Chris Driscoll, LCSW
Westside Psychology & EAP
301 Gallaher View Road*Suite 102 *Knoxville, Tennessee 37919
Phone: (865) 690-0962 Fax: (865) 690-0995

Client Information

Name: _____ Age:_____ Birth date: _____

Sex: M ☐ F ☐ Home Phone*_____Work Phone* _____

Cell Phone* _____ Email _____

Education _____ Employer _____

Occupation _____ Social Security No. _____

Address

_____
(STREET) (APT #)

_____
(CITY & STATE) (ZIP CODE)

Marital Status S ☐ M ☐ W ☐ D ☐ Sep. Date _____ Prev. Marriages _____

**** Only list numbers where it is ok for you to receive phone calls.***

Spouse/Partner Information __ N/A

Name: _____ Age:_____ Birth date: _____

Sex: M ☐ F ☐ Home Phone*_____Work Phone* _____

Cell Phone* _____ Email _____

Education _____ Employer _____

Occupation _____ Social Security No. _____

Is it ok to release information such as billing inquiries or appointment times to your spouse or partner? Yes ☐ No ☐

Emergency Contacts

Name _____

Relationship _____Phone _____

Name _____

Relationship _____Phone _____

Parents, Siblings and Children ___ N/A

Name	Relationship	Age/DOB	Grade/Occupation	Residence

Medical Information

Do you have any medical conditions? Yes ☐ No ☐ Please explain_____

_____

Do you take regular medications? Yes ☐ No ☐ If so, what? (List below)

Name of medication	Dose	Prescribed by

Do you smoke? Yes ☐ No ☐ If so, how much?_____ Years?_____

Do you drink alcohol? Yes ☐ No ☐ If so, how much? _____ How often?____

Have you seen a counselor before or been in a psychiatric hospital? If so, please list:

Type of Mental Health Service	Provider	Date

If you have had previous counseling, was it helpful? Why or why not?_____

_____

Current or expected legal involvement? Yes ☐ No ☐ Please explain_____

_____

What are your leisure interests? _____

_____

What do you consider to be your strengths? _____

_____

Briefly describe the problems that bring you here. _____

_____

_____

What would do like to accomplish by coming here (goals)? _____

_____

_____

Referral Information

Who referred you for services? _____

Do you have a psychiatric advanced directive? Yes ☐ No ☐ **If yes, explain and provide documentation to the staff at your initial appointment.**_____

_____

Primary Care Physician _____Phone: _____

Do you want your therapist to automatically send your personal information to your physician such as your diagnosis, specifics about your troubles, counseling goals, etc.? Yes ☐ No ☐
If yes, please sign the Authorization to Use and Disclose Protected Health Information with the PCP (primary care physician) at the end of this packet. Please note that if you check "No," you can always ask your therapist release specific information to your PCP by signing a release at a later date.

Insurance

Would you like us to bill your insurance for you? Yes ☐ No ☐ ***If yes, please make sure we have a copy of your card.***
Have you called your insurance company for authorization (if required)? Yes ☐ No ☐ ***If yes, please provide the insurance authorization information to the front office staff.***

Employee Assistance Program (EAP)

Does your employer provide Employee Assistance Program (EAP) benefits? Yes ☐ No ☐
If so, have you obtained an EAP referral for this visit? Yes ☐ No ☐ ***If yes, please provide the EAP authorization information to the front office staff.***

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Client Information and Practice Policies

Effective communication is a cornerstone of good relationships. In order to answer questions frequently asked by clients regarding fees, confidentiality, and services, we have developed these policy statements for your information and discussion. Please talk with Mr. Driscoll or his staff about questions you might have. We will make every effort to develop a professional relationship that will be satisfactory to everyone.

***Fee Policy*:**
The fee is $105 per session, with sessions lasting about 45-50 minutes. It is customary to pay professional fees at each visit. This simplifies procedures and minimizes costs. For your convenience, Master Card, Visa, and Discover are accepted. We do not accept American Express.

Fees for services provided for children of divorced parents will be charged to the parent requesting and arranging for the services. We will cooperate as needed to assist with reimbursement from ex-spouses who share financial responsibilities for children's medical expenses.

***Appointments and Scheduling*:**
Mr. Driscoll has office hours Monday through Saturday. Appointments are scheduled with the office staff. The telephone number is (865) 690-0962.

As a courtesy to his patients, Mr. Driscoll offers re-occurring appointments to his patients. If you would like to schedule appointments in advance for the same time of day, same day of the week, please let our front office know. They are able to schedule ten appointments in advance. Please note that if you 'no-show' or late cancel two pre-booked appointments, your remaining pre-booked appointments will be cancelled and you will need to call the front office to reschedule. You will need to check with the front office periodically to ensure that these appointments stay pre-booked. Please request an appointment card when you schedule.

Inquiries regarding charges, account balances, insurance filing, etc. are handled by Lea Motlow, our Billing Manager. She can be reached at 828-484-8195.

