVE: _____

_____

_____

PLEASE LIST ANY SURGERIES AND HOSPITALIZATIONS INCLUDING DATE AND REASON:

_____

_____

_____

PLEASE CHECK ALL OF THE FOLLOWING CONDITIONS YOU <u>ARE</u> OR <u>HAVE BEEN</u> TREATED FOR:

__Allergies	__Asthma	__Arthritis	__Anxiety
__Anemia	__Abnormal EKG	__Alcoholism	__Acid Reflux
__Blood Clots	__Bleeding Problems	__Transfusion	__Back Pain
__Breast Lumps	__Cancer	__Chest Pain	__Diabetes
__Depression	__Dizziness	__Drug abuse	__Drug Overdose
__Eczema/Psoriasis	__Emphysema/COPD	__Erectile Dysfunction	__Epilepsy/Seizures
__Glaucoma	__Gallbladder Disease	__Gout	__Headaches(non-Migraine)
__Hearing Problems	__Heart Attack	__Heart Murmur	__Heart Disease
__Arrhythmia	__Palpitations	__High Blood Pressure	__Hepatitis
__High Cholesterol	__HIV/AIDS	__Insomnia	__Lymphoma
__Kidney Disease/Stones	__Irritable Bowel	__Learning Disability	__Liver Disease
__Leukemia	__Lupus	__Meningitis	__Migraines
__Muscle Disease	__ADD/ADHD	__Panic Attacks	__Obsessive-Compulsive Disorder
__Pancreatitis	__Pneumonia	__Muscle Disease	__Suicide Attempt
__STD	__Stroke	__Sinus Disease	__Thyroid Disease
__Ulcers	__Prostate Problems	__Urinary Infections	__Tuberculosis/ + TB Skin Test

__ OTHER _____

FEMALES: Age of first menses: _____ Date of Last Menstrual Period:_____
Do you suffer from PMS? _____ Date of Menopause: _____
# of Pregnancies: _____ Any miscarriages, abortions or tubal pregnancies?_____

MALES: Prostate Problems: __Yes __No Testicular Problems: __Yes __No
Low Testosterone: __Yes __No Erectile Dysfunction: __Yes __No

FAMILY HISTORY:

Were you adopted? __Yes __No

Please put a checkmark in all applicable boxes below pertaining to your family medical history:

ILLNESS	FATHER	MOTHER	SIBLING	CHILD	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNT/ UNCLE
Heart Disease									
High Cholesterol									
High Blood Pressure									
Diabetes									
Heart Attack									
Stroke									
Kidney Disease									
Liver Disease									
Bleeding or Clotting D/O									
Asthma									
Anemia									
Skin Cancer									
Other Cancer									
Thyroid Disease									
Seizures/ Epilepsy									
HIV/AIDS									
Depression/ Anxiety									
Drug / Alcohol Addiction									
Suicide Attempt									

MISSED APPOINTMENT POLICY

In an effort to provide all of our patients with quality care in a timely manner, Bearden Behavioral Health has implemented a missed appointment policy.

Failure to show for a scheduled appointment, or **notify our office of cancellation at least 24 hours prior to your appointment time,** will result in a $50 missed appointment fee. This fee will be directly charged to a credit card that we will keep on file. We will send you a receipt notifying you immediately of the missed appointment charge. If you decline to provide a credit card upfront and incur a $50 missed appointment fee, we will mail you an invoice with a 10% surcharge resulting in a $55 charge. All remaining appointments will be cancelled and you will not be rescheduled until the $55 fee has been paid in full or payment arrangements have been made. ***Please fill out the attached Credit Card Authorization Form.**

Our missed appointment policy enables us to better utilize available appointment time for all of our patients who are in need of care. Thank you for your consideration of this policy. We are honored that you have chosen Bearden Behavioral Health as your provider.

