Name: ________________________ DOB: _______________

1. **Consent to evaluate/treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Knoxville Family Psychiatry. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medication (when applicable)
    e. Probable consequences of not receiving treatment

2. **Benefits to evaluation/treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or resting, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professions, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges, including co-payments and deductibles. Fees are available to me upon request.

4. **Confidentiality, harm, and inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Knoxville Family Psychiatry, and I consent to disclosure for use by Knoxville Family Psychiatry's staff for the purpose of continuity of my care. Information provided will be kept confidential and released only by the patient's written consent or where otherwise authorized by law.

5. **Right to withdraw consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

6. **Expiration of consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

____ ______________________

Signature of client ages 16 years or older / **Date**
Signature of legal guardian for minor under age 16

KNOXVILLE FAMILY PSYCHIATRY

Date: ____/_____/_________ Relationship to Client:_______________

Client Information

Name: ______________________________ DOB: ____/____/______ Sex: M F Age: _____

Address: _____________________________________ City: ______________ State: _____ Zip: _______

Home Phone: (____) _____-_______ Contact Phone: (____) _____-______

Email Address: ______________________________________ Social Security Number ______-_____-______

Primary Insurance Carrier: _______________________

Policy Holder's Name and Date of Birth: ______________________ ___/_____/______

Member/Subscriber ID #: _________________________________ Group #: _________________________

Secondary Insurance Carrier: _____________________

Policy Holder's Name and Date of Birth: ______________________ ___/_____/______

Member/Subscriber ID #: _________________________________ Group #: _________________________

I, ________________________, state that I am not enrolled in TennCare or any other similar plan AND am not dual eligible for TennCare, except Amerigroup.

Signature of Patient or Patient Guardian Witness

_____________________________________ _____________________________________

Caregiver/Legal Representative Information (if minor or conservator)

Name: ____________________________ DOB: ___/____/_______ Relationship to Client: ____________

Address: ___________________________________City: __________________ State: ________ Zip: _________

Cell Phone: (____) _____-______ Email: ____

Employer: ____

Do you provide insurance coverage for client: Yes No If not, policy holder name: __________________

Policy Holder DOB: ____/_____/_______

Payment Authorization

I understand I am responsible for all fees and agree to stated payment policies, regardless of insurance coverage or pending litigation. Payment is expected at the time of service. Knoxville Family Psychiatry is not in network for all insurance carriers but can assist you in obtaining out of network benefits. My signature below allows Knoxville Family Psychiatry to release any information to my insurance company in order to file claims and/or determine benefits.

Signature: ____ Date: _____/______/________

KNOXVILLE FAMILY PSYCHIATRY

Privacy and Office Policies

- Payment is expected at the time of service.
- Patients not seen within the last three years will be considered a new patient.
- Even though insurance may be filed, I understand that all payment is required at the time of service and that I, not the insurance company, am ultimately responsible party for the payment, regardless of any divorce decree or court order stating otherwise. Should the account be referred to an attorney for collection, I shall be responsible for reasonable fees and collection expense.
- If there is a parenting plan for the minor patient, we must have that plan on file prior to seeing the child.
- Patients not presenting evidence of insurance will be responsible for filing all claims to receive in network/out of network benefits.
- Picture ID's must be presented at the initial visit and you may be asked to present your ID at subsequent visits for verification. Failure to do so may result in you being asked to reschedule your appointment.
- **I understand that this office is out of network for some insurance plans.**
- My signature below allows you to: release any information to my insurance company if the name has been provided in documentation, and/or referring physician requested for the purpose of determining benefits and/or coordination of care. I also understand I may submit a written request for a copy of my medical records. I understand that it may take 10-14 days to receive those records and that there may be a charge for this service.
- **If you are more than 10 minutes late, you may be asked to reschedule your appointment. You may choose to be seen later in the day if an appointment is available or you may reschedule to a later date.**
- This office does not use your Protected Health Information (PHI) for fundraising or marketing. We will not sell your information.
- If for any reason your PHI is breached, you will be notified as required by law.
- I agree to and understand the provider's use of protected health information as described in the notice for treatment, payment, or other health care operations. I understand that I must provide a separate authorization before any disclosure may be made, except as otherwise specified.
- A copy of these regulations is available in the office or by accessing our website.
- Abusive or threating behavior by the patient or their caregivers, including those communicated by social media, will not be tolerated and may be grounds for dismissal from the practice.
- **A medical decision maker must be present with patient under the age of 16.**

Signature ____ Date__________________

KNOXVILLE FAMILY PSYCHIATRY

PHARMACY

Patient Name ____ DOB ______/______/________

Knoxville Family Psychiatry will attempt to transmit your prescriptions electronically to the pharmacy of your choice. Not all pharmacies will accept all prescriptions in the electronic format. If you are receiving any prescriptions for controlled medications, you may be required to have a written prescription for each refill. If your pharmacy has multiple locations, please provide us with the exact address of the location you wish to utilize.

