New Patient Information **Talking with Dr. Toy P.C.**

545 Mainstream Drive, Suite 420, Nashville, TN 37228 Phone: 615-722-7026

Please provide the following confidential information. Please Print. Today's Date _____

Client Information

Name _____ Preferred Name _____
First Middle Last

Address _____
Number Street City State Zip

Home # _____ Cell # _____ Work # _____

Social Security Number _____ Date of Birth _____ Age _____

Sex: M F Other or Gender Identity _____ (Specify if comfortable)

Race/Ethnicity _____ Country of Origin _____

Disability Status (if applicable) _____

Religious Affiliation or Spiritual Practice (if applicable) _____

Employer _____ Job Title/Occupation _____

Work Address _____
Number Street and Suite (if applicable) City State Zip

Military History (if applicable) _____

Branch _____ Military Job _____ Type of Discharge _____

Active Combat Yes No Exposure to Chemicals Yes No Traumatic Brain Injury Yes No

Relational Status: Single Partnered Married Committed Separated Divorced Widowed Other Length of current relationship _____

Dates of Previous Marriage(s) or Committed Relationship(s) _____

_____

Dependant(s) Name(s)/Age(s) _____

Who may I thank for referring you _____

Emergency Contact

Name _____Relationship _____

Contact # _____ Alternate Contact # _____

Address _____
Number Street City State Zip

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Medical Information

Primary Care Physician _____Date of Last Exam _____

Psychiatrist (if applicable) _____Date of Last Appointment _____

Do you have any medical problems or history of medical problems? Yes No If yes, please explain

_____

_____

_____

Current medications & dosage (Prescription/Herbal/Other) Prescribed by

_____

_____

_____

_____

Listing of prior treatment:

Beginning with the most recent, please list all professionals (psychologist, psychiatrists, counselors, social workers, pastoral counselors etc.,) and facilities (hospitals, alcohol & drug programs, clinics etc.,) that have provided psychological evaluation and/or treatment.

Type of Service	Provider	Dates of Service

Has anyone in your family (blood relatives) ever been diagnosed with a mental illness? _____

_____

_____

_____

Has anyone in your family ever attempted or committed suicide? _____

_____

_____

_____

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Briefly describe the problems/reasons that bring you here _____

_____

_____

_____

Legal Problems _____

_____

_____

Financial and/or housing problems _____

_____

_____

What would you like to achieve and/or see happen by coming here for care? _____

_____

_____

_____

_____ _____

Signature Date

_____

Print Name

_____

Name of Minor/Dependent (if applicable)

_____ _____

Clinician/ Therapist Signature Date

_____

Print Clinician/Therapist Name

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To allow for double
sided copies

545 Mainstream Drive, Suite 420 Nashville, TN 37217 Phone: 615-722-7026

Client Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

Home Telephone # _____

___ OK to leave message with detailed information ____ Leave message with call back number only

Work Telephone # _____

___ OK to leave message with detailed information ____ Leave message with call back number only

Cell Phone # _____

___ OK to leave message with detailed information ____ Leave message with call back number only

Email Address _____

___ OK to email this address

Home Written Communication

____OK to mail to home address with counselor's name in the return address

____OK to mail to my home address with return address only, no name

Appointment Reminders

_____ I wish to receive email reminders about upcoming appointments to the above email address.

_____ I wish to receive text message reminders about upcoming appointments at the above cell number.

Emergency Contact

Name _____ Phone _____

Relationship to you _____ Address _____

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. I cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, you should consider that our electronic communications may not be confidential and will be included in your therapy chart. Never send emails of an urgent or emergent nature and please contact me by phone if you have not received a response within 24 hours.

NOTE: USES AND DISCLOSURES MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

_____ _____ _____

Patient signature (or parent) **Print Name** **Date**

_____ _____ _____

Counselor **Print Name** **Date**

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WELCOME: I want you to have a positive and growth promoting experience here. I have designed this disclosure statement to inform you about me and about your rights as a client. I ask that you sign the form to verify you have received this information. You will also be asked to complete several necessary documents. Please take time to read carefully along and feel free to ask questions.

