805 S Church Street
Suite 20
Murfreesboro, TN 37130

TUCKER-HUGGINS & ASSOCIATES

1114 N Main Street
Suite B
Shelbyville, TN 37160

Initial Client Intake

NAME:(first)	(middle init)	(last)
DOB: ____/____/____	Age:	SSN:
GENDER: MALE FEMALE	MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED	
STREET ADDRESS:		
CITY:	ST:	ZIP:

CONTACT INFORMATION

EMAIL ADDRESS:	May we Email you? Yes No
PRIMARY PHONE:	May we call/text/lvg vm? Yes No
SECONDARY PHONE:	May we call/text/lvg vm? Yes No

EMERGENCY CONTACT INFORMATION

NAME:	RELATIONSHIP:		PHONE:
STREET:	CITY:	ST:	ZIP:

INSURANCE INFORMATION **** This MUST be completed even though we have a copy of your card.****

INSURANCE PROVIDER:	ID NUMBER:
SUBSCRIBER NAME:	GROUP NUMBER:
SUBSCRIBER DOB:	REL TO SUBSCRIBER: SELF SPOUSE CHILD

OCCUPATIONAL INFORMATION:

EMPLOYER NAME:	POSITION:
WORK HOURS:	LENGTH OF EMPLOYMENT:
WORK STRESSORS:	
MILITARY HISTORY: Yes No	MILITARY DETAILS:

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious?	If yes, what is your faith?
Do you consider yourself to be spiritual?	Do you attend church regularly?
If so, where?	
Do you wish for your counseling experience to include a Christian perspective?	

Please indicate the reason for your visit today:

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MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN:	PHONE:
PSYCHIATRIST:	PHONE:
SPECIALIST:	PHONE:

LIST ANY MAJOR MEDICAL PROBLEMS SURGERIES, HOSPITIZATIONS, ALLERGIES

(1)	(3)
(2)	(4)

MEDICATION	DOSAGE	MEDICATION	DOSAGE
(1)		(4)	
(2)		(5)	
(3)		(6)	

MENTAL HEALTH TREATMENT HISTORY: Please list any previous psychological/psychiatric services & related information

Type Of Service	Dates Of Service	Provider	Reason for Service

HEALTH AND SOCIAL INFORMATION

How is your current emotional health?	Poor Unsatisfactory Satisfactory Good Very good		
Abortion	Past and/or Present	Panic Attacks	Past and/or Present
Adoption	Past and/or Present	Paranoia/Overly Suspicious	Past and/or Present
Alcohol/Drug Use	Past and/or Present	Poor Memory	Past and/or Present
Anxiety	Past and/or Present	Racing Thoughts	Past and/or Present
Bedwetting	Past and/or Present	Rage/Anger	Past and/or Present
Body Image Issues	Past and/or Present	Repetitive Behaviors/Thoughts	Past and/or Present
Depression	Past and/or Present	Risky Behavior	Past and/or Present
Eating Issues	Past and/or Present	Sexual Dysfunction	Past and/or Present
Excitability	Past and/or Present	Sleep Disturbances	Past and/or Present
Extreme Mood Shifts	Past and/or Present	Social Shyness	Past and/or Present
Fatigue	Past and/or Present	Suicidal Attempts	Past and/or Present
Guilt/Shame	Past and/or Present	Suicidal Thoughts	Past and/or Present
Hallucinations	Past and/or Present	Stress	Past and/or Present
Harm to Self / Others / Animals	Past and/or Present	Unexplained losses of time	Past and/or Present
Headaches	Past and/or Present	Victim of Violence/Trauma	Past and/or Present
Impulsivity	Past and/or Present	Worthlessness	Past and/or Present
Nightmares	Past and/or Present	Other:	Past and/or Present

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How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

Are you currently in a romantic relationship? □ No □ Yes

On a scale of 1-10, how would you rate the quality of your current relationship? _____

List any significant life changes or stressors in the past year: _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Diagnosis		Family Member(s)	Diagnosis		Family Member(s)
Depression	Yes / No	_____	Bipolar Disorder	Yes / No	_____
Anxiety Disorders	Yes / No	_____	Panic Attacks	Yes / No	_____
Schizophrenia	Yes / No	_____	Substance Abuse	Yes / No	_____
Eating Disorders	Yes / No	_____	Learning Disabilities	Yes / No	_____
Trauma History	Yes / No	_____	Suicide Attempts	Yes / No	_____

