

Leigh Anthony, LPC-MHSP, NCC  
7161 Lee Highway, Suite 400  
Chattanooga, Tennessee 37421  
Office: 423-708-8670  
Fax: 423-708-8671

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**ADULT INFORMATION FORM**

Identifying Information

*\*This Form is Confidential\**

Today's date: \_\_\_\_\_

Your name: \_\_\_\_\_  
Last First Middle Initial

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Gender & Sexual Identity**

Male  Female  Transgender  
 Heterosexual  Lesbian  Gay  Bisexual  Asexual  In Question  
 Other \_\_\_\_\_

**Racial/Ethnic Identity:**

African/African-American/Black  Latino/Latino-American  Bi-Racial/Multi-Racial  
 American Indian/Alaska Native  Middle Eastern/Middle Eastern-American  
 Asian/Asian-American/Asian Pacific Islander  White/European-American  Not listed

Home street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Can we leave a message at the numbers listed above? YES or NO

Employer: \_\_\_\_\_

**Address of Employer:**

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referred by: \_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No

Please provide your signature to indicate that we may communicate with the referral source:

(Your signature) \_\_\_\_\_

**Person(s) to notify in case of any emergency:**

\_\_\_\_\_  
Name Phone

\_\_\_\_\_  
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): \_\_\_\_\_

**Pharmacy Info:**

Pharmacy Name: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION:**

**Name of Insured Person:**

\_\_\_\_\_  
Last First Middle Initial  
Insured's relationship to patient \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance ID number \_\_\_\_\_

Insurance Group number \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

**Secondary Insurance**

**Name of Insured Person:**

\_\_\_\_\_  
Last First Middle Initial  
Insured's relationship to patient \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance ID number \_\_\_\_\_

Insurance Group number \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

**Tertiary Insurance**

**Name of Insured Person:**

\_\_\_\_\_  
Last First Middle Initial  
Insured's relationship to patient \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance ID number \_\_\_\_\_

Insurance Group number \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

Please briefly describe your presenting concern(s): \_\_\_\_\_

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**PAST MEDICAL HISTORY:**

Height \_\_\_\_\_ Weight (if applicable) \_\_\_\_\_ Age \_\_\_\_\_

**Previous medical hospitalizations (Approximate dates and reasons):**

Hospital	Date:	Reason:

**Place an X by past surgical procedures (Approximate dates and reasons):**

Procedure:	Date:	Procedure:	Date:
<input type="checkbox"/> Anesthetic Complications		<input type="checkbox"/> Heart Surgery	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Hemorrhoidectomy	
<input type="checkbox"/> Breast Surgery		<input type="checkbox"/> Hernia Repair	
<input type="checkbox"/> Bowel Resection		<input type="checkbox"/> Hip Replacement	
<input type="checkbox"/> Bladder Repair		<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Cancer removal		<input type="checkbox"/> Kidney Removal	
<input type="checkbox"/> Cardiac Pacemaker		<input type="checkbox"/> PE Tubes	
<input type="checkbox"/> Carpal Tunnel		<input type="checkbox"/> Splenectomy	
<input type="checkbox"/> Cesarean Delivery		<input type="checkbox"/> Thyroidectomy	
<input type="checkbox"/> Dialysis		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Gall Bladder Removal		<input type="checkbox"/> Tubal Ligation	
<input type="checkbox"/> Other		<input type="checkbox"/> Wisdom Teeth Ext.	
		<input type="checkbox"/> Vasectomy	
		<input type="checkbox"/> Other	

**Are you allergic to any medications? If yes, please list with reaction:**

Medication/Food Allergy:	Date (age):	Reaction:

**Place an X by any significant medical problems, symptoms, or illnesses:**

<input type="checkbox"/> Anemia	<input type="checkbox"/> Dementia Alzheimer	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Arthritis/Joint Dz	<input type="checkbox"/> Dementia Parkinson	<input type="checkbox"/> HIV	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes Type I	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Diabetes Type II	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bladder Issues	<input type="checkbox"/> DVT/Blood Clot	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> UC/Crohns Dz
<input type="checkbox"/> Bowel Issues	<input type="checkbox"/> Female Issues	<input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Other
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Pain (Chronic)	<input type="checkbox"/> Other
<input type="checkbox"/> Cancer	<input type="checkbox"/> GERD	<input type="checkbox"/> Polycystic ovaries	<input type="checkbox"/> Other
<input type="checkbox"/> COPD/Lung Dz	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other
<input type="checkbox"/> CVA/Stroke	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Skin Disorders	

**Current Medications: (NON PSYCHIATRIC)**

Medication:	Dose:	Purpose:	Prescriber:

**PAST PSYCHIATRIC HISTORY:**

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO  
 (Please list approximate dates and reasons): \_\_\_\_\_

\_\_\_\_\_

Have you ever thought about committing suicide? Please describe:

\_\_\_\_\_

Have you ever tried to commit suicide? Please describe:

