Name_____Date_____
Allergies_____ Date of Birth_____
Height_____ Weight_____ Religious Preference_____
Occupation_____ Highest Level of Education_____

Marital Status_____ Caregiver name (if child)_____
Number & age of children_____ Number & age of siblings_____

Please list your current medications._____

_____

_____

Please rate the following symptoms that currently apply to you

Symptom	Rarely to Never	Monthly	Weekly	Nearly every day (2-7 days weekly)
Sleep problems/fatigue				
Loss of pleasure/motivation				
Helpless/hopeless				
Guilt/shame/anxiety				
Excessive energy				
Poor concentration/forgetful				
Poor appetite				
Excessive appetite				
Anger/irritability/defiance				
Hyperactivity				
Paranoia				
Hallucinations				
Drug/alcohol use				
Suicidal/homicidal thoughts				

Please describe your reason for seeking psychiatric care including when the problem first began (approximate dates)_____

_____

_____

_____

_____

Have you ever seen a psychiatrist or therapist or hospitalized for psychiatric reasons?_____

_____

Have you ever tried to kill yourself or someone else?_____

Please circle any of the following that are creating problems for you

Angry/tense	Lonely/loner	Compulsions	Lies
Annoyed	Self doubt	Short attention span	Worried
Aggressive	Impulsive	Procrastinates	Bored
Appetite problems	Interrupts others	Racing thoughts	Guilt
Argumentative	Job problems	Rituals	Shame
Blames others a lot	Can't wait turn	Temper tantrums	Panic
Depression	Jealous	Talks too much	Scared

Have you ever used any tobacco products, drink alcohol or use illegal drugs? _____

_____

Please answer the following questions about alcohol.

Have you ever thought you need to cut back on your consumption? Yes/no
Has anyone ever commented to you that you drink too much? Yes/no
Have you ever personally felt guilty or upset about how much you drink? Yes/no
Have you ever had to take a drink in order to prevent withdrawal symptoms? Yes/no

Have you ever been arrested or had legal problems?_____

_____

_____

Have you lost or gained weight in the last few months without trying?

_____

Does anyone in your family have mental illness including suicide or homicide attempts?_____

_____

Is there anything you would like to add that would be helpful for me to know?_____

_____

Please list the most important goals that you would like to accomplish

_____

_____

Spiritual/Faith Belief Questionnaire.

We use this information to determine what kind of care you prefer at this facility. We wish to honor all people who come here and honor all viewpoints. You do not have to fill out this information if you are not comfortable.

1. Do you consider yourself to be spiritual and/or to have faith beliefs?

   Yes ☐

   No ☐ if no, then the form is complete, as the rest of these questions inquire further about spiritual/faith beliefs. However, if there are any traditions, ideas, or cultural elements that you would like to discuss in treatment, please list them below.

2. Please describe your spiritual or faith beliefs.

3. Do you use your spiritual or faith beliefs to help you manage your life problems?

4. How do your spiritual or faith beliefs impact your everyday life?

5. Do you identify with a specific spiritual group or a specific faith group within your community? If yes, does your group help to provide support and encouragement?

6. Would you like for your provider at Genesis Psychiatric services to include a faith component (of your preference) into your healthcare plan?

   Yes ☐

   No ☐

Practice information and agreement form

Introduction: Welcome to the services of Genesis Psychiatric Services. We are here to serve you. It is our hope that the following information will help you to understand our office policies. Please talk with our staff or your provider if you have questions regarding our procedures and services. We make every effort to develop a professional relationship that is satisfactory to everyone.

Confidentiality: Our services are confidential. Tennessee law states: Confidential information is controlled by the patient or by the patient's legal representative. No information will be released to anyone without your specific authorization. There are three exceptions to this rule. First, Tennessee law requires that child abuse be reported to the Department of Human Services. Secondly, in the case of an emergency, or when there is imminent danger to the patient or to other persons, the mental health provider may breach the requirement of confidentiality. Lastly, it is possible that a judge may require that certain information be released to the court. Additionally, when a physician or other professional refers you, or your child as a patient, we may communicate with that professional unless you specify to the contrary.

If you choose to submit your insurance claim, confidential information must be released to the insurance company. Information that the insurance company requires depends upon the insurance policy. At a minimum, we will be required to give a diagnosis, service codes and dates seen.