Pharmacy Name ____

Pharmacy Address ____

Pharmacy Phone Number ____

Signature of Patient or Guardian ____

Medication Refills: If you are running low on medication between visits, please contact us at least five (5) days before you run out. This ensures that we have time to access your file, call in your prescription, and sort out any problems that may arise. You must call during business hours to have prescriptions refills.

Clinical History

Patient Name ____ DOB ______/______/________

Allergies (include medication, food, environmental)

Reason for today's appointment (Provide brief description of current symptoms)

Past medical history

1) Personal Medical History: Conditions - current or treated in the past. (Circle all that apply)

anxiety	blood clot	seizures
depression	heart disease/heart attack	stroke
ADHD	hypertension	diabetes
bipolar disorder	high cholesterol	HIV
eating disorder	cancer	congestive heart failure
chronic fatigue/fibromyalgia	kidney disease	
thyroid disease	COPD/breathing problems	
coronary artery disease	liver disease/hepatitis	
	dementia/memory loss	

Pregnant

___Yes _____ No

If female last menstrual period ______________

History of surgeries: ____

Current medical medications: ____

Family medical history (List family member with medical condition)

psychiatric hospitalizations ____________________	diabetes ____________________
dementia ____________________	high blood pressure ____________________
depression ____________________	high cholesterol ____________________
anxiety ____________________	kidney disease ____________________
ADHD ____________________	stroke ____________________
substance abuse ____________________	cancer ____________________
cardiac ____________________	please list type ____________________

Psychiatric History:

Do you have any history of outpatient psychiatric treatment? (please list provider, reason for treatment, and dates of treatment)

____

____

Do you have any history of inpatient psychiatric treatment? (please list facility, reason for admission, and dates)

____

Any history of suicide attempts: _____________________________

Current psychiatric medications

_____________________________ _____________________________

_____________________________ _____________________________

_____________________________ _____________________________

Past psychiatric medications and response

____

____

Please list any history of substance abuse issues

____

Social History:

Do you smoke? ________ If yes, how much? ______________________

Do you drink alcohol? ________ If yes, how much? _________________

Knoxville Family Psychiatry

301 Clark St., Knoxville, TN 37921

865-588-1718

Psychiatric Provider-to-Client Services

Services

We treat children and adults for a variety of psychiatric issues. We provide medication management and care coordination as adjunctive care to the work that you do with your psychotherapist and other community support you may have in place.

Office Hours

Knoxville Family Psychiatry office hours are Monday – Thursday, 7:30am-5:30pm.

Initial Evaluation Phase

Your first meeting will last approximately 50 minutes. We will discuss the issues that have led you to seek assistance, your past history, your current life status, and treatment goals. By the end of this meeting, our goal is to provide you with a sense of how we may be able to help you. We may be able to work out an initial plan of treatment by the end of this meeting, but often, additional meetings are necessary to fully develop a plan.

Ongoing Sessions

Our medical providers will see you primarily for medication management. Your follow-up visits will last approximately 15-20 minutes. Depending on your clinical response, these meetings can occur as often as weekly (during initial medication trials, at times of medication problems, or during periods of stress) or as infrequently as every three months. Except in unusual circumstances, adults will need to be seen at least once every three months and children monthly. This is essential for us to provide appropriate oversight of your medications.

Contacting Me

The best way to contact us is by calling our office staff at 865-588-1718. We will be available Monday-Thursday from 8:30am-4:00pm. Our staff will be able to handle very routine matters such as scheduling appointments and requesting medication refills. **An appointment is required to make any changes to your medications as we are unable to make changes over the phone.** Our care coordinators will also be available at that number. Your call-back may be made by your provider or office staff at your provider's direction.

Emergencies

Our providers will be available to clients whenever there is an urgent situation that is not life threatening and encourage you to contact our staff when a crisis with your medication arises. During the hours of 8:30am-5:00pm, Monday-Thursday, first call our office at 865-588-1718. Please let the staff know that you have an urgent situation but is not a life-threatening emergency. Please use words such as "urgent", "emergency" or "crisis" when you call. They will contact us immediately. If after hours, please call the office number and follow prompts for after hours. This service will also contact the on-call provider immediately. If you are in a hazardous situation and still have not reached someone on our staff or heard back from us in a timely manner, please call 911 or go to the nearest hospital emergency room.

