Champion Healthcare

324 N. Maple St.
Lebanon, TN 37087
Ph. 615-547-4205 Fax. 615-807-3303

WELCOME TO OUR PRACTICE

Thank you for scheduling your appointment with our providers. We look forward to meeting you!

GENERAL INFORMATION

Please arrive 15 minutes prior to the first appointment, this ensures that you have enough time to completely fill out your paperwork. Bring with you your insurance card(s) and any other paperwork requested by our office.

It is our office policy that you provide us with payment in full at the time of the first visit, unless you are part of an HMO/ PPO that provides us with a specific co-pay amount which you are required to pay at the time of service. We will bill your insurance and, if they pay for your services, we will apply your initial payment towards your account. **No refunds** will be given.

Please read and complete all forms!

1. Mental Health Intake questionnaire - **FULLY COMPLETED**
2. Return all other forms in this packet, signed and initialed.
3. A **CLEAR** copy of the **FRONT** and **BACK** of all your insurance card(s).

➔ It is your responsibility to contact your insurance company to open your case for pre-authorization for treatment and confirm benefits before your first appointment:
   1. Call your insurance company and get a prior authorization for **"Outpatient Mental Health"** services.
   2. Ask for the **"Insurance Claim Mailing Address"** to submit your mental health claims.

OFFICE POLICIES

APPOINTMENTS

Patients are seen only by appointment.

You will not be seen in our office unless all forms are filled out.

Upon arrival at the office for any appointment, always check in with the receptionist so that the providers can be informed that you arrived.

Please also make sure to check out before leaving to schedule an necessary appointments.

PRESCRIPTION REFILL POLICY

During your appointment, your provider will write a prescription with the number of refills he/she feels is needed and safe. With your last refill, ensure you have an appointment with your provider for a medication refill **at least two weeks before your medication runs out**. At the time of your appointment, your provider will review your medications and write for appropriate refills. **Medication refills will not be authorized over the phone or by fax.**

Please remind your provider if you require a 90 day prescription and clarify the pharmacy we have on record is correct. Patients are asked to respect the privacy and time concerns of patients who have appointments. In consideration of both patients and providers, patients are reminded not to walk in to the clinic to request a prescription refill. Certain controlled substances may require a monthly appointment.

CANCELLATIONS / MISSED APPOINTMENTS:

When you schedule an appointment, that time is reserved specifically for you. Appointment reminder are sent via text message prior to your appointment. **It is the patient's responsibility to remember and keep scheduled appointments.** A minimum of 24 hours notice is required for canceling or re-scheduling an appointment.

You will be charged **$100** for missed appointments and appointments which are canceled with less than 24 hours notice.

DISCHARGE:
Three consecutive no shows or three consecutive cancelations will trigger an automatic discharge from our practice unless indicated otherwise by your provider.

FINANCIAL RESPONSIBLITY:

- Co-pays or deductibles are due at time of service.
- A minimum of $20.00 will be collected on all services with a deductible or where a deductible applies. Applicable adjustments will be made once your insurance carrier has paid for services rendered.
- Cash discounts are given only at the time of the appointment when ***paid in full*** at check-in.
- Missed Appointment / Late Cancellation Fees $100.00
- **NO REFUNDS** will be given any extra amount will be applied to your account.

PAYMENT:
Co-pays and Deductibles are collected prior to your appointment when you check-in. **If you have no insurance, payment in full is required and must be paid prior to your appointment at the time of check-in. Payment will only be accepted in the forms of credit or debit card, money order or check. Cash payment is accepted only for copays, deductible or coinsurance.**
Many insurance plans require prior authorization for mental health services. It is the patient's responsibility to obtain the authorization for the first visit. We are happy to bill your Insurance with the information you provide us, however, payment by your insurance company is not guaranteed. If your claim is denied or there is lack of authorization, you are responsible for the billed amount.

CONFIDENTIALITY AND RELEASE OF INFORMATION
Information disclosed within sessions and the written records pertaining to those sessions are confidential and will not be released to anyone without the written consent of the patient or the parent/guardian, in the case of minors and/or dependent adults, except where Champion Healthcare is mandated by Tennessee law to report otherwise confidential information. Circumstances which are required by law to be reported are:

1. Patients who pose an imminent threat of danger to themselves or others.
2. Instances of suspected abuse or neglect of a child (physical, sexual and/or emotional abuse).
3. Instances of suspected abuse or neglect of a dependent adult.

