Personal Growth Counseling

CLIENT REGISTRATION Please Print

First Name M.I. Last Name	Today's Date Marital Status Single Married Widowed Divorced
Street Address	Home Phone
	Work Phone
City State Zip	Cell Phone
E-mail	Patient Birth Date Age
Spouse's Name/Parents Names	Patient Social Security number
Sex M F Smoke Y N	Emergency Contact Person, address & Phone number
Race American Indian/Alaska Native Hispanic Asian Caucasian African American Other Native Hawaiian/other Pacific Islander	Ethnicity circle one Hispanic Non-Hispanic

Insurance	Policy # Group #
Policy Holder name Date of Birth	Relationship to Policy Holder
Person Responsible for bill	Physician Referral
Do you have a Living Will? Yes No	Do you have a Declaration of Mental Health? Yes No

PLEASE CHECK ANY OF THE PROBLEMS THAT APPLY TO YOU

- ❑ Nervousness
- ❑ Shyness
- ❑ Separation
- ❑ Drug use
- ❑ Anger
- ❑ Sleep
- ❑ Relaxation
- ❑ Legal matters
- ❑ Energy
- ❑ Loneliness
- ❑ Education
- ❑ Temper
- ❑ Children
- ❑ Depression
- ❑ Sexual problems
- ❑ Divorce
- ❑ Alcohol
- ❑ Self-control
- ❑ Stress
- ❑ Headaches
- ❑ Memory
- ❑ Insomnia
- ❑ Inferiority feelings
- ❑ Career choices
- ❑ Nightmares
- ❑ Appetite
- ❑ Being a parent
- ❑ Fears
- ❑ Suicidal thoughts
- ❑ Finances
- ❑ Friends
- ❑ Unhappiness
- ❑ Work
- ❑ Tiredness
- ❑ Ambition
- ❑ Making decisions
- ❑ Concentration
- ❑ Health problems
- ❑ Marriage
- ❑ Stomach trouble
- ❑ My thoughts
- ❑ Trauma
- ❑ Others_____

_____

_____

509 N. Cedar Ave, Cookeville, TN 38501
931-520-8435 office 931-372-7225 fax

When were you last examined by a physician?
List any major health problems for which you currently receive treatment.
List any medications you are now taking.
Briefly describe your reason for seeking help.
Have you ever received psychological help or counseling of any kind before? If so, please explain.
Please provide any additional information that you feel may be useful to us in assisting you.

Consent for Treatment

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at PGC. Further, I consent to have treatment provided by a social worker, counselor, Nurse Practitioner or intern in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. At no time will the therapist or I record/video a session without the proper consent being obtained. I understand that the therapy may be discontinued at any time by either party. The PGC encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge. I agree to have my photo taken as part of my Electronic Health Record.

Recipient's Rights: I understand that as a recipient of services, I may get more information from my counselor regarding treatment services and options.

Non-Voluntary Discharge from Treatment: A client may be terminated from PGC non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at PGC, and/or B) the client refuses to comply with stipulated program rules – if you miss 3 consecutive appointments but continue to show for your medication appointments, or have a history of broken appointments over time, your therapist may begin the process of ending your service with him/her and the nurse practitioner; refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter and you will be provided with names and addresses of at least 3 appropriate referrals. The client may appeal this decision with the PGC Director or request to re-apply for services at a later date.

Responsibilities

What are my Responsibilities while in Treatment? The major responsibility you have is to keep us informed of changes that occur in your emotions or behavior during treatment. While in most instances, treatment will result in a decrease in uncomfortable emotions and undesired behavior, it is possible that strong feelings of anger, sadness and/or depression may surface for a period of time during the course of treatment. If this occurs for you, it is important to notify us about it as soon as possible. You have the right to refuse treatment and it is your responsibility to choose the provider and treatment modality that best suits your needs. You have the right to be involved in all aspects of your treatment.

If you miss three consecutive appointments (no shows) but continue to show for your medication appointments, or have a history of broken appointments over time, your therapist may begin the process of ending your service with him/her and the nurse practitioner. You will be contacted by your therapist and given an opportunity to discuss whatever interfered with your ability to keep your appointments. If we are unable to establish contact, either by mail or telephone, we will assume you are no longer interested in receiving services here. If this is the case, we will provide you with the names and addresses of at least three appropriate referrals.

Emergencies

In Case Of Emergency. If a situation arises which you believe to be a psychological emergency, you should call us at the number I will provide for you. During non-business hours, there is a beeper number that a provider on call can be reached and return your call. If the situation is critical and cannot wait for up to 24 hours, you should go to the emergency room.

If the specific situation arises in which you feel like you want to harm yourself (suicide) or hurt someone else, you must promise to talk to us about the thoughts or plans before acting upon them. Again, if you feel that you cannot wait until the next regular appointment to discuss such thoughts, you must call us, or if we are not available, contact the Suicide and Crisis Center, call 911, or go to the emergency room.