Medication Refills

It is our shared responsibility to ensure that you do not run out of medications between appointments. It is safest and most efficient for our providers to write new prescriptions in person when patients are in the office, so please check on your supply of medication (and remaining refills) prior to your office visits.

If you are running low on medication between visits, please contact us at least five (5) days before you run out. This ensures that we have time to access your file, call in your prescription, and sort out any problems that may arise. The following information will be needed for a provider to call in a prescription refill:

- Your date of birth
- Your phone number
- The medication dosage
- Your pharmacy phone number
- The full medication name
- The exact way you take your medication

Privacy

We are dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time your care or treatment was provided. We are also required to notify you if your information has been compromised. A copy of these privacy practices is available in office or on our website.

Payment

This practice operates on a fee-for-service basis. This means that your fee for each appointment will be due at the time of session. As payment, we accept personal checks, credit cards or cash.

Correspondence

We require at least a two week notice for most reports, letters, and forms.
Letters will be completed at a rate no less than $25.00.
An additional charge of $25.00 will be assessed for letters needed in less than one week.
Complex forms and lengthy letters will be assessed at a higher rate or a case by case basis.

Cancellations

When you make an appointment with our practice, it is time that we reserve exclusively for you. Barring emergencies, we will be ready to see you at this scheduled time. We do not double book our schedule. Because of this, we ask that you provide us with as much advanced notice as possible should you need to cancel or change an appointment, by calling our office phone at 865-588-1718 during the hours of 8:30am-4:30pm Monday- Thursday.

Our cancellation policy is as follows:

Cancellations more than 24 hours in advance: **NO CHARGE.** Cancellations less than 24 hours: **$35**

We have reserved your appointment time specifically for you. If you no-show more than two consecutive appointments **or** no-show three times over the course of your treatment, you may be subject to termination from the practice. Should this occur, we will provide you with a one month supply of medication and a list of other treatment facilities.

If you fail to show up to your appointment without contacting us, 100% of the visit fee will be due. The fee for a no-show is $75 even if your co-pay is less than the billed amount.

Note: We follow the Pellissippi State Community College closure and delay policy.

RISKS ASSOCIATED WITH TREATMENT

Please be aware that there can be risks associated with psychiatric medications. It is our goal to protect your safety and well-being at all times. However, in many situations progress cannot be made without assuming some risk of adverse effects. All medications can have side-effects, some of which may be quite serious. Prior to starting any new medication, it is our responsibility to discuss with you the most common and most serious potential side-effects and help you weigh these risks against the potential benefits. We will answer any questions you may have about the medications we recommend at any time. Please be aware, however, that we cannot practically inform you of every possible side effect of each medication.

Your responsibility lies in keeping us informed of any serious side-effects you experience, changes in your medical conditions, and new medications prescribed by other providers. We may also ask you to complete a written consent form for some medications.

LIMITS TO OUR RELATIONSHIP

When we negotiate a treatment plan, we will discuss the nature and scope of our relationship. Please understand that in following the standards of this profession and the ethical guidelines of the American Psychiatric Association, we cannot have other roles in your life, such as friend, romantic partner, a friend on social media, or client of your work of services.

As we live in a relatively small community, it is entirely possible you may encounter your provider outside of the office setting, for example at a restaurant or theater. To protect your privacy in such circumstances, it is our policy not to acknowledge you first; please do not misunderstand this as a lack of recognition or caring. If you wish to acknowledge and exchange a brief greeting, that is perfectly fine.

STATEMENT OF PRINCIPLES

We strive to comply with the advisories and ethical principles of the American Medical Association and the American Psychiatric Association. If you have concerns about our work together, please let us know. If you feel that we have treated you unfairly or unethically, please tell us.

Your signature below indicates that you have read and received a copy of the **Psychiatric Provider-to-Client Services** agreement and agree to abide by its terms. You have the right to revoke this agreement in writing at any time.

__________________________________ ____________________

Signature of Client or Parent/Guardian Date

In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your office visit. Please be aware that if a 24 hour notice is not received, a fee of $35 may be charged to your account and if an appointment is missed, a fee of $75 may be charged to your account. Please call us if you are unable to keep your scheduled appointment. This will provide us an opportunity to reschedule your appointment to a more convenient time and avoid any additional charges on your account.