Professional Qualifications: I am a Licensed Professional Counselor that is committed to your care. In order to provide you with the best care possible. I may consult other experts on treatment issues without the use of identifying information. I have a Masters of Education in counseling as well as Ph.D. in communication. My education has prepared me to provide counseling services to individuals, groups, parents, families, youth and teens.

Services Available: I provide individual, family, couples and group assistance. I am committed to helping individuals and families increase their self-understanding and their ability to live rewarding and productive lives through specialized therapeutic services. These services include, but are not limited to: problem solving; communication, coping skills building techniques; parent education; grief/loss; decision making; management of thoughts, feelings and behaviors.

My approach is considered "integrated" meaning I assist clients utilizing a variety of strategies to best fit their needs. I use "strengths focus", psychoanalytic, psychodynamic and cognitive-behavioral strategies to improve your relationships to self and others. These strategies focus on identifying internal conflicts, becoming aware of and changing maladaptive patterns of approaching your personal, social, academic/work life. I view each client in a person-centered, culturally sensitive manner, recognizing their strengths and resources to find solutions to ongoing positive growth.

Services are provided to any individual regardless of race, color, national origin, age, sex, religious preference, sexual orientation, disability or income level.

Working Relationship: For the work to be effective, I ask you to make a commitment to the process which includes participating in sessions and making sure you show up for scheduled appointments.

I usually spend the first session asking questions about you, your history and your relationships as well as exploring feelings and concerns about changes you want or decisions you want to make. This helps me to make a good assessment of your strengths and needs. This initial assessment is very important to help you learn more about yourself in the context of your culture and family and thus I schedule 1 hour for the initial assessment interview. After the assessment, we will, together, write an action plan that states what we will be working on and how we will be spending our time and how we will know if we are making progress. At the end of each session, we will summarize what we have discussed and the goals that we have agreed upon.

We will meet weekly, or as scheduled for up to 50 minutes. (This is considered 1 hour). We use the other 10 minutes for writing notes, making phone calls and doing other follow up relating to your session. The number of sessions varies with each person and their concerns. After I understand your concerns, we will discuss the number of sessions needed.

As your therapist, I will be available at our scheduled times and will also attempt to help you in case of an emergency.

Initials _____

If your phone number or address changes, please notify my office of these changes. You may contact your therapist by voice mail at _____ which is available 24 hours a day and it is our preferred method of communications since we cannot guarantee confidentiality of anything sent via email. If it is ok to leave a message for you, we will do so.

Contact will be limited to sessions that you arrange with your therapist except in emergency situations. You will be best helped if we concentrate solely on your goals and concerns so we ask that you don't invite us to social events, offer gifts or ask us to relate to you in any way other than our working relationship.

Effects of Counseling: Counseling is a voluntary act. There are benefits to therapy but we cannot guarantee specific results. Therapy is a personal exploration that may lead to major changes in your life due to your perspective and decisions. These decisions may affect your relationships and your understanding of self. Some of the changes may be stressful. We cannot predict the exact nature of your change but we will work together to achieve the best possible results.

Client's Rights: As a client (or the guardian of the client) you have the right to:

- Be respected.
- End our working relationship at any time although I ask that you participate in a termination session
- Refuse or discuss modification of any therapeutic techniques or suggestions that you believe may not be helpful.
- Receive services that do not discriminate against you on any basis and is sensitive to your gender, race, ethnicity, national origin, language, age, disability, sexual orientation, religion and income level.
- Understand reasons for making suggestions or using particular procedures. Please ask questions for clarifications.
- Be free of any mistreatment from me such as harassment or sexual misconduct.
- Review records.

