NASHVILLE NEUROCARE THERAPY – CLINIC LOCATIONS – PLEASE SELECT PREFERRED TREATMENT LOCATION:

- ◯ **COOL SPRINGS | MALLORY JOHNSON, DNP, APRN, PMHNP-BC** 2001 Mallory Lane, Ste 304, Franklin, TN 37067
- ◯ **GREEN HILLS I ALI WITTENBERG DNP, APRN, PMHNP** 30 Burton Hills Blvd., Suite 360 Nashville, TN 37215
- ◯ **MURFREESBORO | BETHANY ANDERSEN, MSN, APRN, PMHNP-BC** | 1725 Medical Center Pkwy, Ste 215, Murfreesboro, TN 37219

NEW PATIENT FORM - MEDICATION MANAGEMENT

CONTACT INFORMATION

Last Name: _____ First: _____ MI: _____

Preferred name (if different from legal name): _____

Preferred Pronouns: _____

Date of Birth: _______________ Age: _____ Gender: _____

Preferred Phone Number: _____ Email: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Patient Employer/Occupation: _____ Phone: _____

Preferred Pharmacy: _____ Pharm Phone: _____

How did you hear about Nashville Neurocare? _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____

GENERAL

Please describe your present symptoms:

Do you have any drug allergies? ◯ Yes ◯ No

Drug(s)	Reaction(s)

Please list current and past medical and psychiatric medications (including supplements):

Drug	Dose	Reason for taking	Start date

PSYCHIATRIC HISTORY

Have you ever been admitted to a psychiatric hospital? If yes, please describe:

Have you ever seen a psychiatrist or psychiatric nurse practitioner? If yes, who and when was your most recent appointment?

Have you ever seen a therapist? If yes, who and when was your most recent appointment?

Have you ever taken any psychiatric medications? If yes, please list any PREVIOUSLY trialed medications and any negative side effects:

Drug	Dose	Side effects	Start-Stop date

MEDICAL HISTORY

Please list any current or past medical conditions and/or surgeries with the corresponding year:

FAMILY HISTORY

Please describe any family psychiatric or medical history below:

CURRENT PROVIDER CONTACT INFORMATION

Please list current medical providers (primary care, OBGYN, or other relevant specialists):

PROVIDER	ROLE	PHONE

PRESSING THOUGHTS/CONCERNS

Please share any remaining thoughts or concerns regarding your care:

SUBSTANCE USE

Drug Category	Using now?	Age when first used:	Method, how much and how often?	How many years of use?	Last use/ amount
Alcohol	Yes ☐ No ☐				
Nicotine (Cigarettes, JUUL, vape)	Yes ☐ No ☐				
Caffeine	Yes ☐ No ☐				
Cannabis	Yes ☐ No ☐				
Stimulants (methamphetamine, speed, cocaine)	Yes ☐ No ☐				
Amphetamines (Ritalin/Adderall)	Yes ☐ No ☐				
Benzodiazepines (Valium/diazepam, Xanax)	Yes ☐ No ☐				
Sedatives	Yes ☐ No ☐				
Heroin	Yes ☐ No ☐				
Opioids	Yes ☐ No ☐				
Hallucinogens (LSD, mushrooms, ecstasy, nitrous oxide	Yes ☐ No ☐				
Inhalants	Yes ☐ No ☐				
Other:					

REVIEW OF SYSTEMS

In the past month, have you had any of the following problems?

GENERAL
- ☐ Recent weight gain; how much____
- ☐ Recent weight loss: how much____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES
- ☐ Numbness
- ☐ Muscle weakness
- ☐ Joint pain
- ☐ Joint swelling

Where?

EARS
- ☐ Ringing in ears
- ☐ Loss of hearing

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness

THROAT
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw

HEART AND LUNGS
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen legs or feet
- ☐ Cough

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting/loss of consciousness
- ☐ Numbness or tingling
- ☐ Memory loss

STOMACH AND INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Stomach pain
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Blood in stools
- ☐ Black stools
- ☐ Persistent diarrhea

SKIN
- ☐ Redness
- ☐ Rash
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet

BLOOD
- ☐ Anemia
- ☐ Clots

KIDNEY/URINE/BLADDER
- ☐ Frequent or painful urination
- ☐ Blood in urine

Women Only:
- ☐ Abnormal Pap smear
- ☐ Irregular periods
- ☐ Bleeding between periods
- ☐ PMS

PSYCHIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Poor appetite
- ☐ Risky behavior
- ☐ Food cravings
- ☐ Frequent crying
- ☐ Sensitivity
- ☐ Thoughts of suicide
- ☐ Suicide attempts
- ☐ Stress
- ☐ Irritability
- ☐ Poor concentration
- ☐ Racing thoughts
- ☐ Hallucinations
- ☐ Rapid speech
- ☐ Guilty thought
- ☐ Mood swings
- ☐ Paranoia
- ☐ Anxiety
- ☐ Risky behavior
- ☐ Difficulty w/ sexual arousal

OTHER PROBLEMS:

Please list

HIPAA Privacy Rule
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I, _____, (patient's name) understand that this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness_____

Printed Name of Individual or Legal Representative _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____

Electronic Mail (EMAIL) Policy:

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). We cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we will save email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature and please contact the office if you have not received a reply within 48 hours.

*I have read and agree to the terms of the email policy Signature: _____

Medication Refill policy:

Medication refill requests require a 7-day notice. If medication refills are required between appointments, please have your pharmacy send us a refill request. If you need to call for a refill you can do so during posted business hours. Refills will be communicated to your pharmacy within 48 hours during regular business hours. After hours and weekend requests may not be called in until the next business day. Please call with your prescription information and dosage as well as your pharmacy name, location and phone number. We will need this information to complete your refill request.

