# 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: _____

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**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 minimum of one hour fee must be deposited prior to 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

## 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