Cancellations and No Shows:
It is requested that, if you are unable to keep your scheduled appointment, you cancel 24 hours in advance. I keep a cancellation list for clients who are waiting on appointments. The advanced notice allows me to offer the cancelled appointment to someone on the waiting list. Late cancellations and missed appointments are charged $20, and the insurance company will not reimburse this charge. Exceptions are made for circumstances, such as illness, which are beyond your control. Because Mr. Driscoll believes that consistency and commitment are part of the therapeutic process, two (2) no-shows and multiple cancellations may result in dismissal from services.

***Insurance Reimbursement*:**
Your health insurance may provide reimbursement for mental health services. Consult your policy for specifics. If you are unsure of coverage, we can obtain verification from your insurance carrier if you provide us with the necessary information. Please consult our office manager concerning verification of insurance coverage.

As a service, we will file your insurance claims for you. We will need you to complete the insurance information form that we will give you at this visit. You will need to assign benefits to us as the provider, which allows the insurance carrier to reimburse us directly. After you assign the insurance benefits to us, we ask that your estimated portion of the payment be made at the times services are rendered. Please be aware that, in the process of filing for insurance reimbursement, you are required by the insurance

carrier to authorize release of information to them concerning diagnosis, service provided, and--in the case of managed care policies--clinical information and treatment plans. If you are concerned about confidentiality in the context of third party payment, please consult your insurance carrier and/or raise the issue for discussion with Mr. Driscoll.

***Confidentiality*:**
Tennessee law provides strict protection for clients seeking mental health services: all information regarding services is controlled by the client and is not to be released to anyone without the client's written authorization. There are, however, two exceptions in which mental health professionals may be required to breach the rule of confidentiality. First, when in an emergency there is imminent danger to the client or other person(s), the mental health professional must act so as to protect the lives of those involved and may breach confidentiality to assure such protection. Second, in cases of child abuse, mental health professionals are required to act so as to protect the child form ongoing abuse and must breach confidentiality, if necessary, to do so.

***Credentials*:**
Chris Driscoll is a Licensed Clinical Social Worker in the State of Tennessee, with competence in the area of clinical social work. A copy of his vita is available upon request. Mr. Driscoll adheres to statutes of the State of Tennessee, Ethical Principles of Social Work, and other policies of the National Association of Social Workers.

HIPAA Notice of Policies and Practices to Protect the Privacy of Your Health Information:
As healthcare professionals, we are required by state and federal laws (including HIPAA) to maintain the privacy of your health information. Though all clinicians at Westside Psychology & EAP are independent practitioners, we share a commitment to adhere to a set of common privacy policies. Your confidence in us to strictly protect your privacy is extremely important to us. Posted in the office is Chris Driscoll's Notice of Privacy Practices. You may request an individual copy at any time. This Notice of Privacy Practices describes how Chris Driscoll, LCSW may use and disclose your protected health information as well as your rights to access and control it. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health and related health care services.

Your signature below acknowledges your review and understanding of these policies.

_____ _____
Signature of Client or Guardian Date

If a guardian, please indicate your relationship to the client:
_____

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Your Informed Consent to Care:
We have provided this information to you in the hope of fully informing you about the policies of our office and some of the parameters of care you will receive here, such as the importance of confidentiality. *Psychiatric and psychological care, like other things in life, offers no absolute guarantee of success and there are limitations to any form of care offered a client.* I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider's license, certification and training. If the patient is under the age of sixteen or unable to consent to treatment, I attest that I have legal custody of this individual and/or am authorized to initiate and consent for treatment on behalf of this individual. The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions. Since such limitations are always a function of the particular problem in question, we invite you to discuss your treatment plan with Mr. Driscoll. Moreover, your treatment plan will be specifically tailored to your individual needs and *we urge you to actively discuss your treatment plan with Mr. Driscoll so* that you have a sense of direction regarding the care you are receiving.

Please feel free to discuss any of these matters with us in more detail. By signing below, you acknowledge having read, understood, and agree to these policies and procedures. Your signature acknowledges your informed consent for care with your or your child's therapist and your understanding that you may terminate treatment at any time.

_____ _____
Signature of Client or Guardian Date

If a guardian, please indicate your relationship to the client:
_____

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Insurance Verification and Acknowledgment

I certify that the insurance information given by me is correct. I authorize the release of any information regarding my examination or treatment necessary to process the insurance claim. I authorize the release of pertinent information required by my Managed Care Company for Treatment Plans and Summaries of Care. I authorize the payment of benefits to the provider for services provided.

_____ _____
Signature of Client or Guardian Date

Contact Preferences

How would you like us to communicate with you?