Disclosure may also be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from Champion Healthcare In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Providers will use their clinical judgment when revealing such information.

Disclosure of confidential information may be required by your health insurance or workman's compensation carrier, or HMO/PPO/MCO/EAP in order to process your claims. Only the minimum necessary information will be communicated to the carrier. Providers have no knowledge or control over what insurance companies do with the information submitted and assumes no responsibility for any actions which result from a third party misusing or re-releasing such information without his expressed consent.

As a patient, you have the right to review or receive a summary of your records at any time (with notice of 10 or more working days), except in limited legal or emergency circumstances or when Champion Healthcare, assesses that releasing such information might be harmful in any way. In such circumstances Champion Healthcare may provide the records to a qualified mental health professional of your choice and that individual may then choose to review the information with you if it is deemed clinically appropriate. You will be charged an appropriate fee for any preparation time which is required to comply with an information request.

All other requests to release information regarding your treatment and your condition must be authorized in writing specifically allowing the release of psychiatric records. Champion Healthcare will provide you with a Release of Information form or you may choose to place your request in writing. There will be no charge for releasing records to other treating medical or mental health professionals. For all other requests to copy records, there will be a minimum charge of $25.00 to cover the expenses of photocopying, postage and handling.

CONSENT TO TREAT :

I authorize CH providers to provide treatment that they deem advisable for my dependents and me. I understand these services are voluntary and I have the right to refuse these services before they are rendered. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment.

FINANCIAL AGREEMENT & OFFICE BILLING / INSURANCE POLICIES

1. I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance. I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account. **I understand that if I do not present my insurance card to the receptionist that I will be liable for the costs of my scheduled office visits.**

2. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account. I understand that **NO REFUNDS** will be given and the remaining amount will be applied to my account.

3. I understand that if my insurance(s) require a referral from my primary care physician, Champion Healthcare must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).

4. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s), including that an insurance company representative may review the clinical record.

5. I authorize direct payment by my insurance company(s) to Champion Healthcare.

6. I accept ultimate responsibility for payment for the services that I or my dependent(s) receive, whether or not my insurance(s) cover these services. This includes, but is not limited to fees for: clinical services or treatment, failed appointments and/or appointments not canceled with 24 hours notice, report/letter writing, time spent in court or talking with attorneys on my behalf or the behalf of my dependent(s), telephone conversations longer than 5 minutes, site visits, reading records, longer sessions, travel time, etc.

7. I understand that I will receive a statement if I have an outstanding balance on my account, and I am to pay any portion that is my responsibility within 15 days of receipt of a statement. A finance charge of 1% per month may be added to my account if payment is overdue.

8. I understand that there will be a $25.00 service fee for any checks returned by my bank due to non sufficient funds, closed accounts, etc. I agree to accept full responsibility for such fees. The amount of the returned check, plus the service fee, must be paid within 10 days of written notice.

9. I will notify the Office if any problem arises regarding my ability to make timely payments. If my account is overdue (unpaid) and there is no agreement on a payment plan, I understand that this office can use legal means (court, collection agency, etc.) to obtain payment. I understand that all legal fees associated with collection are my responsibility

10. I am aware of Champion Healthcare's office policy requiring 24 hours notice to cancel an appointment. I understand that I may notify the office staff or the answering service of my intention to cancel an appointment. I further acknowledge that I will be charged $100.00 for any appointment which I or my dependent(s) fail to keep without providing 24 hours notice.
    My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies.

_____
Patient Name (Printed)

_____
Responsible Party (Printed) (If patient is a minor or dependent adult)

_____ _____
Signature of Responsible Party Date

Champion Healthcare

Patient Registration

Are these services Court ordered? ❑ Yes ❑ No

PATIENT INFORMATION ❑ New Patient ❑ Information Update

Patient Name: _____ Social Security #: _____
Date of Birth: _____ Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Other
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____
Primary Contact Phone: _____ Secondary Phone: _____
Employer: _____ Occupation: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Education Level: _____ Highest Grade Completed: _____
Race: ❑ Asian ❑ Black ❑ Native American ❑ White ❑ More than one race Preferred Language: _____
Ethnicity: ❑ Hispanic ❑ Non-Hispanic
Smoking Status: Current Smoker: ❑ Yes ❑ No History of Smoking: ❑ Yes ❑ No Stop Date: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Referring Physician: _____ Driver's License #: _____

SPOUSE / PARTNER INFORMATION (If relevant)