\_\_\_\_\_

**Previous psychiatric hospitalizations (Approximate dates and reasons):**

Hospital:	Date:	Reason:	Treatment:

**Place an X by any significant psychiatric problems for which you have been treated:**

<input type="checkbox"/> ADHD inattentive	<input type="checkbox"/> Autism	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Panic Disorder with agoraphobia
<input type="checkbox"/> ADHD hyperactive	<input type="checkbox"/> Bipolar Type I Depression	<input type="checkbox"/> Generalized Anxiety	<input type="checkbox"/> Panic Disorder without Agoraphobia
<input type="checkbox"/> ADHD mixed type	<input type="checkbox"/> Bipolar Type I Mania	<input type="checkbox"/> Impulse Control d/o	<input type="checkbox"/> Psychosis <input type="checkbox"/> PTSD
<input type="checkbox"/> Adjustment Disorder	<input type="checkbox"/> Bipolar Type I Mixed	<input type="checkbox"/> Kleptomania	<input type="checkbox"/> Reactive Attachment Disorder
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Bipolar Type II	<input type="checkbox"/> Marijuana abuse	<input type="checkbox"/> Schizoaffective
<input type="checkbox"/> Asperger's	<input type="checkbox"/> Borderline Personality	<input type="checkbox"/> OCD	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Other	<input type="checkbox"/> Depression	<input type="checkbox"/> ODD	<input type="checkbox"/> Substance Abuse <input type="checkbox"/> Trichotillomania

**Current Psychiatric Medications**

Medication:	Dose:	Reaction or Reason Discontinued	Prescriber:

**Previous Psychiatric Medications:**

Medication:	Dose:	How Long:	Prescriber:

**SOCIAL HISTORY:**

Do you smoke or use tobacco? YES NO If YES, how much per day? \_\_\_\_\_

Do you consume caffeine? YES NO If YES, how much per day? \_\_\_\_\_

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? \_\_\_\_\_

Do you use any non-prescription drugs? YES NO

Have any of your friends or family members voiced concern about your substance use? YES or NO

Have you ever been in trouble or in risky situations because of your substance use? YES or NO

If you answered yes to anything of the substance abuse questions, please place an "X"

<input type="checkbox"/> Adderall	<input type="checkbox"/> Cocaine derivatives	<input type="checkbox"/> Marijuana	<b>Others (please list):</b>
<input type="checkbox"/> Air Duster	<input type="checkbox"/> Crack	<input type="checkbox"/> Mushrooms	
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Inhalants	<input type="checkbox"/> PCP	
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Ketamine	<input type="checkbox"/> Triple CCCs	
<input type="checkbox"/> Bath Salts	<input type="checkbox"/> LSD	<input type="checkbox"/> Valium, Xanax, Ativan, Klonopin	

**LEGAL:**

Have you ever been arrested? If yes please list

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Are you currently on probation or ever been on probation? If yes please list

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**RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:**

Currently in Relationship?  How Long?  Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered?  How Long?  Previously Married/Life Partnered? YES NO  
If so, length of previous marriages/committed partnerships \_\_\_\_\_

Do you have Children?  If YES, how many and what are their ages: \_\_\_\_\_

Describe any problems any of your children are having: \_\_\_\_\_

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List the names and ages of those living in your household: \_\_\_\_\_

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Please briefly describe any history of abuse, neglect and/or trauma: \_\_\_\_\_

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Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care: \_\_\_\_\_

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Is spirituality important in your life and if so please explain: \_\_\_\_\_

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Briefly describe your diet and exercise patterns: \_\_\_\_\_

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**EDUCATION & CAREER**

High School/GED  College Degree  Graduate Degree(or Higher)  Vocational Degree

What is your current employment? \_\_\_\_\_

**Please place an “x” in the now or past box if the problem listed applies to the patient:**

Problems with	Now	Past	Problems with	Now	Past
Anxiety			Makes careless mistakes		
Depression			Fidgets frequently		
Anger/Temper			Impulsive		
Panic			Waiting their turn		
Fears			Completing tasks		
Irritability			Easily distracted		
Concentration			Hyperactivity		
Worries			Alcohol abuse		
Talking with others			Drug use		
Separation anxiety			Problems falling asleep		
Tantrums			Problems staying asleep		
Parents Divorced			Unexplained weight loss		
Cries easily			Unexplained weight gain		
Problems with friends			Frequent upset stomach		
Problems in school			Frequent headaches		
Fear of strangers			Diarrhea		
Afraid of the dark			Excess sweating		
Sexually acting out			Shortness of breath		
History of child abuse			Dizziness		
History of sexual abuse			Fainting		
Thoughts of hurting others			Nausea		
Thoughts of hurting self			Constipation		
Nightmares			Chest pain		