I vow my services will be rendered in a professional manner consistent with legal and ethical standards. At any point if you are dissatisfied with the service, please let me know. If you feel that you have received unfair treatment due to race, color, national origin, age, religious preference, sexual orientation, disability or income level, you may file a complaint with the State of Tennessee Division of Health Related Boards at 615.532.5133

Crisis/Emergencies: If you ever feel you are in crisis and you need to talk to someone right away but are unable to reach us due to the time and nature of the crisis, you can call the Crisis Intervention Center at 615.244.7444 or Mobile Crisis at 615.726.0125 (Davidson County), 800.704.2651 (Rutherford County) and talk with a Crisis Counselor. You may go to an Emergency Room or a local hospital for assistance. Tell them the nature of your emergency and a crisis plan will be developed.

Referrals: At times, I may suggest you talk with another professional such as a physician, psychiatrist or another therapist. Referrals will be discussed with you and you will have choices in the matter.

Initials _____

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Cancellation: Your session is reserved for you. If you arrive more than 15 minutes late for an appointment, you risk not being seen and will need to reschedule. If you are unable to make an appointment, I ask that you notify me at least 24 hours in advance, however I understand that emergencies sometimes occur. A message can be left during the day or after hours at 615.722.7026 if a session needs to be cancelled. If you are absent for two (2) consecutive sessions, I may ask what might be blocking your participation and what is needed to assist you.

Fees: Fees are dependent upon insurance, co-pay or self-pay. 45 minutes is the standard length of a session following the initial assessment interview. The initial assessment interview is scheduled and billed as 1 session. Additional charges will take effect beyond 60 minutes. An occasional 5 – 10 minute telephone call is manageable as part of the services provided, but longer calls can only take place within the therapist's available time. Fees for this service will apply after 15 minutes as with a session.

A $30 fee will be charged for the first no-show or late cancellations (less than 24 hours) except in the case of illness or an urgent/emergency situation. The second no-show or late cancellation will be billed at the full price of your session

A $35 fee will be charged for any check that is returned.

Records and Confidentiality: I will keep anything you tell me in strictest confidence unless:

- I have your permission to tell someone and you provide me consent for release of information.
- I consult about your concerns and how I might proceed in order to help you.
- You tell me you are going to harm yourself or someone else.
- My records are ordered by the court.
- You are a minor and you report to me neglect, child or elderly abuse, sexual abuse, victim or subject of crime.
- You are a minor; I may discuss with your parent(s) or guardian(s) some of the information from our sessions.
- You report elder abuse.

All of our communication becomes part of a clinical record but you have the right to view the information within your record.

If I see you in public, I will protect your confidentiality by conversing with you only if you approach me first.

Thank you for your interest in my services. I am looking forward to the opportunity to working with you.

Please note: There is not supervised childcare during client sessions. If it is necessary for you to bring your child(ren) to your appointment, please ensure that a responsible adult accompanies you to supervise the child(ren) and to ensure that they remain in the designated waiting area.

Initials _____

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Please sign below indicating that you have read and understood your rights and responsibilities, fee policy, are willing to abide by these guidelines and are wishing to seek services under these conditions.

_____

_____

Client Signature Print Name Date (parent/guardian if client is a minor)

_____

Client Signature Print Name Date (2nd client/spouse)

_____

Therapist Signature Print Name Date

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

For your treatment. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist (inside practice), I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me and Authorization to do so.

To obtain payment for your treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me and Authorization to do so.

For health care operations. I can use and disclose your PHI for purpose of conducting health care operations pertaining to my practice, including contacting your when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is

a. For my use in treating you.

b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law, and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2**. Marketing Purposes**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. **Sale of PHI**. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to ob-tain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS REGARDING YOUR PHI. You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. **The Right to Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. **The Right to See and Get Copies of Your PHI**. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.

5. **The Right to Get a List of the Disclosures I Have Made**. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.

6. **The Right to Correct or Update Your PHI**. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. **The Right to Get a Paper or Electronic Copy of this Notice.** You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES. If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and phone number are:
545 Mainstream Drive, Suite 420, Nashville, TN 37228 615.722.7026

You can also file a complaint with the State of Tennessee Division of Health Related Boards at 615.532.5133.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE This notice went into effect on July, 2017.

