Corinne Lewis, LCSW
7161 Lee Highway, Suite 400
Chattanooga, Tennessee 37421
Office: 423-708-8670
Fax: 423-708-8671

CHILD & ADOLESCENT INFORMATION FORM

This Form is Confidential

Identifying Information

Today's date: ________________

Your child's name:

____
Last First Middle Initial

Child's Address:____

____

Telephone number: ________________ **Can we leave a message at this number? YES or NO**

Child's date of birth: __________ **Age:**_____ **Child's Social Security #**__________________

Gender and Sexual Identity:

__ Male __ Female __Transgender __Nonbinary

__Heterosexual __Lesbian __Gay __Bisexual __Asexual __In Question

__Other _____________

Racial/Ethnic Identity:

__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__White/European-American
__Not listed

Referred by: _____________________/**Child's PCP:**_____________________________

Child's current school attend school? ___________________________Current grade?________

Please provide your signature to indicate that we may communicate with the referral source:
(Parent/Guardian Signature):_____________________________________

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

____
Name Phone

____
Name Phone

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so:
(Parent/Guardian Signature):_____________________________________

Parent's Name:

____
Last First Middle Initial

Parent's Date of Birth: ___________ **Parent's Social Security #:** ________________

Parent's Address: Same as child's YES or NO, if NO please list

____

City: ____________________________**State:** __________ **Zip:**______________

Parent's Name:

____
Last First Middle Initial

Parent's Date of Birth: ___________ **Parent's Social Security #:** ________________

Parent's Address: same as child's YES or NO, if NO please list

____

City: ____________________________**State:** __________ **Zip:**______________

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'sDOB:**_______________

Insurance Company: __________________ **Insurance ID number** __________________

Insurance Group number __________________ **Insured's SSN:**____________________

Please briefly describe your child's presenting concern(s):

____

____

____

PAST PSYCHIATRIC HISTORY:

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

____

____

Place an X by any significant psychiatric problems for which your child has been treated:

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

Current Medications:

Medication:	Dose:	Reaction or Reason Discontinued:	Prescriber:

Corinne Lewis, LCSW

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been given the opportunity to review the "Notice of Privacy Practices." This document contains a description of the users and disclosures of my healthcare information and my rights regarding such information. The "Notice of Privacy Practices" are displayed in the Administrative Office.

I understand that Corinne Lewis, LCSW has the right to change its "Notice of Privacy Practices" and that if changes are made, a revised copy of the notice will be posted in the Administrative Office. I also understand that if I have any questions or wish to receive copies or a current copy of the "Notice of Privacy Practices," I may contact:

Corinne Lewis, LCSW
7161 Lee Highway, Suite 400
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Telephone: (423) 708-8670 Fax: (423) 708-8671

By signing this for, I am acknowledging that I have read the "Notice of Privacy Practices" and agree to the uses and disclosure information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:
Client/Legal Representative:____ Date:_____/_____/_____

If Legal Representative, relationship to Client:____

Witness (optional):____

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

Presented on (date):________/________/________

By: Name____ Title:________________________

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Authorization For Treatment, Payment and Healthcare Operations:

I authorize Corinne Lewis, LCSW 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 Corinne Lewis, LCSW, reserves the right to request future payments be made in cash or credit card.

I give consent for evaluation and treatment by Corinne Lewis, LCSW

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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Missed Appointment and Late Cancellation Policy

Corinne Lewis, LCSW, 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 Corinne Lewis, LCSW, 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 Corinne Lewis, LCSW 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.

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: ______________________________

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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_____/_____/_____