In order to be respectful of the needs of other patients, please be courteous and call our office if you are unable to keep your scheduled appointment. This will allow us to reallocate this appointment time to another patient in need of care. Please provide us with a minimum of 24 hours' notice should you need to cancel or reschedule. To cancel or reschedule an appointment please call our office at (865) 212-6600. We understand that occasionally we are busy and you are connected to our voicemail. **If you are trying to cancel by phone and reach our voicemail, please leave your full name and the time of your appointment in order to cancel. Please note if you do reach our voicemail and you choose not to leave a message and fail to notify us of cancellation, this will also result in a missed appointment charge**.

Financial Statement:
Any amount owed by a client at the end of the month will be sent in an invoice at the end of the month. Should payment or payment arrangements not be made within **30 days** of the invoice date, any unpaid balance will be sent to a collection agency for non-payment. At this point, you understand and agree that the money owed to Bearden Behavioral Health will be collected by the collection agency plus a 40% collection fee.

☐ I accept this policy and will sign the credit card authorization form.
☐ I accept this policy and decline to sign the credit card authorization form.

Patient Name _____ Date: _____

Guardian Name (if applicable): _____

Patient/Guardian Signature: _____

Credit Card
Pre-Authorization Form

Patient Name: _____ Date: _____

Patient DOB: _____

Patient Address: _____

The undersigned Patient/Cardholder hereby authorizes Bearden Behavioral Health, to obtain payment of fees for services from the Patient/Cardholder's Credit Card account identified below. Bearden Behavioral Health may charge the account for missed appointments *(minimum of 24 hours cancellation notice is required)*, without requirement of the Patient/Cardholder's signature for each payment. A receipt of the transaction will be mailed to the address provided by the Patient/Cardholder above.

By signing this form, the Patient/Cardholder acknowledges and agrees as follows:

- *This signed form is confidential and will be kept on file at Bearden Behavioral Health.*
- *The Patient/Cardholder authorizes Bearden Behavioral Health to automatically charge the below-referenced Credit Card any remaining balance on the above-named patient's account (including copays, co-insurances, deductibles or missed appointment fees).*
- *The Patient/Cardholder certifies, warrants and represents that the Cardholder named above agrees to pay the credit charge(s) in accordance with the agreement described above.*
- *Credit Card payments will appear on your statement as Bearden Behavioral Health.*
- *If the Patient/Cardholder fails to dispute a charge within 30 days from the time the Credit Card is charged, the Patient/Cardholder agrees that the charges are valid and agrees not to dispute said charges.*
- *This authorization will remain valid for 12 months and will automatically renew on an annual basis, unless revoked in writing with 30 day notice of revocation.*
- *This authorization serves as agreement for receipts to be noted "signature on file" when charged.*

PLEASE CIRCLE ONE: Visa MasterCard American Express Discover

Name on Card: _____

Credit Card #: _____

CVV Number: (3 digits on back of card – AMEX (4 digits on front): _____

Expiration Date: (Month/Year): _____

Printed Name of Authorized Signer: _____

Patient/Cardholder Authorized Signature: _____

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ AUTHORIZE: _____
(name of client) (name of clinician)

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information related to the scheduling of appointments (this may include support staff for clinician)
- Information related to billing and payment (this may include support staff for clinician)
- Completed forms, including forms that may contain sensitive, confidential information (this may include support staff for clinician)
- Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- My health record, in part or in whole, or summaries of material from my health record

BY THE FOLLOWING NON-SECURE MEDIA: Unsecured email.

Bearden Behavioral Health takes all security measures required to protect the confidentiality of our client's protected health information. However, Bearden Behavioral Health is unable to control outside email servers and is therefore unable to safeguard these transmissions completely. We must inform all clients who prefer to communicate with their clinician this way at any time, that there may be some level of risk that the information in the email could be read by a third party.

TERMINATION
This authorization will terminate 12 months after the date listed with the signature below.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____
(Signature of client) Date

_____ _____
(Witness Signature & Relationship to client) Date