ADULT INFORMATION SHEET

Provider: Sharon L. Bryant, PhD

Today's Date: _____

Full Name (first, middle initial, last):_____

Street Address:_____

City/State/Zip:_____

Home Phone:(____)_____ Work Phone:(____)_____

Cellular Phone:(____)_____ Pager:(____)_____

Age:_____ Birthdate:_____ Sex:_____ Social Security #:_____

Occupation:_____ Employer:_____

Marital Status:_____ Date Married:_____ Previous Marriages?:_____

Education:_____ Religion:_____

Spouse's/Partner's Name:_____

Street Address:_____

City/State/Zip:_____

Home Phone:(____)_____ Work Phone:(____)_____

Cellular Phone:(____)_____ Pager:(____)_____

Age:_____ Birthdate:_____ Sex:_____ Social Security #:_____

Occupation:_____ Employer:_____

Education:_____ Religion:_____

In case of emergency, call_____

Phone: (____)_____ Relationship to you:_____

There may be occasions in which our office needs to contact you concerning your appointments, billing problems, or any other situation relating to your visit at our office. Please indicate if you give our office permission to leave messages (on an answering machine or with anyone that answers the phone) at the following locations:

Home Phone:	Yes	No
Work Phone:	Yes	No
Cell Phone:	Yes	No

Other numbers we may use to contact you:_____

_____

List children:

Name	Age	Education	Occupation	Resides

List parents/siblings:

Name	Relationship	Age	Education	Occupation	Resides

Who referred you?_____ Phone:(____)_____ May I contact him/her to acknowledge the referral? YES NO

Briefly describe your reason for seeking help now:_____

_____

How long has this been a problem for you?_____

Primary Care Physician:_____ Phone ( ) _____

Do you want this office to file insurance claims for you? YES NO
If "YES," complete this section. If "NO," skip this section.

Have you called your insurance company to pre-authorize these services? YES NO

Primary Insurance:_____ Policyholder:_____

Relationship to Policyholder:_____ Policyholder's Date of Birth:_____

Policy/ID#:_____ Group #:_____

Claims Address:_____

_____

Secondary Insurance:_____ Policyholder:_____

Relationship to Policyholder:_____ Policyholder's Date of Birth:_____

Policy/ID#:_____ Group #:_____

Claims Address:_____

_____

Are you experiencing any legal problems? YES NO (If YES, please explain) _____

_____

Who is responsible for the bill?_____

Will you be paying today by: Check_____ Cash_____ Credit Card_____

THANK YOU for completing this questionnaire. *PLEASE* let me know if any of the above information changes.

PROFESSIONAL PSYCHOTHERAPY ASSOCIATES
1002 Bradford Way Kingston, TN 37763
Phone (865) 376-1585 FAX (865) 376-1587

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Sharon Bryant, Ph.D. to release to my insurance company and/or insurance plan management company information requested on the HCFA-1500 claim form and/or the plan management company's outpatient treatment report for the purpose of pre-authorizing services and/or processing claims for reimbursement of services rendered by above-named therapist. I also authorize above-named therapist to release the information necessary to secure full payment of my account through other parties, such as a collection agency/credit bureau or court of law, if my account becomes delinquent.

Date:_____ Patient or Guardian's Signature:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and direct my Insurance Company and/or insurance plan management company to pay Sharon Bryant, Ph.D. such amount as may be payable pursuant to the provision of my contract.

I also authorize above-named therapist to initiate a complaint to the Insurance Commissioner on my behalf if my insurance company fails to respond to a claim or to pay a claim in a timely fashion.

Date:_____ Patient or Guardian's Signature:_____

PAYMENT AGREEMENT

I accept responsibility for payment of fees for services provided to myself and/or my dependent by Sharon Bryant, Ph.D.. I understand and agree that having health insurance coverage does not relieve me of full responsibility for all charges, even when the therapist agrees to accept direct payment of benefits from the insurance and/or the plan management company. I understand that my insurance benefits may not pay for all charges incurred by my dependent or myself. I understand that I may be charged for appointments not canceled 24 hours in advance and agree to pay those charges. I further agree to pay all charges (such as collection agency commissions, attorney's fees, court costs, returned check charges) incurred by above-named therapist in the pursuit of payment for my delinquent account balance in addition to the full balance of my account. I also understand that interest charges may accrue on delinquent account balances and agree to pay such charges if my account becomes delinquent.