Insurance Policy:

Nashville Neurocare Therapy / Neurocare Centers of America is contracted with several insurance providers, which you can review at https://nashvilleneurocare.com/insurance-coverage/. We will file your insurance for you and you will be responsible for any deductible or copay as determined by your insurance company.

For all other insurance companies that **Nashville Neurocare Therapy** is out-of-network with we are happy to file your insurance claims for you, however, arrangements for payment in full will need to be made at the time of service, except if your insurance is through Cigna.

Consent to Treatment and Patient/Guarantor Responsibility:

If I choose to have my insurance filed for me, I hereby authorize payment by my insurance company directly to **Nashville Neurocare Therapy.**

I hereby authorize **Nashville Neurocare Therapy** to release any information my insurance company may require concerning patient care in regard to billing or prescription needs.

Patient's Signature: _____ Date: _____

Appointment Charges / Cancellation Policy:

We do not overbook appointments therefore all slots are reserved specifically for the patient. If you need to change or reschedule an appointment, please call our office as soon as you can so we can accommodate other patients who wish to be seen.

We require a 24-hour cancellation notice. Patients will be charged $50.00 if they cancel an appointment within the 24-hour time frame or if they fail to keep their appointment on the day it is scheduled.

Payment Policy:

Payment is required in full at the time of service. We accept credit/debit/checks/cash (please note we do not keep change in the office for cash payments but are happy to put a credit on your account if you do not have exact cash). For your convenience we can keep a credit card on file to charge your deductible, copay or out-of-network payment at your appointments.

Credit/Debit Card Payment for missed or canceled appointments:

I authorize Nashville Neurocare Therapy to charge the below credit/debit card when I do not give advance notice for a late-cancellation or no-show, as per the policies below. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature: _____Date: _____

☐ Visa ☐ Master Card ☐ Discover ☐ AMEX

Name on Card: _____Security Code: _____

Billing Zip Code _____

Card #: _____

Exp. Date _____

Termination of Treatment:

Patients are not obligated to continue treatment. If you decide to terminate at any time, you are encouraged to discuss your decision to terminate care with your doctor.

Emergencies:
To reach your doctor after office hours call the main office at 615-465-4875 and leave a voicemail, your doctor will be contacted and return your call within 24 hours. If you are experiencing an emergency and cannot wait, please call 911.

Patient's Signature: _____ Date: _____

ELECTRONIC SIGNATURE ACKNOWLEDGEMENT AND CONSENT FORM

I, _____ , agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement. I further agree my signature on this document is as valid as if I signed the document in writing. This is to be used in conjunction with the use of electronic signatures on all forms regarding any and all future documentation with a signature requirement, should I elect to have signed electronically. Under penalty of perjury, I herewith affirm that my electronic signature, and all future electronic signatures, were signed by myself with full knowledge and consent and am legally bound to these terms and conditions.

Patient's Signature: _____ Date: _____

COMMUNICATION CONSENT FORM

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Nashville Neurocare Therapy respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. **We will only be using email, text and voicemail to leave you messages confirming your appointment, schedule an appointment, regarding insurance or billing and medical record request.** Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. Nashville Neurocare Therapy will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

Please indicate below what types of correspondence you consent to receive by email or text:

☐ I do not consent to any voicemail, email or texting communication.

☐ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means **(check all that you consent to):**

☐ Email ☐ Text ☐ Voicemail

E-mail address you are consenting to communicate through: _____

Phone number you are consenting to communicate through: _____

Patient Signature: _____ Date_____

Authorized Representative/Guardian Signature: _____ Date_____

NASHVILLE NEUROCARE THERAPY
Phone: (615) 465-4875 | Fax: (615) 472-9479

neurocare Centers of America | Nashville Neurocare Therapy

Nashville Neurocare Therapy
Phone: (615) 465-4875
Fax: (615) 472-9479
www.nashvilleneurocare.com

COOL SPRINGS
2001 Mallory Lane, Ste 304
Franklin, TN 37067

MURFREESBORO
1725 Medical Center Pkwy, Ste 215
Murfreesboro, TN 37219

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD
(Also known as Protected Health Information)

Patient Name: _____ Date of Birth: ____________

Address (Mailing): _____

City: _____ State: _____ Zip Code: _____

Phone: _____

_____

I authorize the release of my protected health information:

To/From: Nashville Neurocare Therapy

To/From: _____

Phone: _____

Information to be released: Intake/Psych eval, Medical records, Diagnoses, Medications w/ doses and durations

Purpose of disclosure: Coordination of Care

This form, when properly completed, permits the release of confidential information about a person receiving services. Any information to be released under this form shall be released in accordance with HIPAA. The records released through this authorization are protected by HIPAA. Further disclosure of this information to parties other than those designated on this form is prohibited without the written consent of the person to whom the information pertains.

1. I understand that information used or disclosed pursuant to this authorization carries with it the potential for an unauthorized re-disclosure which may not be protected by Federal Privacy regulations.
2. I understand that signing this Authorization is voluntary and refusing to will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment.
3. I understand that I may revoke this Authorization by doing so in writing at any time; except to the extent that action has already been taken in reliance upon it, and that the revocation does not affect any information that was released before the revocation. Even if I do not revoke this Authorization, the Authorization expires automatically one (1) year from the date of signature.

Signature: _____ Date: _____

Signature of Parent or Guardian: _____