**FAMILY HISTORY: Please mark an "X" in the box that applies to family members.**

Disorder	mother	father	maternal grandma	maternal grandpa	paternal grandma	paternal grandpa	uncle	aunt	sister	brother
Adhd										
Anxiety										
Aspergers										
Autism										
Bipolar										
Depression										
Psychiatric Hospitalization										
OCD										
Panic Attacks										
PTSD										
Schizophrenia										
Substance Abuse										
Suicide attempt										
Suicide Completion										

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**Authorization For Treatment, Payment and Healthcare Operations:**

I authorize Leigh Anthony, to release to my insurance company, managed care organization, state agency, Health Care Financing Administration, Third Party Administration any information needed to process my claims and or determine benefits payable for related services.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges at the time of service. I understand that unless otherwise restricted by a contractual agreement with selected insurance plans/third party payers, the entirety of the charges incurred will be transferred to the the guarantor's responsibility if the payment is not received from the insurance company within 60 days. I understand that I will be bound by any conditions of this agreement regarding guarantor/patient responsibility charges. I understand that failure to meet my financial responsibility in a timely manner may result in my account being turned over to a collections agency. I understand that payment is due at the scheduled appointment.

There is a \$30 fee for all returned checks. If two returned checks are received, Leigh Anthony reserves the right to request future payments be made in cash or credit card.

I give consent for evaluation and treatment by Leigh Anthony.

I have read, understand and agree to the above policies.

\_\_\_\_\_  
Print Patient/Guarantor Name

\_\_\_\_\_  
Patient/Guarantor Signature (must be at least 18 years old)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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**Acknowledgement of Receipt of Patient Notification of Privacy Practices**

I, \_\_\_\_\_ have been presented with a copy of Leigh Anthony, LPC-MHSP, NCC, Patient Notification of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law and I understand the contents of the Notification. By law, Leigh Anthony, LPC-MHSP, NCC, is required to obtain your signature indicating that you have received this document. Your signature below does not surrender any rights or confidentiality. Any updates to this policy will be posted on our website or in our waiting room for your review.

\_\_\_\_\_  
Print Patient/Guarantor Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guarantor Signature (must be at least 18 years old)

\_\_\_\_\_  
Date

**For Internal Use**

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date the notice was presented to the patient and sign below.

Presented on (date) \_\_\_\_\_

By: (name and title) \_\_\_\_\_

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**Missed Appointment and Late Cancellation Policy**

Leigh Anthony whenever possible, will call you to remind you of your appointment but, you are responsible for attending your scheduled appointment. A \$50 fee will be added to the patient's account if a patient does not attend their appointment or if they cancel their appointment within 24 hours of the scheduled appointment time. This fee is not covered by insurance and must be paid at the next appointment.

**\*Please initial if you would or would not like to receive notification about your appointment.**

\_\_\_\_\_ Yes, I want Leigh Anthony, to text me at this number to remind me of a scheduled appointment. Telephone number \_\_\_\_\_. An email is required to set up text reminder services. Email: \_\_\_\_\_

\_\_\_\_\_ No, I DO NOT want Leigh Anthony to attempt to contact me to remind me of my scheduled appointment time.

**After Hour Calls Policy**

Calls made to the provider after hours are subject to a \$25 fee due at the next scheduled appointment.

**Paperwork Policy**

There is a \$35 fee for any paperwork (FMLA paperwork, Disability forms, Letters, School forms etc.) completed by a provider.

**Medication Refill Policy**

Comprehensive Psychiatric Care requires a **72 hour** notice for medication refill request to be processed. When requesting a refill patient/guardian must provide the following information: name of medication, dose, when medication is taken, pharmacy name and telephone number. Request for refills may be left on the refill line, please keep in mind calls received after 3pm daily will not be returned until the next business day.

**I have read, understand and agree to the policies listed above.**

\_\_\_\_\_  
Print Patient/Guarantor Name

\_\_\_\_\_  
Patient/Guarantor Signature (must be at least 18 years old)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

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7161 Lee Highway, Suite 400

Chattanooga, TN 37421

Phone: (423) 708-8670 Fax: (423) 708-8671

**CONSENT FOR RELEASE OF MEDICAL INFORMATION:**

I, \_\_\_\_\_ grant permission for the person(s) listed below to have access and all of my information that pertains to my care from the physicians or providers of this group. This includes but is not limited to, appointment time, lab results, my physician's plans for health care, etc. I agree to notify in writing, if there are any changes in the person(s) authorized.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Signature (patient or legal guardian): \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**Debit/Credit Card Payment Authorization Form**

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card information.
6. I understand that my signature and payment information will be maintained on file for future use by the practice. The applicable payment card or bank account number will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information.
7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
8. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
10. I will not be provided with advance notice of payments authorized hereunder for transactions up to an amount specified by me. I will be provided with a courtesy notification prior to processing any payment in excess of such amount. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
11. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

\_\_\_\_\_  
Name as it appears on Card/ACH Account

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Billing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Phone Number

AUTHORIZED SIGNATURE \_\_\_\_\_

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_