Date:_____ Patient or Guardian's Signature:_____

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information . Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can do protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Sharon L. Bryant, PhD
Clinical Psychologist

I, _____, understand and have been provided a copy of Dr. Bryant's Patient Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____
Patient Signature or Parent if Minor or Legal Charge Date
If Legal Charge, describe representative authority: _____

CLINICAL ASSESSMENT SURVEY

Name: _____ Date: _____

Provider: _____

Below is a list of difficulties people sometimes experience. Please read each one carefully and mark the most appropriate answer.

	How often were your troubled by:	not at all	occasionally	moderately	quite often	very frequently
		1	2	3	4	5
1	Your feelings being easily hurt by others					
2	Feeling lonely					
3	Feeling fearful					
4	Thinking others are to blame for your troubles					
5	Nervousness, shakiness, or unsteadiness inside					
6	Problems remembering things					
7	The idea that something is wrong with your mind					
8	Feeling afraid when you are in open spaces					
9	Feeling guilty					
10	Feeling tense					
11	Thinking that others can control your thoughts					
12	Having thoughts of killing yourself					
13	Being easily annoyed or irritated					
14	Thinking that you cannot trust most people					
15	Feeling no interest in activities you used to enjoy					
16	Feeling like your eating is out of control					
17	Experiencing temper outbursts that you cannot control					
18	Your mind suddenly going blank					
19	Becoming scared for no reason					
20	Feeling that people dislike you					
21	Having to check over what you do several times					
22	Feeling inferior to other people					
23	Arguing frequently					
24	Feeling uneasy or nervous when alone					
25	Feeling like you couldn't sit still					
26	Feeling an urge to break things					
27	Feeling worthless					
28	Thoughts of death or dying					
29	Thinking you should be punished					
30	Experiencing difficulty making decisions					
31	Having trouble falling asleep					
32	Feeling others are watching or talking about you					
33	Feeling like you had to avoid certain things or places because they scared you					
34	Feeling hopeless					
35	Experiencing difficulty concentrating					
36	Feeling like you wanted to injure or harm someone					
37	Experiencing spells of terror or panic					
38	Thinking that people will take advantage of you if you let them					
39	Feeling physically weaker than normal					
40	Feeling others are not giving you the credit you deserve					

MEDICAL REVIEW FORM

NAME _____ DATE _____

FAMILY PHYSICIAN _____ PHONE _____

REASON FOR LAST PHYSICAL EXAM _____ APPROXIMATE DATE _____

Have you ever been treated for or had indication of: (underline applicable items and explain in space below).

[A] High blood pressure, hypoglycemia, diabetes, anemia or any other disorder of the blood.

[B] Chest pains, shortness of breath, heart attack, stroke, rheumatic fever, heart murmur, irregular pulse or other disorders of the heart or blood vessels.

[C] Disorders of the thyroid, skin, or lymph glands.

[D] Sugar albumin, blood or pus in the urine, or syphilis, gonorrhea or other sexually transmitted disease.

[E] Any disorder of the kidney, bladder, prostate, breast, or reproductive organs.

[F] Ulcer, chronic indigestion, intestinal bleeding, hepatitis, colitis, diarrhea, or other disorders of the stomach, intestine, rectum, spleen, pancreas, liver, or gall bladder.

[G] Asthma, tuberculosis, bronchitis, emphysema, or other disorders of the lung.

[H] Fainting, convulsions, tension or migraine headaches, paralysis, epilepsy, memory loss or confusion or any disorders of the brain or nervous system.

[I] Arthritis, gout, back pain, or other disorders of the muscles, bones, or joints.

[J] Disorders of the eyes, ears, nose, throat, or sinuses.

[K] Other physical illnesses or concerns.

[L] Problems related to alcohol, prescription medication, non-prescription medication, smoking or drugs.

Have you noticed any recent changes in your (A) vision, hearing, coordination, balance, strength, speech, memory, or thinking; (B) changes in energy, sleeping, eating, elimination, menstrual cycle, sexual activity/interest. Please underline any changes.