__________________________________ ____________________

Signature of Client or Parent/Guardian Date

Name: ____________________________________ **DOB:** ______________________

KNOXVILLE FAMILY PSYCHIATRY

INFORMED CONSENT FOR TELEMEDICINE (TELEHEALTH) SESSIONS

1. Telehealth is any meeting with a healthcare provider via a phone call or a video call in place of an in-person session.

2. I understand that my health care provider wishes me to engage in telehealth as an alternative to an in-person session or sessions.

3. My provider has explained to me how the video conferencing technology will function and how it will differ from an in-person session.

4. I understand that a telehealth session has potential benefits, including greater access to care and the convenience of meeting from a location of my choosing.

5. Client Communication and Responsibilities:

   a. I understand I will need to have access to and be familiar with the appropriate technology in order to participate in this service. I agree to use my own equipment and not equipment owned by another.

   b. I agree not to use my employer's equipment. I understand that any information I enter into an employer's equipment can be considered by the courts to belong to the employer, and my privacy may be compromised.

   c. It is my responsibility to maintain privacy on the client end of communication. I agree to use a secure and private environment while "meeting" with my practitioner. I will not allow any other person(s) in the session unless discussed and agreed upon with my counselor.

6. I understand that my provider is using a HIPPA compliant platform (AdvancedMD via Zoom or 3CX Platform). However, I also understand that there are potential risks to this technology, including interruptions, unauthorized access by others, and technical difficulties. I recognize that the transmitted information may be unclear or inadequate. I understand that my provider will exercise care to minimize these risks, and in the case of disruption that the provider will then attempt to call the client via other means.

7. I understand that telehealth sessions are not adequate for emergency situations and my provider will require me to contact a local crisis response team or go to the nearest emergency room in an emergency situation.

8. I acknowledge have read the document and fully understand the benefits and risks. I have had the opportunity to ask questions and received satisfactory information.

9. I voluntarily consent to participate in the telehealth services, including but not limited to care, treatment, ad services deemed necessary and advisable under the terms described herein.

CONSENT TO USE ADVANCEDMD TELEMEDICINE (VIA ZOOM) or the 3CX Platform, which is the technology services we will use to conduct telehealth video conferencing appointments. By signing this document, I acknowledge: This is not an emergency service, and in the event of an emergency, I will use a phone to call 911.

To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. By signing this form, I certify: I have read or had this form read to me or had this form explained to me. I fully understand its contents, including the risks and benefits of the procedure(s). That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

____ __________________________

Signature of client ages 16 or older /
Signature of legal guardian for minor under age 16

Date

Authorization for Release of Medical Information

Phone: (865) 588-1718 Fax: (865) 338-5897

301 Clark St. Knoxville, TN 37921

Patient Name: ________________________________

Birthdate: ___________________________________

Address: ____________________________________

City: _________________ State: _____ Zip: ________

I authorize Knoxville Family Psychiatry to ☐ **release to** and/or ☐ **obtain** information regarding my treatment to:

Name/Organization/Office: ________________________________ **Phone Number**: ___________________

Person providing and/or obtaining information: ○ Health Care Provider ○ Family Member ○ Therapist ○ Other

- The purpose of this release is: ☐ at the request of the patient ☐ continuum of care ☐ other
- Information to be **released** and/or **obtained:**

☐ Office Notes
☐ Labs
☐ History & Physical
☐ Abstract
☐ Imaging
☐ Discharge Summary
☐ Scheduling
☐ Billing
☐ Medication List
☐ Verbal on-going communication
☐ All the above

Due to the nature of this practice, we will only release notes generated by our practice provider. If you desire copies of notes released to you by other providers, you must obtain those independently.

Unless otherwise revoked, this authorization expires ________________ (insert applicable date or event). If no date or event is indicated, this authorization will not expire.

I understand that I may revoke this authorization at any time by notifying in writing the Medical Records Department of Knoxville Family Psychiatry. Such notice will not affect any actions made prior to this authorization. I understand that my healthcare, payment for my healthcare, or insurance status will not be affected if I do not sign this form. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA privacy rules. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this authorization for release of medical information.

______ **(initials)** I acknowledge, and hereby consent to such, that the released information may contain psychiatric, alcohol and drug abuse, drug testing, HIV testing and results, or AIDS information.

Date __________________

Signature of Patient or Parent/Guardian _____________________________

Printed Name ___________________________ **Relationship to Patient** ____________________