Rhonda Wilson, LPC-MHSP
7161 Lee Highway, Suite 400
Chattanooga, Tennessee 37421
Office: 423-708-8670
Fax: 423-708-8671

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): _____

_____

_____

_____

_____

_____

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:
___Anesthetic Complications		___Heart Surgery	
		___Hemorrhoidectomy	
_____Appendectomy		___Hernia Repair	
_____Breast Surgery		___Hip Replacement	
___Bowel Resection		___ Hysterectomy	
___Bladder Repair		___Kidney Removal	
___Cancer removal		___PE Tubes	
___Cardiac Pacemaker		___Splenectomy	
___Carpal Tunnel		___Thyroidectomy	
___Cesarean Delivery		___Tonsillectomy	
___Dialysis		___Tubal Ligation	
___Gall Bladder Removal		___Wisdom Teeth Ext.	
		___Vasectomy	
___**Other**		___**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:

___Anemia	___Dementia Alzheimer	___Hepatitis C	___Sleep Apnea
___Arthritis/Joint Dz	___Dementia Parkinson	___HIV	___Stomach Ulcers
___Asthma	___Diabetes Type I	___Insomnia	___Stroke
___Bleeding Disorder	___DIabetesType II	___Kidney Disease	___Thyroid Disease
___Bladder Issues	___DVT/Blood Clot	___Liver Disorder	___UC/Crohns Dz
___Bowel Issues	___Female Issues	___Narcolepsy	
___Bronchitis	___Gastritis	___Pain (Chronic)	___Other
___Cancer	___GERD	___Polycystic ovaries	
___COPD/Lung Dz	___Heart Attack	___Seizures	___Other
___CVA/Stroke	___Hepatitis B	___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:

___ADHD inattentive	___Autism	___Eating Disorder	___Panic Disorder with agoraphobia
___ADHD hyperactive	___Bipolar Type I Depression	___Generalized Anxiety	___Panic Disorder without Agoraphobia
___ADHD mixed type	___Bipolar Type I Mania	___Impulse Control d/o	___Psychosis ___PTSD
___Adjustment Disorder	___Bipolar Type I Mixed	___Kleptomania	___Reactive Attachment Disorder
___Alcoholism	___Bipolar Type II	___Marijuana abuse	___Schizoaffective
___Asperger's	___Borderline Personality	___OCD	___Schizophrenia
___**Other**	___Depression	___ODD	___Substance Abuse ___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"

___Adderall	___Cocaine derivatives	___Marijuana	**Others (please list):**
___Air Duster	___Crack	___Mushrooms	
___Alcohol	___Inhalants	___PCP	
Barbiturates	___Ketamine	___Triple CCCs	
___Bath Salts	___LSD	___Valium, Xanax, Ativan, Klonopin	

LEGAL:

Have you ever been arrested? If yes please list

_____

_____

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

_____

_____

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: _____

_____

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

_____

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

_____

_____

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:_____

_____

_____

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

_____

Briefly describe your diet and exercise patterns:_____

_____

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 Rhonda Wilson, 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, Rhonda Wilson reserves the right to request future payments be made in cash or credit card.

I give consent for evaluation and treatment by Rhonda Wilson.

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 Rhonda Wilson, LPC-MHSP, 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, Rhonda Wilson, LPC-MHSP, 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

Rhonda Wilson 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 Rhonda Wilson, 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 Rhonda Wilson 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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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: _____

Revised (2/2017)

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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_____/_____/_____