THIS SECTION TO BE USED ONLY WHEN NEW CLIENT IS A MINOR CHILD *(under 18yrs old)*

Biological parents are: Married Separated Divorced Other **Child resides with:**

Legal Guardian:_____ **County of Jurisdiction:** _____

Parenting Plan?_____Yes (*If yes, a copy is required by the next appointment*) ____No

DCS Involvement? __Yes __No **Previous Abuse Issues?** ___Yes____No **Circle all that apply:** Emotional Physical Sexual

Name of school: **Grade:**

Are any legal proceedings currently pending that involve the minor child? _____**Yes** _____**No**

Do you foresee needing our services for court? _____**Yes** _____**No**

I assert that this information is correct to the best of my knowledge and ability.

_____ _____

Signature Date

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Informed Consent to Treatment

I,_____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at TUCKER-HUGGINS & ASSOCS, hereby referred as the Provider. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, pre-licensed counselor or intern in collaboration with his/her supervisor. I also acknowledge that interns and pre-licensed individuals will have cameras in treatments rooms so that supervisors may view, in real time, current sessions. The rights, risks and benefits associated with the treatment have been explained to me. I understand either party may discontinue therapy at any time. The clinic encourages that this decision be discussed with the treating therapist. This will help facilitate a more appropriate plan for discharge.

Client's Rights and Responsibilities: I certify that I have received the Client's Rights information and certify that I have read and understand its content.

Expectations: Counseling is based o the relationship you develop with your counselor. Every case is unique, but generally you can expect the following:

- Education: You can expect some information and education about what you are facing.
- Assignments: Homework is a vital part of making the most of your counseling process.
- Client Centered: You can expect to have topics that revolve around you and your concerns.
- Sharing: You will be asked questions and there is an expectation that you will openly share your thoughts and feelings.
- Discovery: Expect to examine yourself through looking at your thoughts, feelings, and behaviors.
- Length of Treatment: Sessions last 45-50 minutes. In most cases, therapy will last a minimum of 10 sessions.
- Frequency of Appointments: One session per week is typical but can be adjusted to meet individual needs.
- Interruptions: It is in your best interest to have uninterrupted care. Time between sessions can substantially lessen the desired effects of treatment.

Non-Voluntary Discharge from Treatment: A client may be terminated from the Provider non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter.

Client Notice of Confidentiality: Federal and/or State law and regulations protect the confidentiality of patient records maintained by the Provider. Please refer to the Privacy of Information Policy that addresses all matters of confidentiality.

Risks: Therapy is very safe, but there are some risks. The biggest risk is the result of change. Change can have an undetermined impact on your life and in significant relationships. Another risk is emotional pain or anxiety but should be elevated with continued treatment.

Benefits: Change is also the most significant benefit of therapy. You will learn new way of interacting, thinking, and behaving. Often changes will result in the reduction of problems and reported symptoms prior to therapy.

About your Counselor: As you review this form with your counselor, he/she should explain their individual counseling style. This should include qualifications, approach to therapy, school of thought, and other information. If you have any questions, now or later, feel free to ask your counselor.

I consent to treatment and agree to abide by the above stated policies and agreements with TUCKER-HUGGINS & ASSOCIATES.

_____ _____
Signature of Client *or* Legal Guardian (for clients under 18) Date

_____ _____
Therapist Date

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Client's Bill of Rights Notification

As a recipient of services at our facility, we would like to inform you of your rights as a patient.

YOUR RIGHTS AS A PATIENT:

1. Complaints. We will investigate your complaints.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil Rights. Federal and state laws protect your civil rights.
4. Cultural/spiritual/gender Issues. You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment. You have the right to take part in formulating your treatment plan.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
8. Availability of records. You have the right to obtain a copy and/or inspect your protected health information; however we may deny access to certain records in which we will discuss this decision with you.
9. Amendment of records. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. Medical/Legal Advice. You may discuss your treatment with your doctor or attorney.
11. Disclosures. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

YOUR RIGHTS TO RECEIVE INFORMATION:

1. Costs of services. We will inform you of how much you will pay.
2. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our clinic.
3. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.
4. Policy changes.

