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:_____

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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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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: _____

Revised (2/2017)

Rhonda Wilson, LPC-MHSP, NCC
7161 Lee Hwy. Ste 400,
Chattanooga TN. 37421

Electronics Privacy Agreement

This form is to notify clients that contacting Rhonda Wilson, LPC-MHSP, NCC through any form of electronics could result in a breach of confidentiality.

I _____ agree that if I utilize any form of electronics including but not limited to: texting, e-mail, or social media to contact Rhonda Wilson, LPC-MHSP I understand that confidentiality cannot be guaranteed. By signing this form, I assume all responsibility for information sent via electronics.

-I understand that by utilizing text messages any and all information disclosed may be subject to a privacy violation.

-I understand that by utilizing e-mail any and all information disclosed may be subject to a privacy violation.

-I understand that by utilizing any form of social media any and all information may be subject to a privacy violation.

-I understand that by using any form of electronical devices any and all information may be subject to a privacy violation.

-I understand that if I reach out to Rhonda Wilson, LPC-MHSP by any form of electronics she will respond Monday through Friday and I may need to wait for this response (I do not check my e-mail, texts, or messages daily).

-I understand that Rhonda Wilson LPC-MHSP, NCC will also utilize electronical devices to contact me. By signing I agree that I will assume all responsibility for both parties utilizing electronical device.

By signing this form, I acknowledge that I have read and understand all of the above information. I give my permission for any form of electronical devices to be used.

Name of patient: _____ DOB_____

Legal Guardian:_____ Date: _____

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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_____/_____/_____