I may be contacted as follows:

_____ Home Telephone: (_____) _____
_____ OK to leave information with other house members
_____ Speak to client ONLY
_____ Leave call-back number only
_____Work Telephone: (_____) _____
_____ OK to leave message with information
_____ Speak to client ONLY
_____ Leave call-back number only
_____ Cell Phone: (_____) _____
_____ OK to leave message with information
_____ Leave call-back number only

In case of emergency, please contact: _____

Home Number: (_____) _____
Work Number: (_____) _____
Cell Phone: (_____) _____
Relationship to Patient: _____

_____ _____
Signature of Client or Guardian Date

If a guardian, please indicate your relationship to the client: _____

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Client Rights and Responsibilities

As a client of Chris Driscoll, LCSW, you have the following rights and responsibilities:

Rights

- You have the right to be treated with consideration, respect and dignity. To be protected from abuse or neglect.
- You have the right to fair treatment. This is regardless of race, religion, gender, ethnicity, age, disability, or source of payment. 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 have information about you and the services received kept private unless the law says the information must be released to someone.
- You have the right to know your diagnosis, how your problems will be treated and what you can expect during the term of treatment. These things should be explained you to you in a way you can understand.
- You have the right to be involved in planning your treatment including knowing about your treatment options and what may happen if you do not follow your plan of treatment.
- You have the right to be treated in the setting that is best for you and least confining.
- You have the right to refuse treatment as long as you do not put yourself or others in danger.
- You have the right to decide in advance what kind or treatment you would want in the future if you were to become unable to tell someone what you would want. Any advanced directives need to be shared with your treatment provider and will be included as a part of your treatment record.
- You have the right to see your records unless your provider thinks that would be harmful.
- You have a right to have your records treated confidentially, in accordance with the laws.
- You have the right to make a complaint concerning a violation of any rights listed here or concerning any other matter, and a right to be informed of the procedures and process for making such a complaint.

Responsibilities

- You have the responsibility to treat those giving you care with dignity and respect.
- You have the responsibility to give your provider the information needed to deliver the best possible care.
- You have the responsibility to ask questions about your care so you can understand your treatment and your role in that care.
- You have the responsibility to participate in the development of your plan of care and follow your treatment plan.
- You have the responsibility to keep all appointments and to be on time. You should call the office as soon as possible if you need to cancel an appointment. This allows others the opportunity to use the time. You will be asked to sign and adhere to an office attendance policy.
- You have the responsibility to let us know of any special arrangements you might need due to a disability or special condition.
- You have the responsibility to respect others' confidentiality. Please keep confidential any information (including identity) about others who might be seeking treatment at Westside Psychology & EAP.
- You have the responsibility to let us know if your name, address, phone number, financial status, or information changes.
- You have the responsibility to make payments for all services in a timely manner,
- You have the responsibility to let us know if you do not plan to return for services. If you plan to discontinue services, please let your treatment provider, practice manager, or receptionist know.

- You have the responsibility to participate in your child's treatment (if applicable). You will be asked to give consent for treatment and to participate in the development and implementation of your child's treatment plan.
- You have the responsibility to assist us in coordinating your care with any outside provider. Your treatment provider can explain to you why this communication would be beneficial.
- You have the responsibility to notify your treatment provider if a crisis or emergency situation exists. A crisis plan will be developed as an initial treatment goal so you are aware of the steps to take and resources available in the event of a crisis or emergency.
- You have the responsibility to discuss your opinions, concerns or complaints about your health care and these rights and responsibilities with our provider.

I have reviewed and discussed the above rights and responsibilities with my provider, Chris Driscoll, LCSW.

Client: _____ Date: _____

Parent/Guardian: _____ Date: _____

Clinician: _____ Date: _____

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Authorization to Use and Disclose Protected Health Information with the PCP

1. I am completing this form to allow the use and sharing of Protected Health Information about:
   Printed Name:_____Date of Birth:_____
2. I authorize this person or organization: Chris Driscoll, LCSW with Westside Psychology & EAP 301 S. Gallaher View Road, Suite 102, Knoxville, TN 37919
   a. To use or disclose the following information:
   Complete copy of the medical record
   Outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness Treatment plans
   Social, family, educational, and vocational histories
   Social work assessments and plans
   Progress, case or similar notes
   Information about how the patient's condition(s) affects or has affected his/her ability to work, and to complete tasks or activities of daily living
   HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here:
   DO NOT RELEASE THESE Signature:_____

   Other:_____
   b. Dates of care included: From _____ to end of treatment
3. To my Primary Care Physician: _____
   _____
   _____
   Phone:_____ Fax:_____
4. The information will be used/disclosed for the following purposes: medication coordination, psychiatric and medical treatment and notification.
5. I understand and agree that this authorization will be valid and in effect until end of treatment. I understand that after that event, this information cannot be released unless I send a new authorization.
6. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Chris Driscoll, LCSW who is to supply this information. This revocation will prevent any releases after the date it is received but cannot change the fact that some information may have already been sent or shared before that date.
7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at #2 above, nor will it affect my eligibility for benefits.
8. I understand that I may inspect a copy of the health information described in this authorization
9. I affirm that I have a clear understanding of the contents and purpose of this form.
   _____ Date: _____ **Signature of patient (or parent/legal guardian)** _____
   Printed name of patient (or parent/legal guardian)
   Relationship to patient:
   _____

   I, as a mental health professional, have discussed the issues above with the client and/or his/her personal representative. My observations of his/her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.
   _____ Date: _____ **Signature of professional**
   _____
   Printed name of professional