Denise Y. O'Neil, MSN, APRN, PMHNP-BC, FNP-C
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 __Other _____

__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 address:** _____

**City:** _____ **State:** _____ **Zip:**_____

**Email:** _____

**Cell Phone:** _____ **Work Phone:** _____

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

**Referred by:** _____ telephone number:_____

Your signature indicates that we can communicate with the referral source:

(Parent/Guardian Signature):_____

**Patient'sPCP:**_____Office number _____

Your signature indicates that we can communicate with your PCP as needed :

(Parent/Guardian Signature):_____

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

_____ _____
Name cell number

_____ _____
Name. cell number

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:**_____

Employer:_____

Address of Employer:

_____

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'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<br>___Hemorrhoidectomy | |
| _____Appendectomy<br>_____Breast Surgery | | ___Hernia Repair<br>___Hip Replacement | |
| ___Bowel Resection<br>___Bladder Repair | | ___ Hysterectomy<br>___Kidney Removal | |
| ___Cancer removal<br>___Cardiac Pacemaker | | ___PE Tubes<br>___Splenectomy | |
| ___Carpal Tunnel | | ___Thyroidectomy | |
| ___Cesarean Delivery<br>___Dialysis | | ___Tonsillectomy<br>___Tubal Ligation | |
| ___Gall Bladder Removal | | ___Wisdom Teeth Ext.<br>___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<br>___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<br>___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 give consent for evaluation and treatment by Denise Y. O'Neil
*I give consent for telehealth services. I am aware that it is my responsibility to contact my insurance company to make sure telehealth is covered by my policy.

*I authorize Denise Y. O'Neil 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, and 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 all patient responsible charges are due at the time of the appointment. I reviewed this document and am aware of the policy.

_____
Print Patient/Guarantor Name

_____ _____
Patient/Guarantor Signature (must be at least 18 years old) Date

_____ _____
Witness Signature Date

Updated August 2023

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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. I am aware I can revoke my consent for release at any time.

Patient's Name:_____ DOB:___/___/___

Signature:(patient or legal guardian) _____

Date:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Updated August 2023

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**Missed Appointment and Late Cancellation Policy**

If requested by patient, Denise Y. O'Neil will send a text and/or email reminder about the upcoming scheduled appointment. The patient is ultimately responsible for attending the 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. It is the patient's responsibility to call and reschedule any missed appointment.

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

_____ Yes, I want Denise Y. O'Neil 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 Denise Y. O'Neil 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. Calls should be made for mental health emergencies only.

**Paperwork Policy**

There is a $45 fee for requested letters written by provider and a $50 fee for completion of FMLA paperwork or Disability forms etc.

**Medication Refill Policy**

Denise Y. O'Neil 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

# Denise Y. O'Neil, MSN, APRN, PMHNP-BC, FNP-C

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been given the opportunity to review the Comprehensive Psychiatric Care, PLLC "Notice of Privacy Practices." This document contains a description of the users and disclosures of my healthcare information and my rights regarding such information. Comprehensive Psychiatric Care, displays the "Notice of Privacy Practices" in the Administrative Office.

I understand that Comprehensive Psychiatric Care, PLLC 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:

**Office Manager: Deena Olivas/Jennifer Lambert, LCSW**
**7161 Lee Highway, Suite 400**
**Chattanooga, TN 37421**
**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:_____

Updated August 2023

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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_____/_____/_____