Financial Policies

The staff at, Personal Growth Counseling (hereafter referred to as the PGC) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers. The financial policy of PGC is designed to clarify the payment policies as determined by the management of PGC.

Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, PGC will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments.

The Person Responsible for Payment will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the PGC), this amount will be collected by the PGC until the deductible payment is verified to PGC by the insurance company or third-party provider.

All insurance benefits will be assigned to PGC (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to a charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged $32.50.

All prescriptions picked up are subject to an office visit charge per the discretion of the Nurse Practitioner.

Payment methods include check, cash, or charge cards.

There is a $30 return check fee.

Questions regarding the financial policies can be answered by the Office Manager.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____

I consent to treatment and have read the policies stated and will abide by the terms described with PGC.

_____ _____

Signature of Client/Legal Guardian Date

(In a case where a client is under 16 years of age, a parent or legal guardian must sign paperwork)

_____ _____

Witness Date

Personal Growth Counseling

New Patient Medication Policy

Providers in this office do not prescribe controlled substances such as **Xanax, Klonopin, Valium** or other **Benzodiazepines, Opioids,** or **Stimulant** medications.

We are no longer accepting new patients for taper-down of controlled substances. An addiction specialist is the most appropriate type of provider if you are trying to taper down or discontinue addictive medications.

Personal Growth Counseling may require drug testing or pill count at each provider's discretion.

Early prescriptions will not be provided. Patients must see their provider for prescriptions. Patients are responsible to schedule and attend appointments and comply with treatment recommendations.

Controlled substance prescriptions will be discontinued for current patients that are also prescribed pain management medications.

Psychological testing from outside this office may be required for continuation of certain types of medications.

Immediate discontinuation of medication services will result from treatment non-compliance including but not limited to: more than 2 missed appointments, overtaking, selling or giving away medications, using multiple providers to prescribe medications, substance abuse or legal problems, failed drug screen, disrespect to treating providers or staff, misreporting medication regime.

Patient Signature	Date
Elizabeth Rodgers, PMHNP-BC	Date
Amy Emerick, PMHNP-BC	Date
Crystal Maxwell, PMHNP-BC	Date
Carole Lovell, PsyD, LCSW Program Administrator	Date

Patient Name: _____

Appointment Reminders

We use an automated system for appointment reminders. Please select your preferred method for your appointment reminder sent the day before your appointment.

Phone Call: _____ preferred number: _____

Mobile Call: _____ preferred number: _____

Text: _____ preferred number: _____

Email: _____ preferred email: _____

Patient Preferences Regarding their Protected Health Information

Mail Communication Preferences May we send mail to your home address? (If no, please provide an alternate mailing address.)

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information and/or financial information? (Check all that apply)

	Name:	Telephone:
Spouse	_____	_____
Caretaker	_____	_____
Child	_____	_____
Parent	_____	_____
Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature Date

_____ _____

Printed Name Relationship to Patient

Personal Growth Counseling

509 N. Cedar Ave
Cookeville, TN 38501
931-520-8435 fax 931-372-7225

Authorization for Release Of Information

Client's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____ , authorize Personal Growth Counseling to:

___ (send) ____ (receive) the following ____ (to) _____ (from)

Family Care Doctor: _____

Address: _____ City: _____ State: _____ Zip: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

____ Academic testing results
____ Behavior programs
____ Progress reports
____ Intelligence testing results
____ Medical reports
____ Personality profiles
____ Psychological reports
____ Psychological testing results
____ Service plans
____ Summary reports
____ Vocational testing results
____ Entire record, except progress notes
____ *Psychotherapy Notes
____ Other, specify_____

The above information will be used for the following purposes:

____ Planning appropriate treatment or program
____ Continuing appropriate treatment or program
____ Determining eligibility for benefits or program
____ Case review ____ Updating files
____ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered
by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year from signature this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: __Self __Parent/legal guardian __Personal representative
__Other (describe)_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: ____/____/_____

Parent/guardian/personal representative (if applicable)
Signature: _____ Date: ____/____/_____

Witness (if client is unable to sign)
Signature: _____ Date: ____/____/_____

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Cookeville, TN 38501
931-520-8435

Privacy of Information Policies

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

Your Rights
You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $25 per record, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

Patients have the right to refuse to participate in community activities (including cultural, educational, and religious) community service, vocational or recreational activities.

Patients have the responsibility to treat health care providers at PGC with respect and dignity. Patients have the right to be treated with respect and dignity.

You have the right to be protected by the licensee from neglect, physical, verbal, and emotional abuse, and from all forms of exploitation.

You have the right to be assisted by the facility in the exercise of your civil rights.

You have the right to be free of any requirement by the facility that they perform services which are ordinarily performed by the facility/staff.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

You have the right to voice grievances to the staff, the licensee and outside representatives with freedom from restraint, interference, coercion, discrimination or reprisal.

Grievances
If you have any grievances or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Tennessee Department of Health and Human Services. If you file a grievance/complaint we will not retaliate in any way.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): _____

Signature: _____ Date: _____/_____/_____

Signed by: __client __guardian __personal representative