APPOINTMENT AGREEMENT

I consider your (or your child's) treatment plan important to providing the best possible service. In respect to that principle, and also to my time that will be designated to your needs, I expect that All appointments will be kept. ***Please note that a $50 fee will be charged for late cancellations or no-shows and will be due at the time of the next appointment***. The $50 missed appointment fee is y our responsibility as I cannot charge it to your insurance or EAP company. There will be no fee charged if you provide at least 24-business hours' notice for a cancellation and/or rescheduling of an appointment. *(For example, an appointment on Monday or following a holiday must be cancelled on the previous business day with consideration of the 24-business hours' notice requirement.)* As there is a limited number of appointment slots available, this policy allows us to offer the appointment time to someone else who needs to be seen.

Payment of fees is expected at the time of each appointment. You are not expected to pay the portion of fees that insurance covers. When there is a deductible to meet you are expected to pay the full fee at each visit until the deductible amount is paid in full. *It is important to remember that your insurance may require payment of a new deductible at the beginning of each year. Also, if you change insurance companies, a new deductible may be required by the new company.*

Please note that your therapy (or testing) appointments will last for 50 minutes, and will sometimes be 40-45 minutes for children.

My signature below indicates that I have read, understand and agree to the terms stated above and will continue to force throughout the time that provision of services continue.

Client/Parent/Guardian Signature__________________________________ Date ___________

Witness Signature ____ Date ___________

Therapist's Name: ______________________________ Dx Code: ______________

Referral Source: Description:

Client's Name: ____

Last First Middle

Address: ____

Street Number & Name (Apt #) City State Zip

Home Phone( )_____ - ___________ DOB: _______/_______/_______ SSN:______/______/______

Work Phone( )_____ - ___________ Cell Phone( )_____ - ___________

Client's Employer's Name: ____

Emergency Contact Person:____

Address: Phone (H): - (W) -

Marital Status: ☐ Married ☐ Divorced ☐ Single Client's Gender: ☐ Male ☐ Female

Responsible Party or Insured's Name: ____

Last First MI

Address: ____

Street Number & Name (Apt #) City State Zip

Home Phone( )_____ - ___________ DOB: _______/_______/_______ SSN:______/______/______

Client's Gender: ☐ Male ☐ Female Relationship to insured: ______________________

Insured's Employer's Name: ____

Employer's Office Phone: ( ) -

Insurance Company Name: ____

Insured's Name: ____

Last First MI

DOB: _______/_______/_______ SSN:______/______/______ Relationship to insured: ________________

I give permission for my therapist to collect monies from and communicate directly with my Insurance Company about me.

Signature:____

Client's Physician's Name: ______________________________ Phone ( )________________

Have you ever been treated by a Counselor/Therapist before Yes No

HOUSEHOLD MEMBERS (Including the client)

Name	Birth Date/ Age	Employer/ School	Occupation/ Grade	Religious Affiliation	Education Level

RESPONSIBLE PARTY : I understand that I am financially responsible for payment of all charges made during the course of treatment and agree to pay as treatment progresses. Should I default on payment, I understand my balance is subject to collections and I am also responsible for the collections charges. (*TennCare members are exempt from this financial responsibility).*

Signature:____ **Date:** ______________

Revised: June 2006

YOUR RIGHTS AND RESPONSIBILITIES

You have the right to good treatment - to be treated nicely, no matter what your state of mind or condition. You have the right to be cared for and not be neglected, abused, have your feelings hurt or be yelled at.

You have the right to privacy.

You have the right not to be exploited: That is, your provider cannot use you or your case for her or his own personal gain.

You have the right to treatment no matter your age, race, sex, religion, ethnic background or handicap. If this provider cannot treat you for any reason, you have the right to be referred to a provider who can and will treat you.

You have the right to know your diagnosis, how your problems will be treated and what you can expect during the term of treatment.

You have the right to make choices about your care. If a particular treatment is known to be dangerous (except in emergencies) you will be given all the information you need to make a good decision about your treatment.

You have the right to refuse treatment. If you say, "No", to a particular treatment, you have the right to know what might happen with and without the treatment.

You have the right to see your records. You have the right to have your records treated confidentially, in accordance with the laws.

You have the right to plan and help decide the kinds of future mental health care you receive if you get sick and cannot tell someone (for example, living wills, power of attorney, guardianship).

You have the right to file a complaint/grievance with your provider or the Health Related Boards about your services or care given to you. You cannot get in trouble if you file a complaint/grievance.

You have the right to treatment in the proper place. You won't be sent to a hospital for inpatient treatment if all you need is a therapist. The best location and level of care will be discussed.

If you have questions or do not agree with your treatment plan, you should discuss it with your provider.

You have the responsibility to be on time for all appointments with your provider.

You have the responsibility to give information to your provider if it's needed for your care.

You have the responsibility to give your opinions, concerns or complaints about your health care and these rights and responsibilities to your provider.

Signed:____ Date:____________________

Complete Counseling

Clinician's Name: ___________________________

Receipt of "Notice of Privacy Practices"
Written Acknowledgment Form

I, ____, have received a copy of Complete
Client's Name (please print)

Counseling's "Notice of Privacy Practices", version 2004.