OUR ETHICAL OBLIGATIONS:

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will appropriately end services or refer clients to other programs when appropriate.
6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
7. We hold respect for various institutional and managerial policies but will help improve such policies if the best interest of the client is served.

PATIENT'S RESPONSIBILITIES:

1. You are responsible for your financial obligations to the clinic as outlined in the Payment Contract for Services.
2. You are responsible for following the policies of the clinic.
3. You are responsible to treat staff and fellow patients in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.
5. Therapy is an individual process for which you will need to assume responsibility for making changes.
6. In order to receive the greatest benefit, you need to be actively involved in the treatment process. Goal setting, assignments, and talking are all important and critical to treatment success.
7. Treatment is voluntary and you may end counseling at any time without fear of penalty.
8. You can expect to be treated with respect.

WHAT TO DO IF YOU BELIEVE YOUR RIGHTS HAVE BEEN VIOLATED:

If you believe that your patient rights have been violated, contact our Recipient's Rights Advisor or Clinic Director.

Signature:_____ Print Name: _____

Date:_____ Signed by: __client __guardian __personal representative

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This *Notice of Privacy Practices* describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related care services.

I. Uses and Disclosures of Protected Health Information Requiring Authorization

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

II. Treatment

We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

III. Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

IV. Health Care Operations

We may use or disclose, as needed, your protected health information in order to support the business activities, employee review activities, and training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to a medical school student that sees patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law; Public Health Issues as Required by Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers Compensation, Inmates and Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization and opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing; except to the extent that your physician or the physician's practice has taken an action previously on the use or disclosure indicated in the authorization.

V. Complaints

You may complain to use or to the Secretary of Health and Human Services if you believe your privacy rights may have been violated. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

VI. Effective Date

This notice shall go into effect October 1, 2013 and will remain so unless new notice provisions effective for all protected health information are enacted accordingly.

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YOUR RIGHTS: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your provider is not required to agree to a restriction that you request.

If the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communication from us by alternative means or an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Signature:_____ Print Name: _____

Date:_____ Signed by: __client __guardian __personal representative

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Practice Policies and Disclosure

- **Cancellation Policy**
  - Cancellations require a minimum of 24 hours' notice. Any cancellation made less than 24 hours prior to the scheduled appointment will be automatically assessed a fee of $65. Your counselor may permit a one time "excuse" and waive the fee. However, the fee may not be waived more than once.
- **Text Messge/Email Reminder**
  - Appointment reminders will be sent 48 hours in advance of your scheduled appointment. You may choose to have these delivered via text message or email. The default choice is that of text message. Should you prefer to have your reminders sent via email, please notify your provider.
- **Credit Card Processing/Payment**
  - It is a requirement to have a credit card on file with our office. Should there be No Show charges for an appointment, those fees will be assessed to your card immediately. For additional information on how cards can be charged, please refer to the Payment Contract for Services.
- **Payment Policy/Sliding Scale Fee**
  - It is required that all co-pays or deductibles be made at the time of service, prior to the beginning of the session. Should it not be clear as to the amount of the co-pay or deductible, clients will be required to pay a fee of $75 per session until the insurance has responded with accurate totals.
  - Sliding scale fees are available for services performed by THA associates. Income tax returns and/or paycheck stubs will be required to receive the sliding scale fee. This fee will be reassessed no less than once per year.
- **Filing of Insurance**
  - THA files insurance only as a courtesy. We are only in network with Amerigroup, however, we often accept the out of network rates of several companies which results in a reduced rate for our clients. Each policy is different and because we are not in network, we cannot guarantee your insurance's reimburse rate with us. You are responsible for the full fee of services unless otherwise noted.
- **Supervision of Pre-Licensed Providers**
  - Pre-licensed providers will be under the supervision of Laura L. Tucker-Huggins, LPC-MHSP or another supervisor approved by Ms. Huggins. During the course of supervision, the supervisor will consistently review session progress notes, videoed session tapes, and/or be physically present in sessions. The purpose is to provide feedback to counselors, assist with client treatment, and ensure best interest for all concerned.
- **Uses of Video/Surveillance Equipment**
  - Video and surveillance equipment is used throughout the building. Cameras are located in the waiting room so that counselors may check for the arrival of clients as well as ensure the safety of those in the waiting room. Additionally, cameras are located in counseling offices to allow for real time supervision of pre-licensed counselors and interaction from the supervisor should it be required.
- **Office Etiquette and "Quiet Zones"/Cell Phone Policy**
  - Please refrain from using your cell phone within the waiting room, hallways, or counseling rooms of THA. THIS SHOULD BE CONSIDERED A QUIET ZONE. All conversations are to be contained within the counselors' offices, NOT in hallways or common areas.
- **Minor Supervision**
  - Minors under the age of 16 are not permitted to be on the premises without parental/adult supervision. Should there be an emergency, any minor should have access to the adult who transported them to their session.