Spouse/Partner Name: _____
Date of Birth: _____ Sex: ❑ Male ❑ Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____

FINANCIAL RESPONSIBILITY (Must complete if patient/client is under 18 years of age)

Responsible Party: _____ Social Security #: _____
Relationship to Subscriber: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____

INSURANCE INFORMATION (Must complete ALL the information below in order to bill your Insurance)

Primary Insurance: _____ Subscriber Name : _____
Subscriber Date of Birth: _____ Subscriber ID #: _____ Group #: _____
Claim Mailing Address: _____ City: _____ State: _____ Zip: _____
Relationship to Patient: _____
Secondary Insurance: _____ Subscriber Name : _____
Subscriber Date of Birth: _____ Subscriber ID #: _____ Group #: _____
Claim Mailing Address: _____ City: _____ State: _____ Zip: _____
Relationship to Patient:

PHARMACY INFORMATION (PLEASE FILL OUT COMPLETELY WITH CORRECT ADDRESS AND PHONE NUMBER)

Pharmacy Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Cross Street: _____ Pharmacy Phone#: _____
Mail Order Pharmacy Phone #: _____ Pharmacy Fax #: _____

SIGNATURE and DATE

Patient or Responsible Party: _____ Date: _____

TELEPHONE APPOINTMENT REMINDER CONSENT

I _____ give **Champion Healthcare** and members of the staff
Patient Name (print)
working at the location indicated above, my permission to call or text me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):

❒ Home _____
May we leave voicemail? ❒ Yes ❒ No

❒ Work _____
May we leave voicemail? ❒ Yes ❒ No

❒ Cell _____
May we leave voicemail? ❒ Yes ❒ No

Yes, this office may leave (check all that apply):
❒ Messages with _____at my Home
❒ Messages with _____at my Work

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician practice specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician practice specified above is otherwise notified by me.

_____ _____
Patient Signature Date

Champion Healthcare

Authorization to Obtain Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of PHI on the above named individual which may contain medical, mental health, or substance abuse history and treatment information.

Name of organization or individual authorized to disclose the information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Are there any restrictions on PHI to be disclosed? ❒ Yes ❒ No

_____No one other than myself may have access to my medical records:

May our office leave a message on your answering machine? ❒ Yes ❒ No

I consent to the use or disclosure of my protected health information by Champion Healthcare for the purposes of diagnosis of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Champion Healthcare I understand that diagnosis or treatment of me by Champion Healthcare may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information (PHI) is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Champion Healthcare is not required to agree to the restrictions that I may request. However, if Champion Healthcare agrees to restriction that I request, the restriction is binding on Champion Healthcare. I have the right to revoke this consent, in writing, at any time, except to the extent that Champion Healthcare has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This PHI relates to my past, present or future physical or mental condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that the "Notice of Privacy Practices" describes how Champion Healthcare may disclose and use my protected health information (PHI). I am encouraged to read the "Notice of Privacy Practices" in full.

Signature: _____ Date: _____
(Patient Signature or Authorized Representative and relationship)

Printed Name: _____

Champion Healthare

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This is a read "friendly" version. A complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Medical and Mental Health Intake Form

Name _____ Date_____

Date of Birth _____ Primary Care Physician _____

Do you give permission for ongoing regular updates to be provided to your primary care physician?
❒ Yes ❒ No

Current Therapist/Counselor_____Therapist's Phone_____
Referred by:_____
What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

❒ Depressed mood
❒ Unable to enjoy activities
❒ Loss of interest
❒ Concentration/forgetfulness
❒ Increase in appetite
❒ Decrease in appetite
❒ Excessive guilt
❒ Fatigue
❒ Racing thoughts
❒ Increased libido
❒ Decreased libido
❒ Impulsivity
❒ Increased risky behavior
❒ Decreased need for sleep
❒ Increased need for sleep
❒ Excessive energy
❒ Increased Irritability
❒ Crying spells
❒ Excessive worry
❒ Anxiety attacks
❒ Avoidance
❒ Hallucinations
❒ Suspiciousness
❒ _____
❒ _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ❒ Yes ❒ No. If YES, please answer the following. If NO, please skip to the next section.
Do you currently feel that you don't want to live? ❒ Yes ❒ No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

_____

Past Medical History:

Medication Allergies_____ Current Weight _____ Height_____
❒ Mild ❒ Moderate ❒ Severe

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: _____

Current medical problems: _____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

Have you ever had an EKG? ❒ Yes ❒ No If yes, when _____

Was the EKG? ❒ normal ❒ abnormal ❒ unknown

For women only:

