Patient Intake Form (Adult)

Facility: **Resilience Counseling & Psychiatric Services**
Nashville, TN

Clinician: **Brandon Teeftaller, APN & Debra Cohen, APN**

Name: _____ Date of Visit: _____

Date of birth: _____ Referral source: _____

Social Security Number (if applicable): _____

Current Address: _____

_____

Contact Phone: _____ Voicemail Allowed: Yes / No

Occupation: _____

Current Employer, Address and Phone Number: _____

_____

Emergency Contact Person, Relationship, Phone number: _____

_____

Do you provide consent to contact the person above when deemed required: Yes / No

_____

Please provide your proof of insurance to the receptionist at your first visit Thank you. Primary

Insurance / HMO: _____ Member ID: _____

Subscriber's Full name: _____ Subscriber's Employer: _____

Subscriber's Address: _____

Subscriber SSN: _____ Subscribers Date Of Birth: _____

Group Number: _____ Policy number: _____

Patient's Relationship to the Subscriber: Self Spouse Child Other

Phone Number and Address of Insurance Company: _____

_____

Managed Care Company: _____

Secondary Insurance Information (if applicable): _____

Claims address and phone number (if applicable): _____

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Resilience Counseling & Psychiatric Services or the insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

_____

Medical History: Please list your current and past medical problems below (including surgeries)

_____

_____

Medications: Please list your current medications below

_____

Allergies: Please list your current allergies below

Medication allergies: _____

Food allergies: _____

Environment allergies: _____

Family History:

Has anyone in your family received help with mental health issues? Yes / No

Has anyone in your family received psychiatric medications? Yes / No

---

Socio-cultural History:

Marital Status: _____ Children: _____

Religious/ spiritual affiliation: _____

Legal problems: _____

_____

Financial and housing problems: _____

Military History (if applicable): _____

Branch: _____ Military Job: _____ Type of Discharge: _____

Active combat: Yes/ No Exposure to chemicals: Yes/ No Traumatic Brain Injury: Yes/ No

---

1. All the information provided above is true to the best of my knowledge and I have not falsified any information provided to the clinician above. (Pt. Initials) _____

2. I understand all the risks, benefits, alternatives of the proposed treatments above, and hereby verbalize understanding of and provide consent to the diagnostic impressions and planned treatment initiation.
(Pt. Initials) _____

Patient Name: _____

Signature: _____ Date: _____

Clinician Signature: _____

Informed Consent for Treatment and Medication Form

Consent for Treatment

I, _____, (Patient's name) agree and consent to participate in behavioral health care services offered and provided by Brandon Teeftaller, APN and/or Debra Cohen, APN a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within:

1. The scope of the provider's license, certification, and training; or

2. The scope of the license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.

If the patient is under the age eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am legally authorized to initiate and consent for treatment on behalf of this individual.

Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient (if applicable):_____

Provider's signature: _____

Consent for Medication

1. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication and the possible effects of this medication if the person taking this medication becomes pregnant. I have also been informed of the reason or purpose for which this medication was prescribed. Benefits of proposed treatments and other treatment alternatives have been explored according to evidence-based guidelines, and I fully verbalize understanding of all the information above.

2. Brandon Teeftaller, APN and/or Debra Cohen has educated me in all aspects regarding the medication that has been prescribed to the patient (myself/my child - a person for whom I am the legal guardian) and I consent to the administration of this medication.

Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient (if applicable):_____

Provider's signature: _____

It has been recommended to me that women who are or may become pregnant, or are breast-feeding, discuss this potential conflict with their doctor **before** taking any medication (if applicable).

I have been sufficiently educated about all side effects that I may experience, including, but not limited to, the more important side effects that needs to be reported immediately to a health care provider/ or go to nearest emergency services provider.

Patient/Legal Guardian Signature: _____ Date: _____

Late Charges / No Show Charges

I understand that canceling an appointment without giving 24 hours notice may result with a cancellation fee. I the guarantor/ patient/ financial responsible party understand that if the patient fails to show for an appointment that a missed appointment charge will be placed on the account. If you receive a "Late Cancellation" or "No Show" charge on the patient's statement and want the charge removed, send the statement back to the office with an explanation as to why the appointment was missed so it can be presented to the physician for their approval.