____ ___________________
Client's Printed Name **Client's Date of Birth**

____ ___________________
Client's Signature **Today's Date**

"Notice of Privacy Practices" Form (continued)

Client's Name: _____________________________________

In case of an emergency, change of appointment, or other important information, how may we contact you?

Home Phone: ______________________ May we leave a message on answering machine or voice mail? Yes No

Cell Phone: ________________________ May we leave voice mail message? Yes No

Work Phone: _______________________ May we leave a message? Yes No

Other Phone: _______________________ For this phone, please write detailed instructions below:

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Client Signature: ________________________________

Complete Counseling
Permission to Treat Client

Check Here if Adult ☐ **Check Here if Minor Child ☐**

Name:_______________________________________ **Date of Birth:** _______________________
Last First MI

Social Security Number: _________ _______ _________ **Phone:** ___________________________

Address: ____
Number & Street City State Zip

If the above-named is a minor child (age under 18), complete this section and sign below.

Name of Parent/Legal Guardian: ____

Social Security Number: _________ _______ _________ **Date of Birth**__________________

Address: ____
Number & Street City State Zip

Home Phone: _________________________ **Work Phone** __________________________________

PERMISSION TO TREAT ADULT CLIENT: My signature below indicates that I give full legal permission to be treated.

____ **Date:** ____________________
Adult Client Signature

OR

PERMISSION TO TREAT MINOR CHILD (Under age 18): My signature below indicates that I give full permission to treat my minor child.

____ **Date:** ____________________
Parent/Legal Guarding Signature if Client Under 18

Witness: ____ **Date:** ____________________

Therapist ____

North Location: 2507 Mineral Springs Ave, Suite C, Knoxville, TN 37917• TEL 865-688-0661• Fax 865-688-5780
West Location: 11808 Kingston Pike, Suite 100, Knoxville, TN 37934 • TEL 865-688-0661• Fax 865-392-5760

Complete Counseling

RELEASE FROM / NOTIFICATION TO PRIMARY CARE PHYSICIAN OR OTHER MEDICAL PROFESSIONAL

THIS IS NOT A REQUEST FOR MEDICAL RECORDS

To:_________________________ **Phone:**____________________ **Fax:**______________________

Address:____

Re:____ **Date of Birth:**__________________________

From: ______________________________________ **Location:** North West

If you have any pertinent information regarding this person, please forward it to the therapist at the address listed below. Also needed are results of EPSDT screening on patients 20 and younger. If requested information is more that two (2) pages, please MAIL rather than fax. Thank you.

First Request for EPSDT Information, Date: ____________________________
Second Request Date: ___________________
Third Request Date: ____________________

______ I hereby freely, voluntarily and without coercion, authorize the behavioral health clinician indicated above to release the information contained on the form to the clinician/facility identified above. I also consent to other necessary communication between the be behavioral health provider indicated above and the clinician/facility identified above. The purpose for exchanging information is to provide continuity and coordination of care. This agreement is valid for one year. I understand that I may revoke my consent at any time.

______ I do not wish to have information shared with:

_____ My PCP/Medical Provider _____ My other behavioral health clinicians/facilities
_____ I am not currently receiving services from a PCP/ other medical practitioner
_____ I am not currently receiving services from any other behavioral health clinician/facility

____ **Date:** ____________________
Signature (If child, legal guardian signature)

____ **Date:** ____________________
Clinician Signature

NOTICE TO PERSON RECEIVING THIS INFORMATION: The information disclosed as a result of this authorization is released to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR OFFICE USE ONLY:
The patient is being treated for the following diagnoses:___________________________________
Date Treatment Began: _____________________

North Location: 2507 Mineral Springs Ave, Suite C, Knoxville, TN 37917 • TEL (865)688-0661• FAX (865)688-5780
West location: 11808 Kingston Pike, Suite 100, Knoxville, TN 37934 • TEL (865)688-0661• FAX (865)392-5760

Revised October 2007

Complete Counseling
Dovile Paulauskas, MD

Adult Intake Form

Client's Name____

Date of Birth __________________________ **Today's Date**_________________________

Referral source____

Please describe the concerns / problems that triggered this visit/consult:

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Previous Psychiatric Care

Please list past diagnoses (such as Depression, Bipolar, Anxiety, OCD, Schizophrenia, Schizoaffective, ADHD, etc)

Please list prior psychiatrists (if any)

Have you ever been in therapy or counseling? Please list therapists and dates:

Have you ever been hospitalized for behavioral / mental problems? Please provide the information below:

Hospital	Date	Length	Triggers

Have you ever been treated with medication for the above problems? Please list the names below:

Name of Medication	Dose	Length	Benefit

Are you taking any medication at this time? Please list below:

Name of Medication Dose Length Benefit

Have you ever been abused (sexually or physically) or neglected? If, yes, please explain:

Does anyone in your blood relatives have any Mental Disorders or Substance Abuse History? If yes, please list the diagnoses:

Mother's side of the family Father's side of the family

Do you have any medical problems or chronic illnesses? If yes, please list below:

Diagnoses Medication

Any prior Surgeries?

Head traumas?

Seizures ?

Heart problems ?

Drug Allergies ?

Please provide your current employment status:

Please list previous jobs:

Thank you for taking the time to fill out this form.