UNCOPE SURVEY

Please circle YES or NO for the following questions:

1. Have you spent more time drinking or using drugs than you intended to?	YES	NO
2. Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?	YES	NO
3. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	YES	NO
4. Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use?	YES	NO
5. Have you found yourself thinking a lot about drinking or using drugs?	YES	NO
6. Have you ever used alcohol or drugs to relieve emotional discomfort such as sadness, anger, or boredom?	YES	NO

Help us understand you better.

Please check off ONLY the items below that are bothering you.

- [ ] On going feeling of sadness or irritability
- [ ] Loss of interest or pleasure in daily activities for at least two weeks
- [ ] Changes is your weight or appetite
  - [ ] weight gain
  - [ ] weight loss
  - [ ] eating too much
  - [ ] not eating enough
- [ ] Unable to concentrate, remember things or make decisions
- [ ] Changes in your sleep
  - [ ] Sleeping too much
  - [ ] Sleeping too little
  - [ ] Having nightmares or vivid dreams
  - [ ] Difficulty falling asleep or staying asleep
- [ ] Feeling of guilt
- [ ] Feeling hopeless or worthless
- [ ] Thoughts of suicide or death
- [ ] Fatigue, loss of energy, tired
- [ ] Crying spells
  - [ ] Urges to act on suicidal thoughts
  - [ ] Had a suicide attempt in the past
  - [ ] Have a current plan to commit suicide
- [ ] Shortness of breath or a smothering sensation
- [ ] Heart palpitations, pounding heart or rapid heart rate
- [ ] Chest pain or discomfort in your chest
- [ ] Trembling, shaking or sweating
- [ ] Nausea or stomach discomfort
- [ ] Feeling dizzy, lightheaded, faint or unsteady
- [ ] A feeling of choking or difficulty swallowing
- [ ] Fear you will lose control of feel you are going crazy
- [ ] Numbness or tingling sensation or muscle tensions
- [ ] Pulling your hair out
- [ ] Counting too much
- [ ] Repetitive behaviors or rituals
- [ ] Decreased need for sleep
- [ ] Excessive involvement in high risk activities
  (spending sprees, sexual indiscretions, foolish business investments, gambling)
- [ ] More talkative than usual or feeling pressure or keep talking
- [ ] Thoughts are racing because of a flood of ideas
- [ ] Mood swings from extreme happiness to extreme sadness
- [ ] Excessive energy, working on too many projects and unable to finish them
- [ ] Inflated sense of importance
- [ ] Feeling irritable or angry with everyone and everything
- [ ] Hearing voices or strange sounds
- [ ] Seeing things you know are not there
- [ ] Excessive mistrust or suspicion of others
- [ ] Thinking other people are talking about you
- [ ] Thinking God is talking directly to you
- [ ] Thinking the tv or radio has special messages just for you

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	City & State:	Zip Code

Social Security#	Home Phone ( )	Cell ( )	Work ( )

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Email address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate **primary** insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of **secondary** insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize practitioners at Cool Springs Psychiatric Group or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

TREATMENT – SNAP PLAN

We are interested in understanding your Strengths, Needs, Abilities, and Preferences. The information that you provide below will help us work together to develop an individual service plan to meet your needs.

What are your strengths? What do you do well? Examples: Good relationship with family, close friends, spiritual faith, enjoy cooking, taking care of my children, motivation for change, satisfied with my housing/living situation; hard worker, play sports, physically healthy).

STRENGTHS: _____

_____

_____

What are you hoping will be different in your life as a result of coming to therapy? What can therapy provide to help meet your needs?

NEEDS: _____

_____

_____

What are your abilities? Examples: Drawing, writing, painting, athletic ability, gardening, maintaining a job, maintaining my household, parenting skills, good listener, etc.)

ABILITIES: _____

_____

_____

Do you have any specific preference regarding types of service, providers, involvement of family, times for appointments?

PREFERENCES: _____

_____

_____

GOALS: (for the next year)
(How will your life be better?)

1. _____
2. _____
3. _____

OBJECTIVES: (for the next six months)
(What change will you be working on daily/weekly/other regular intervals?)

1. _____
2. _____
3. _____

CONSENT TO TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you would like to discuss.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the Therapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so be mindful about the therapist you select. If you have questions during our process, it is beneficial to discuss them whenever they arise.

APPOINTMENTS & APPOINTMENT CANCELLATION

I normally conduct an evaluation/consultation during your first/Intake appointment. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-50 minute session (one appointment hour of 45-50 minutes duration) at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation. If the appointment is not cancelled, a broken appointment fee of $100.00 will be charged with the credit card on file. To cancel an appointment, you must speak with me, or leave a voicemail or text on 615-538-8017.

PROFESSIONAL FEES

My hourly fee is $150.00 for the initial intake appointment, and $150.00 for therapy appointments, plus $5. Processing fee. In addition to weekly appointments, I charge $150. /hr. for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include: Report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Requests for refunds must be made within 90 days of billing, otherwise the Chart Review Fee is applicable.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have Insurance coverage, which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. (If such legal action is necessary, its costs will be included in the claim.) In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will provide a receipt, if requested at the time of service, for you to file your insurance; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. Read carefully the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be

necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. (Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.) Note that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases) and will become part of the insurance company record. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 8 AM and 5 PM, I do not answer the phone when I am with a patient. When I am unavailable, my telephone, 615-538-8017, may receive text or voicemail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist (psychiatrist) on call. If I will be unavailable for an extended time, the same applies.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged a $150. Chart review fee for any professional time spent in responding to information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a Therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. While this written summary of exceptions to confidentiality is helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. I do not dispense formal legal advice needed because the laws governing confidentiality are complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

I have been explained my rights and responsibilities and privacy practices and may obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.

Signature: _____ Date: _____