Financial Information

Co-payments are required at the time of services. If you have a financial agreement on file for payment on an outstanding balance this does not exclude you from paying a co-payment at the time of services. If a co-payment is not paid at the time of service, the doctor does have the right to refuse care.

Insurance Changes

If the insurance coverage for the patient changes a copy of the insurance card (front & back) will be presented to the office either in person or by fax to prevent charges from being denied. If a charge denies for failure to be submitted to a correct insurance carrier within a timely manner, the guarantor/patient/financial responsible party will be responsible for the charges.

Medication and Medication Refills

Please call the office refill line at least 3 days prior to being out of your medication. This will prevent you from running out of your medication while the physician authorizes a refill or makes a change to your medication where appropriate. If an appointment is called or missed by you and a prescription is needed, there will be a separate charge associated with that prescription refill or written prescription.

Delinquent Accounts

If the financial portion of the account with the doctor becomes delinquent and the account is turned over to a collection agency there is 30% balance mark up placed on the account to cover the collection agency's fee. This amount will be added to the account balance at the time the account is turned over to the collection agency. This does not include costs if the account is perused in court.

Patient / Guardian Name: _____

Signature: _____ Date: _____

HIPAA

I have read and will be given a copy **(by request)** of the Notice of Private Practices for Resilience Counseling & Psychiatric Services and I acknowledge receipt of these documents. (If applicable)

I am a patient of Resilience Counseling and Psychiatric Services and I understand I may review the Policies and Procedures Manual for HIPAA compliance to protect my confidential medical information and all processing necessary for my care; at any time.

Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient (if applicable):_____

IMPORTANT INFORMATION REGARDING INSURANCE AND COLLECTIONS

RESILIENCE COUNSELING & PSYCHIATRIC SERVICES
2200 21st AVENUE SOUTH, STE. 406
NASHVILLE, TN 37212

Professional services are rendered and charges to the patient and not to insurance companies. Even though we file your insurance claims, we cannot accept responsibility for collecting you claim or negotiating a settlement for a disputed claim.

In order for us to file your insurance claims, we often have to release a significant amount of information regarding your case. You need to be aware that we are releasing this information to your insurance company and cannot be responsible for the insurance company's use of or disclosure of this information.

Your insurance company may further "manage" your care. This means that sessions may have to be approved in advance in order to be paid. It is your responsibility to have your initial session approved. We will assist in the process, if we can. Insurance companies may further have their own definition of medical need for treatment, which may differ with our opinion or your opinion of the situation. In the event that you continue treatment beyond that which has been approved by your insurance, you will be responsible for charges.

**** COPY OF INSURANCE CARD IS REQUIRED TO FILE YOUR INSURANCE****

Primary Insurance Company: _____

Secondary Insurance Company: _____

POLICY REGARDING APPOINTMENTS, PRIVACY AND MEDICATION REFILLS

There will be a $25.00 charge for any medication refills requested after the appointment time and a $50.00 charge for mail in prescriptions. It is your responsibility to get adequate refills until the next appointment.

It is your responsibility to keep the appointment's you schedule with Resilience Counseling and Psychiatric Services.
If you are not able to make your appointment that you have scheduled, you will need to call 24 hours in advance to cancel or reschedule the appointment. If you fail to cancel your appointment 24 hours in advance you will be charged $60 for late cancellation or for failure to show for the appointment, and $160 as a new patient for failure to show or late cancellation.

We will not reschedule an appointment for you until this fee is paid in full. Any legal services, paperwork and letters requested by the patient outside of the appointment will be charged accordingly. Legal services are not covered by the insurance carrier.

We may need to use your name, address, phone number, and your clinical records to contact you, leave a message on your telephone answering machine to provide you will appointment reminders, lab results, prescription or billing information.

You have the right to revoke/refuse to give us authorization to contact you regarding your case at this office. Any restriction should be requested in writing. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care including billing you by mail or collection proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time (i.e. appointment reminders, care alternatives and etc.)

By signing this statement,

I,_____ , acknowledge that I have read and fully
(Please print) (Patient/Legal Guardian/Guarantor/Financial Responsible Party's Name)

understand all the information on this page.

_____ _____
Patient/Legal Guardian/Guarantor/Financial Responsible Party's Signature Date