The Starting Place

2790 N Highland Ave Suite B
Jackson, TN 38305
Office (731) 445-0089 Fax (731) 732-4083 www.thestartingplacetn.com

We want to take a moment to thank you for entrusting us with your health and well-being. *The Starting Place* strives to provide therapeutic services that encompass emotional, mental, and spiritual components. Our mission is to bring the love of Christ to those we meet which therefore will bring life and healing in the lives of those we come in contact with. The staff at *The Starting Place* feels it is not our place to judge or condemn others but to meet each person where they are and be a support as they move from where they are to where they are going.

Our four Core Values include:

- Provide Sound, Christ centered, evidence based treatment to every client
- Uphold the standards set forth in our respective Code of Ethics
- Manage our lives in such a way as to be a witness and an example of the love of Christ
- Manage the agency in a way that reflects the Mission Statement and these Core Values

In order to assure a productive first visit please review and complete the attached forms prior to your initial appointment. The initial appointment will flow more easily if I have the opportunity to review these documents prior to your appointment. If at all possible, please mail or fax your completed paperwork AND bring the original copy to your first appointment.

Address: The Starting Place
2790 N Highland Ave Ste B
Jackson, TN 38305

Email: thestartingplacetn@gmail.com

Appointment Scheduling

Please schedule, cancel, and reschedule all appointments by contacting us at (731) 445-0089. A 24 hour notice is required to avoid a $100 charge for cancelled appointments.

INFORMATION SHEET

PATIENT INFORMATION

Date: _____

Name: _____

Address: _____

_____

Home Phone: _____

Birthdate: _____

Soc. Sec. #: _____

Emergency Contact: _____

Phone #: _____

Employer: _____

School/Grade: _____

Work Phone: _____

Occupation: _____

Relationship to Insured: _____

Marital Status: Married ☐ Sep ☐ Div ☐ Widow ☐ Single ☐ Co-Habit ☐

PRIMARY INSURANCE INFORMATION

☐ self ☐ parent ☐ spouse ☐ guardian

Name _____
Last First M.I.

Address _____
(if different)

_____

Home Phone _____
(if different)

Birthdate _____

Soc. Sec. # _____

Insured's Employer _____

Work Phone (____)_____

Insurance Co _____

Plan Name _____

Insured's ID # _____

Policy Group # _____

RESPONSIBLE PARTY/SECONDARY INSURANCE

☐ self ☐ parent ☐ spouse ☐ guardian

Insured's Name _____
Last First M.I.

Address: _____
(if different)

_____

Home Phone: _____
(if different)

Birthdate: _____

Soc. Sec. #: _____

Insured's Employer _____

Work Phone (____)_____

Insurance Co. _____

Plan Name _____

Insured's ID # _____

Policy Group # _____

Authorization to Release Information: I authorize the release of any medical or other information necessary to process Insurance claims.

_____
Signature Date

Authorization to Pay Benefits to Provider: I authorize payment of benefits directly to the therapist for the services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

_____
Signature Date

CLIENT REPORT OF PROBLEM

Name _____ Today's Date _____ Case # _____

Briefly describe your reason(s) for seeking help

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

History of treatment for emotional problems and family history

Outpatient treatment ☐ yes ☐ no
Did it help ☐ yes ☐ no

Therapist's name _____
Dates in treatment _____

Inpatient treatment ☐ yes ☐ no

Where _____

When _____

How long _____

Family history of emotional problems ☐ yes ☐ no

Who _____

Relationship to you _____

Check any of the following items that apply to you:

- ☐ Thoughts of suicide
- ☐ Trouble getting to sleep
- ☐ Waking during the night
- ☐ Waking early every day
- ☐ Financial problems
- ☐ Loss of appetite
- ☐ Hearing voices
- ☐ Problems at work
- ☐ Trouble concentrating
- ☐ Racing thoughts
- ☐ Legal problems
- ☐ Thoughts of harming others
- ☐ History of attempts to kill yourself
- ☐ Cutting or otherwise hurting yourself
- ☐ Feelings of hopelessness
- ☐ Inability to make decisions
- ☐ Trouble controlling your temper
- ☐ Large weight gain or loss
- ☐ Seeing things others don't
- ☐ History of physical abuse
- ☐ History of sexual abuse
- ☐ Phobias
- ☐ Panic attacks
- ☐ Excessive quilt
- ☐ Forgetfulness
- ☐ Mood swings
- ☐ Health problems
- ☐ Family problems
- ☐ Violence toward others
- ☐ Tingling or numbness
- ☐ Depressed mood

(Please complete the other side of this form)

Health Status

List any medical problems or physical problems and when they were diagnosed

1.
2.
3.

List any major (where you were put to sleep) surgeries you have had to date

1.
2.
3.

List any serious illness or injuries especially anything involving the head

1.
2.
3.

List ***any*** allergies to foods or drugs

1.
2.
3.
4.