Please list all allergies: _____

_____

Please list type and approximate dates of all surgeries: _____

_____

_____

_____

Please list all prescription medicines you are currently taking: _____

_____

_____

Please list all non-prescription medications you routinely use: _____

_____

History of significant accidents: _____

_____

_____

Additional notes regarding personal or family medical/psychiatric history (use reverse side if necessary):

SHARON L. BRYANT, PH.D.
CLINICAL PSYCHOLOGIST

In preparation for your initial appointment, I would like to provide you with a brief introduction to answer questions you may have about office procedures and what to expect from today's appointment. People seek counseling or psychotherapy for many different reasons – marriage or family problems, job or financial stress, depression, anxiety, or traumatic events in the present or past, to name a few. The appropriate course of treatment depends on the nature and history of your personal concerns, so today's session will focus on obtaining information about your reasons for seeking therapy and relevant background information. Please try to be as frank and direct as you can in expressing your concerns, as this will allow us to be more effective in working together to formulate a helpful treatment approach. Also, please do not hesitate to ask any questions you have about office or billing procedures or the process of therapy itself. Should you decide to end treatment, please discuss this with me in advance so closure, resolution of any misunderstandings, or possible referrals can be made.

The confidentiality of the therapy process is protected by state and federal law. This means that anything discussed or disclosed in the course of treatment will be held in strictest confidence. Should you wish me to release information to a third party, I will obtain your written consent to do so. That consent may be revoked by you at any time.

There are several circumstances under which a psychologist may be required to release information without patient consent: 1) if the psychologist has clear reason to believe that a patient poses imminent bodily danger to him or herself or to a specific third person; 2) if the psychologist has reason to believe that a minor child is being or has been abused or neglected; 3) if a judge specifically orders the release of records; and 4) under the Patriot Act, we may disclose your health information to authorized federal officials who are conducting national security and intelligence activities in providing services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government.

Attached to this Patient Agreement Form is the newly required **Notification of Patient Rights** document now required with the passage of federal "medical records privacy law" known as **HIPAA** (Health Insurance Portability and Accountability Act). I am required by law to give you a copy of this document and to secure your signature indicating you have received a copy of it. Laws such as these are important, but complex and in my **Notification of Patients Rights** document I have tried to inform you about your rights in plain, simple language. Please read the contract and do not hesitate to ask me about any questions you might have about these matters.

If you wish to use insurance to assist with treatment costs, please note that many insurance and managed care organizations require either limited or full release of clinical information to authorize payment of claims and to document medical necessity for services provided. The information required may be limited to diagnosis and dates of service or may be as extensive as on-site review of all records included in your designated record set. Please feel free to speak with me or to contact your insurance carrier or managed care organization if you have questions about these procedures. Your sense of privacy is very important for successful treatment, so I strongly encourage you to raise any concerns you have about confidentiality or its limitations.

For routine messages, you may leave a message for me at my office **[(865)-376-1585], extension 103** . For an urgent message, please contact the secretary at my office during regular business hours or leave a message on my voice mail and follow the prompts so that I may be notified quickly. In the event that I am out of town or otherwise unavailable, my voice mail greeting will advise you of the name and number of the clinician who is providing emergency coverage. You may also seek emergency treatment at any time by dialing 911 or consulting your area hospital Emergency Room.

Fees will be discussed in your initial session. If you wish to pay for sessions on a fee-for-service basis, full payment is expected at the time of the appointment unless other arrangements are made. MasterCard and Visa payment options are available also. If you wish to use you health insurance to help with the cost, co-pay and deductible payments are expected at the time of the appointment. You will be responsible for any unpaid balance with the exception of circumstances or fees specified in provider agreements with your insurance or managed care company. Statements are issued once monthly. Should you have any questions regarding your statement or insurance claim, please contact Ms. Debra Patterson, office manager, at (865) 376-1585. I recognize that from time to time circumstances may arise which impact one's capacity to meet payments on the agreed upon schedule. Should this occur, please let me know. I will be happy to work with you on a payment plan which is manageable for you. However, in the event a good faith effort is not made toward payment for services, I reserve the right to turn delinquent accounts over for collection.

Appointment times are reserved specifically for you, and 24 hours notice is requested if you are unable to keep a scheduled appointment. You may leave a message at (865) 376-1585 extension 103 if you must cancel a scheduled appointment. Should you fail to give such a notice, a half-fee charge will apply which will not be reimbursed by insurance.

I hope this information is useful in explaining basic policies. Please keep a copy of this document for your records. Your signature below indicates that you have read and understand the above information. Your signature acknowledges your informed consent for care and that you are aware that the mental health profession is not an exact science and that psychological care, like other things in life, offers no absolute guarantee of success. Please feel free to discuss any of these matters with me in more detail.

Patient	Witness	Date

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