Cost: Each new patient appointment requires a $65.00 nonrefundable deposit that will be applied to your initial visit. If you do not show up for your appointment or cancel your appointment without rescheduling, then you forfeit your $65.00 deposit. If you reschedule your initial appointment more than one time, then you must pay your entire first visit before we will reschedule an initial appointment with you. We accept cash, American Express, Discover, Visa and MasterCard. We will provide a receipt for your records. You are expected to make payment the day of services. Accounts that are thirty or more days past due will be charged a monthly service fee of $20.00. Another visit will not be scheduled until financial arrangements are made with our office manager. The maintenance of your account is part of your therapeutic agreement and may be an indicator of your motivation and other treatment issues. Failure to bring your account current within 90 days may result in your account being turned over for collections.

Medication Policy: We do not fill any controlled substances medication unless you are seen for an appointment in the office. The only medication that may be called in is non-controlled substances medication. Whether the prescription will be filled is at the provider's discretion. If the provider chooses to fill your prescription, then there is a $35.00 charge in addition to paying for the price of the missed appointment.

A drug screen may be ordered at any time.
Your care may be terminated if we discover any misuse of your medication.
Any request for specific medication will be considered but will be at the discretion of the provider.

Office Hours: Hours are scheduled by appointment only. We do not have walk in hours.

Murfreesboro office: Monday, Tuesday, Wednesday from 7:00 am- 4:00 pm. Thursday 7:00 am- 12:00 pm, Friday closed.

Brentwood office: Thursday's only (hours vary. Please call for schedule)

We reserve the hours between 11:30 am and 12:30 pm to return telephone calls, attend to other patient related issues, and have lunch. Appointments made outside these hours will be billed at a higher rate, which will be discussed on an individual basis.

During the time our phone is unattended, voice mail will record your confidential message and your call will be returned within 24 hours. If you have an urgent/emergent need, we will be on call from 5:00 pm–9:00pm. If you have an emergency, please contact the Crisis Intervention Center at (615) 244-7444, call mobile crisis (for children

call Youth Villages at 1-866-791-9221; for adults living in Rutherford County, call 893-0770) or go to the nearest emergency room.

We complete all paperwork (FMLA, short-term disability, school letter requests, etc…) within one week. The cost for this service is $25.00

Cancelling appointments: At the end of our first appointment, we may make arrangements for further sessions. Due to our caseloads, there are usually limited appointment times available. As with all appointments, we individually reserve time for you.

Cancellations must be made 24 hours prior to your scheduled appointment otherwise you will be billed the cost of your appointment which must be paid prior to your next appointment. There are a limited number of hours available for patient care each day. Therefore, it is imperative that you give 24-hour notice of appointment cancellations.

Insurance Information: We do not take insurance. This allows for you to choose whether financial parties have access to your medical record. Additionally, this also allows us to provide affordable rates for all patients. However, we will provide a receipt for you to submit to your insurance company with your diagnosis and procedure code if you wish.

Services provided: We treat children, adolescents and adults For ADHD, anxiety, PTSD, depression, bipolar, schizophrenia and other psychotic disorders, alcohol and drug addiction recovery, post partum depression, phobias, and other mood disorders. We do not promise or guarantee any specific outcome. If you have questions about the benefits and risks of psychotherapy (or any other service) ask us for specifics. We will be glad to discuss these matters in simple, non-technical terms. The main purpose of medication management is to determine medication needs and treat you medicinally. We will work closely with your therapist (if you have one) involving your mental health treatment.

We do not treat sex offenders: people who have ever been accused of, charged or convicted of any sort of sexually abusive behavior including child abuse, rape, sexual assault, indecent exposure, crimes related to child pornography or solicitation of children. We do not provide forensic services. We do not provide SSI or SSDI disability determination. We are willing to provide names of those who do provide these types of services.

Multiple Providers: It is important to maintain one provider for your psychiatric issues. We will not provide medication if you are receiving medicine for the same or similar condition by another provider as this affects our ability to monitor your care. However, we do encourage patients to seek therapy and see medical providers for other physical needs or problems.

Practice information and agreement form

I have read and understood the Practice Information and Agreement form and agree to abide by its terms during my contract.

Name

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW GENESIS PSYCHIATRIC SERVICES, PLLC MAY USE OR DISCLOSE YOUR HEALTH INFORMATION.