545 Mainstream Drive, Suite 420, Nashville, TN 37228 Phone: 615-722-7026

By law, I am required to secure your signature indicating that you have received this Patient Notification of Privacy Rights document.

PATIENT NOTIFICATION OF PRIVACY RIGHTS

I _____ UNDERSTAND AND HAVE PROVIDED A COPY OF Talking With Dr. Toy P.C. 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 that I have the right to review this document before signing this acknowledgment form.

_____ _____
Client's Signature Date

_____ _____
Parent Signature or Legal Guardian or Legal Charge Date

_____ _____
Counselor's Signature Date

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sided copies

Authorization for Release of Information **Talking with Dr. Toy P.C.**

545 Mainstream Drive, Suite 420, Nashville, TN 37228 Phone: 615-722-7026

RE: Name: _____ SSN: _____ Date of Birth: _____

Address: _____

_____

City State Zip Code

I hereby authorize the release of the following specific information (check all items):

YES	NO		
		1	Psychological test reports
		2	Psychiatric evaluation reports
		3	Periodic reports of current mental health counseling
		4	Social history data including family, education, employment, arrest, drug and alcohol information
		5	Summary of previous mental health treatments
		6	Specify:

FROM/TO (circle one) Talking with Dr. Toy P.C. 545 Mainstream Drive, Suite 420, Nashville, TN, 37228
615.722.7026 (P)

FROM/TO (circle one) _____
Name of Individual or Agency

Address: _____

_____

City State Zip Code Phone

I understand that this information will be used for the following specific purposes (check all items):

YES	NO		
		1	To determine service most appropriate for client's needs
		2	To develop a diagnosis and treatment plan for counseling
		3	To facilitate coordination of services
		4	Specify:

I understand information may not be re-disclosed by either agency to any other individual or agency without my written consent or by court order. I further understand that if release is required by law, the agency will have to comply. As detailed in our Notice of Privacy Practices, this authorization may be revoked at any time by my written statement, and it is automatically revoked at the end of 90 days or under the following specific condition(s): _____

This consent for release of information is given freely, voluntarily, without coercion or as a condition of treatment.

_____ _____

Signature of client (parent/guardian, if applicable) Signature of therapist

_____ _____

Signature of client (minor, if applicable) Date

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Fee Agreement Form—Insurance **Talking with Dr. Toy P.C.**

545 Mainstream Drive, Suite 420, Nashville, TN 37228 Phone: 615-722-7026

Client Name	**DOB**	**SSN**

1. Policy Holder Information

Client relationship to policy holder Same Spouse Child Other _____

Policy holder name Same Name (If different from client) _____

Policy holder DOB (if different from client) _____

Policy holder SSN (if different from client) _____

Policy holder Address _____
Number Street City State Zip

Policy holder's employer _____

Name of Insurance Company or BHO _____

Group # _____ ID# _____

Phone number for verification of benefits _____ _____

2. The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to the counselor. I understand that I am financially responsible for any balance. I also authorize Talking with Dr. Toy P.C. or the insurance company to release any information to process my claims.

Client Signature _____ **Date _____**

Insurance Verification and Authorization (outpatient mental health coverage) FOR OFFICE USE ONLY

Pre Auth required Yes No	Authorization #	Covers Group? Yes No
Auth. Effective date _____	Auth. End date _____	Spoke with _____
Procedure Code_____	Number of Visits _____	
Procedure Code_____	Number of Visits _____	
Outpatient coverage Yes No	If yes, Effective Date _____	
Pre-existing clauses _____		
Limits (if appl) _____	Visits _____	
Deductible $ _____	Has deductible been met? Yes No	
	If NO, how much has been met $_____	
Co-Pay Amount $ _____	Covers LPC? Yes No	
Mail claim to _____		

Administrative Approval _____ **Date _____**

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