Date of last menstrual period: _____

Are you currently pregnant or do you think you might be pregnant? ❒ Yes ❒ No

Are you planning to get pregnant in the near future? ❒ Yes ❒ No

Birth control method_____ How many times have you been pregnant? _____

How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ❒ Yes ❒ No

Date and place of last physical exam: _____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease	❒	❒	
Anemia	❒	❒	
Liver Disease	❒	❒	
Kidney Disease	❒	❒	
Diabetes	❒	❒	
Asthma/respiratory problems	❒	❒	
Stomach problems	❒	❒	
Cancer (type)	❒	❒	

	You	Family	Which Family Member?
Fibromyalgia	❒	❒	
Heart Disease	❒	❒	
Epilepsy (seizures)	❒	❒	
Chronic Pain	❒	❒	
High Cholesterol	❒	❒	
High blood pressure	❒	❒	
Head trauma	❒	❒	
Liver problems	❒	❒	
Other	❒	❒	

Is there any additional personal or family medical history? ❒ Yes ❒ No If yes, please explain:

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Past Psychiatric History:

Outpatient treatment ❒ Yes ❒ No If yes, Please describe when, by whom, and nature of treatment.

Psychiatric Hospitalization ❒ Yes ❒ No If yes, describe for what reason, when and where.

Past Psychiatric Medications: If you have ever taken any of the following medications

	Dates	Dosage	Response/Side-effects
Antidepressants			
Mood Stabilizers			

	Dates	Dosage	Response/Side-effects
Antipsychotics			
Sedative/Hypnotics			
ADHD medications			
Anti-anxiety medications			

Your Exercise Level:

Do you exercise regularly? ❒Yes ❒No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	❒Yes	❒No
Depression Anxiety	❒Yes	❒No
Anger	❒Yes	❒**No**
Suicide	❒Yes	❒No
Schizophrenia	❒Yes	❒No
PTSD	❒Yes	❒No
Alcohol abuse	❒Yes	❒No
Other substance abuse	❒Yes	❒No
Violence	❒Yes	❒No

If yes, who had each problem?

_____

_____

_____

Substance Use:
Have you ever been treated for alcohol or drug use or abuse? ❒Yes ❒No

If yes, for which substances? _____

_____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day ____ What is the most? _____

Have you used any street drugs in the past 3 months? ❒Yes ❒No

If yes, which ones? _____

_____

Have you ever abused prescription medication? ❒Yes ❒No
If yes, which ones and for how long? _____

_____

_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How many packs per day on average? _____ How many years? _____

In the past? ❒Yes ❒ No

How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ❒Yes ❒No In the past? ❒Yes ❒No

What kind? _____ How often per day on average? _____ How many years? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ❒ Yes ❒ No
Please describe when, where and by whom: _____

_____

_____

Educational History:

Highest Grade Completed? _____ Where: _____

Did you attend college? ❒ Yes ❒ No Where: _____

What is your highest educational level or degree attained? _____

Are you currently: ❒ Working ❒ Student ❒ Unemployed ❒ Disabled ❒ Retired

How long in present position? _____ What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? ❒ Yes ❒ No If so, what branch and when? _____

Honorable discharge ❒ Yes ❒ No Other type discharge: _____

Relationship History and Current Family:

Are you currently: ❒ Married ❒ Partnered ❒ Divorced ❒ Single ❒ Widowed How long? _____

If not married, are you currently in a relationship? ❒ Yes ❒ No If yes, how long? _____

Are you sexually active? ❒ Yes ❒ No

How would you identify your sexual orientation? ❒ straight/heterosexual ❒ lesbian/gay/homosexual ❒ bisexual ❒ transsexual ❒ unsure/questioning ❒ asexual ❒ other ❒ prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

Have you had any prior marriages? ❒ Yes ❒ No If so, how many? _____ How long? _____

Do you have children? ❒ Yes ❒ No If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

_____

_____

List everyone who currently lives with you: _____

_____

Legal History:

Have you ever been arrested? _____

Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ❒ Yes ❒ No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ❒ more helpful ❒ stressful

Is there anything else that you would like us to know? _____

_____

_____

_____

_____

_____

By signing below, I agree that I have received the office policies and procedures and agree to the terms stated within those policies and procedures.

Signature: _____ Date: _____

Emergency Contact: _____ Phone # _____

For Office Use Only:

Reviewed by: _____ Date: _____