1. State Law requires us to maintain the privacy of individual identifiable health information and to provide you with notice of our legal duties and privacy practices with respect to such information. Genesis Psychiatric Services, PLLC must abide by the terms and conditions of this privacy notice. We reserve the right to change our practices and to make the new provisions effective for all individual identifiable health information that we maintain.

2. Information contained in your health record:
· Health History
· Examination and Test Results
· Diagnosis
· Treatment
· Plan for Future Care or Treatment

3. **Uses or disclosures of health information for treatment, payment and healthcare operations.**

· **Treatment**. Treatment could include information recorded in your record to diagnose your condition and determine the best course of treatment for you. It could also include consulting with or referring your case to another healthcare provider. Copies will be provided to your physician, other healthcare professionals, or a healthcare provider, copies of your records to assist them in treating you. Genesis Psychiatric Services, PLLC may use or disclose your individually identifiable health information for its own provision of treatment or may disclose such information for the treatment activities for another healthcare provider.

· **Payment**. Payment could include Genesis Psychiatric Services, PLLC efforts to obtain payment and/or reimbursement from you or a third party payor for services that Genesis Psychiatric Services, PLLC has provided to you. The bill which will be prepared for the treatment given by Genesis Psychiatric Services, PLLC may include information that identifies you, your diagnosis, treatment received andsupplies used. Genesis Psychiatric Services, PLLC, may use or disclose your individually identifiable information for its own payment or for the payment activities of another healthcare provider, health plan or health insurer. Healthcare operations could include activities such as quality assessment, risk management, audits

of the process of billing you or a third party payor for healthcare services which Genesis Psychiatric Services, PLLC provides to you. As part of Genesis Psychiatric Services, PLLC treatment of you and operation of a healthcare organization, Genesis Psychiatric Services, PLLC may contact you by phone; by mail or e-mail to provide appointment reminders or to provide information about treatment alternatives or other health related services that may be of interest to you. Genesis Psychiatric Services, PLLC may use or disclose your individually identifiable health information for its own healthcare operations or for the healthcare operations of a health plan, or healthcare provider that is subject to certain federal health information privacy laws. The entity, which receives this information, must have or have had a treatment relationship with you and the information we disclose must pertain to that relationship.

· **Communication with Family.** Unless you object, health professionals using their best judgment may disclose to a family member, another relative, a close personal friend or any other person you identify, health information relative to that person's involvement in your care for payment related to your care. If you are unable to object, we may exercise our professional judgment to determine if the disclosure is in your best interest and disclose only information that is directly relative to the person's involvement with your healthcare.

· **Notification.** May use or disclose information to notify or assist in notifying a family member, personal representative, or any other person responsible for your care and general condition.

· **Business Associates.** There are some services provided in Genesis Psychiatric Services, PLLC through contracts with business associates, which may include but are not limited to third party billing entity, a practice management company, laboratory testing. When these services are contracted, we may disclose your health information to our business associate so they can perform the job we have asked them to do and bill you or your third party payor for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information and to comply with the same federal privacy rules as we do.

· **Food and Drug Administration**. We may disclose to the Food and Drug Administration health information relative to adverse effects, events with respect to drugs supplements, product or product defects or post-marketing information to enable product recalls, repairs or replacement.

· **Incidental Uses and Disclosures.** We are permitted to use and disclose information incident to another use or disclosure of your protected health information permitted or required under law.

YOUR RIGHTS UNDER THE FEDERAL PRIVACY STANDARDS

Federal and State Laws protect your right to keep your individual identifiable health information private. You have the following rights with regard to the information contained therein;

· You generally have the right to inspect and obtain a copy of any protected health information in your medical record, with the exception of psychotherapy notes, information compiled in anticipation of use in a civil, criminal, or administrative proceeding and certain other health information in which the law restricts Genesis Psychiatric Services, PLLC from disseminating. Psychotherapy notes include notes that are recorded in any medium by a healthcare provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and they are separated from the rest of your medical records. You do not have a right of access to information that was obtained from someone other than a healthcare provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information. In other situations we may deny you access to certain healthcare information. If access is denied, we must provide you a review of our decision denying the access. The grounds for reviewing a denial include the following: a licensed healthcare professional has determined in the exercised professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person. If the request is made by your personal representative and a licensed healthcare professional has determined, in its exercised professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person. For these reviewable grounds, another licensed healthcare professional must review the decision of the provider denying access within sixty (60) days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what actions you have to take to obtain access. We reserve the right to charge a reasonable, cost-based fee for making copies.