Date of last physical examination _____ Doctor's name _____

May we contact your doctor? ☐ yes ☐ no

Drug and Alcohol Information

List all of the prescription and over-the-counter drugs you are taking

Check substances you use <u>in any amount at</u> all

	Age first used	How much do you use per: Weekday	Weekend	Month	Last used
☐ Beer					
☐ Liquor					
☐ Wine					
☐ Marijuana					
☐ Cocaine/Crack					
☐ Methamphetamine/Crystal					
☐ Heroin					
☐ Barbiturates (downers)					
☐ PCP, LSD (Hallucinogens)					
☐ Tobacco (in any form)					
☐ Other _____					

To be completed by adults (18 yrs and older)

Have you ever felt like you should cut down on your drug or alcohol use? ☐ yes ☐ no

Has a friend or relative expressed concerns about your use? ☐ yes ☐ no

Have you ever felt guilty about your drinking or drug use? ☐ yes ☐ no

Have you ever had to take a drink or use a drug the next day to steady your nerves? ☐ yes ☐ no

Are you a recovering alcoholic or a recovering drug addict? ☐ yes ☐ no

Is there a history of problems with drug or alcohol use in your family? ☐ yes ☐ no

To be completed by adolescents (12 yrs to 17 yrs)

Have you ever used alcohol or drugs before or during school? ☐ yes ☐ no

Have you ever missed school (or been truant) because of use or just to use? ☐ yes ☐ no

Have you ever avoided non-users? ☐ yes ☐ no

How often do you get drunk/high? _____

About how often do you use more than one drug when you get high? _____

Is there a history of problems with drug or alcohol use in your family? ☐ yes ☐ no

_____ _____

Therapist Date Client signature Date

MEDICATION LOG

Provider/Facility:

NAME: _____

TELEPHONE #: Home _____

Work _____

ALLERGIES: Drug _____

_____

_____

Other _____

_____

FAMILY DOCTOR: _____

TELEPHONE #: _____

OTHER PRESCRIBED MEDICATION (include use of over the counter and/or herbal drugs):

_____

_____

_____

_____

PHARMACY:

_____ (#) _____

NOTES: _____

DATE	DRUG/DOSE	#	RE	SMPL	DR	CALL	PHARMACY/TIME

Mental Health Disclosure Forms

Treatment Philosophy - Explanation of Brief Therapy

Brief therapy is goal-directed, problem focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. A treatment plan is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time efficient manner. You will take an active role in your treatment goals. Your commitment to a treatment plan is necessary for you to experience the most successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask. **Initial here:** _____

Confidentiality

All information between practitioner and patient is held strictly confidential. This means that we will not discuss the details of your case or your presence with anyone without your expressed written consent. The legal exceptions to this would include:

- Suspected abuse or neglect of a child or elder
- Patient presents a danger to self or others
- Patient's mental condition becomes an issue in a lawsuit
- Children under the age of 16 (family's confidentiality will be protected)

If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling center. **Initial here:** _____

Release of Information

I authorize the release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information for claims, certifications, case management, quality improvement, benefit administration and other purposes related to my health plan. **Initial here:** _____

Confidential Record Requests

In the event records are requested, a treatment summary of the general medical notes will be given. Writing such a summary will require a fee at the hourly rate and is not reimbursable by insurance companies. This does not include disability claims; this office will no longer submit any information for disability claims. **Initial here:** _____

Financial Terms: Insurance Coverage and Copayments

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance, however, you are responsible for co-payment amounts and deductibles as set by your benefit plans, these amounts will be collected at the time of visit. Missed appointments are not covered by insurance and the charges associated with them are your responsibility.

At any time during treatment should you become ineligible for insurance coverage, you will notify the practitioner and you understand you will become responsible for 100% of the charges. You also understand if you are self-pay, you are required to pay at time of visit. **Initial here:** _____

Cancellation and Missed Appointment Policy

Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than a 24 hour notice, you will be billed a $100.00 fee, your insurance company cannot be billed. Repeated "no-show" appointments will not be given a standing appointment. This may also result in referring you back to the insurance company for reassignment to another practitioner. **Initial here:** _____

Contact Information

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at thestartingplacetn@gmail.com. Please remember however, that this form of communication is not appropriate for use in an emergency. Our office does not maintain an answering service, **if you are experiencing a mental health emergency at any time during your treatment, it is your responsibility to contact the crisis unit at Pathways, (731) 541-8258, go to the nearest emergency room or call 911. Initial here:** _____

Consent for Treatment

I authorize and request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures which now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the

outcome of my treatment. Furthermore, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. **Initial here:** _____

_____ _____

Patient/Guardian Signature

_____ _____

Practitioner/Witness Signature as needed

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the patient and on the patient's behalf I legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____ _____

Patient Name **Patient Social Security #**

_____ _____

Signature of Legal Guardian/Legal Representative **Date**

_____ _____

Relationship to Patient **Benefit Plan Subscriber Name**

_____

Mental Health Benefit Plan

By signing below, I understand that I will be financially responsible for any damages caused by _____

Patient Name

_____

Signature of Legal Guardian/Legal Representative