· If you feel the health information about you is incorrect or incomplete, you may ask us to amend or correct the information. We do not have to grant the request if the following conditions exist:

a. We did not create the record, therefore we do not know if the information is correct or accurate. In those cases, you must seek an amendment or correction from the party creating the record.
b. Does not include a reason to support a request.
c. That the information is accurate and complete. If we deny your request for an amendment or correction, we will notify you why, how you can attach a statement of disagreement to your records and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those that you identified to us that you want to receive the corrected information.

· You have the right to obtain an accounting upon request for uses and disclosures for treatment, payment and healthcare operations. However, we are not required to provide an accounting for the following disclosures:

a. Disclosures are protected health information to you.
b. For the facility director or to persons involved in your care or for other notification purposes as required in Section 164.510 of the Federal Privacy Regulations.
c. For national security or intelligence purposes under Section 164.512 (k) (2) of the Federal Privacy Regulations.
d. To law enforcement officials or correctional institutions under Section 164.512 (k) (5) of the Federal Privacy Regulations.

We will provide the accounting within sixty (60) days and it will include the date of each disclosure, name and address of the organization or person who received the protected health information, a brief description of the information disclosed and a brief statement of the purpose of the disclosure that reasonably informs you of the basis for disclosure or, in lieu of such statement, a copy of your written authorization or copy of the written request for disclosure. We will provide the first accounting in any twelve (12) month period at no cost. Thereafter, we reserve the right to charge a reasonable cost-based fee.

· You may revoke your consent or authorization to use or disclose health information except to the extent that we have taken action and reliance on the consent or authorization.

THE RESPONSIBILITIES OF GENESIS PSYCHIATRIC SERVICES, PLLC UNDER THE FEDERAL PRIVACY STANDARD.

· Provide you this notice as to our legal duties and privacy practice with respect to individually identifiable information that we collect and maintain about you.

· Abide by the terms of this notice.

· Train our personnel concerning privacy and confidentiality.

· Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.

· Implement a policy to discipline those who breach privacy or confidentiality or our policies of providing healthcare

information.

· Request of confidential information. We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law. You have the right to request that we communicate with you about matters in a certain way or at a certain location, such as contacting you only on certain telephone numbers. To request confidential information, the request must be in writing to Genesis Psychiatric Services, PLLC, 37 Castlewood, #A, Murfreesboro, TN 37129.

· Right to a paper copy of this notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. You may obtain a copy at www.genesispsychiatricservices.com or contact Genesis Psychiatric Services, PLLC at (615) 494-4804.

· Changes to this notice. We reserve the right to change this notice effective for information we already have about you as well as any information we receive in the future. We will display a copy of the current notice and display in the common area of Genesis Psychiatric Services, PLLC. Additionally, you may have a copy of the current notice in effect. You may obtain a current copy at www.genesispsychiatricservices.com or contact Genesis Psychiatric Services, PLLC at (615) 494-4804.

· How to report a problem. If you believe your privacy rights have been violated, you may file a complaint with Genesis Psychiatric Services, PLLC or the Office for Civil Rights, U. S. Department of Health and Human Services. To file a complaint with Genesis Psychiatric Services, PLLC, please call (615) 494-4804. To file a complaint with the U.S. Department of Health and Human Services, write to: Region 4, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3, V70, 61 Forsyth Street Southwest, Atlanta, GA 37303, (404) 562-7886, Fax (404) 562-7881. There will be no retaliatory actions towards you for filing a complaint to either party.

· Amendments. Genesis Psychiatric Services, PLLC reserves the right to amend the terms of this Privacy Notice at any time and to apply the revised Privacy Notice to all individually identifiable information that it maintains.

This Privacy Notice is effective on May 31, 2012.

Notice of Privacy Practice
Patient's Acknowledgment

By signing below, patient hereby acknowledges that he/she was offered a copy of your notice of privacy practices

Patient Signature Date

Print Name of Patient

If you are signing on behalf of a patient, please indicate your relationship to the patient or capacity to serve as a patient's representative.

Signature Date

Relationship