My signature represents acknowledgements of these policies and disclosures and my willingness to abide by the rules set forth within.

Signature:_____ Print Name: _____

Date:_____ Signed by: ___client ___guardian ___personal representative

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Payment Contract for Services

By signing the Payment Contract for Services, you acknowledge and agree to the following fees and policies.
If you utilize insurance coverage, the fee will be adjusted according to the contracted rate.
We file your insurance as a courtesy to you.
Should your insurance fail to reimburse for services, you will be responsible for the full amount due.

Description of Service	Amount	Insurance Estimate
Initial Intake and Assessment Appointment	$135.00/Hr	
Counseling Services:Indv/Family/Marriage	$120.00/Hr	
Late Cancellation or No Show for Appointment	$65.00 Each	WILL NOT COVER
Phone Calls (Client/Atty/Med Providers/Etc.)	$50.00/15 Min	WILL NOT COVER
Completed Paperwork (Disability/Ins/Etc.)	$200.00/1Hr	WILL NOT COVER

Charges will be automatically assessed and processed, as applicable, to the credit card information provided:

Name on Credit Card:_____ Credit Card Number:_____

Expiration Date:_____ CVV:_____

A credit card is required to be kept on file and will be stored on an offsite secure server.

Any bill delinquent 60+ days will be billed to the credit card on file.

****We reserve the right to reprocess any denied charges.****

Good Faith Estimate

Under Section 2799B-6 of the Public Health Service Act, mental health providers are required to provide a good faith estimate of expected charges for services to clients who are not enrolled in a plan, coverage, or federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling mental health services.

Service Description	Service Code	Diagnostic Code	Cost per Service	Anticipated Quantity	Total Est. Cost/Srv
				Estimated Total Cost for all Services:	

Disclaimer: This Good Faith Estimate shows the costs of services that are reasonably expected for your mental health care. The estimate is based on information known at the time the estimate was created. This estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you are billed for more than this estimate, you have the right to dispute the bill. You may contact the provider or facility listed on this form to let them know the billed charges are higher than the estimate. You can ask them to update the bill to match the estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit ww.cms.gov/no surprises. Keep a copy of this Good Faith Estimate in a safe place or take a picture of it. You may need it if you are billed a higher amount.

Signature:_____ Print Name: _____

Date:_____ Signed by: ___client ___guardian ___personal representative

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PCP Authorization to Disclose Protected Health Information

Client Name: _____ DOB _____

Address: _____ SSN _____

_____ Phone: _____

I hereby
AUTHORIZE_____ OR REFUSE_____

□ **Laura L. Tucker-Huggins, LPC/MHSP** □ **Deborah A. Driggs, LPC/MHSP** □ **Alison Hill, MMFT**
to release/exchange/receive verbal and written communication and information with the following identified **PCP**:

PCP NAME:_____ PHONE NUMBER:_____ FAX:_____

The following information:

□ Psychiatric/Psychological/Social History	YES _____	NO _____
□ Psychological, psychiatric, or neurological evaluations/testing/results	YES _____	NO _____
□ Physical Examination Results	YES _____	NO _____
□ Medical History	YES _____	NO _____
□ Current Medical Status	YES _____	NO _____
□ Medications Currently Prescribed	YES _____	NO _____
□ Substance Abuse/Dual Diagnosis	YES _____	NO _____
□ Periodic reports of current treatment progress, barriers to treatment, or prior treatment	YES _____	NO _____
□ OTHER: _____	YES _____	NO _____

The purpose of the disclosure of the above information is:

_____

I understand that this release of information is subject to revocation by me, in writing, at any time and that this release is not valid beyond one year (_____). I also understand that the person(s) or agency receiving this information is prohibited from making any further disclosure of such information except with my specific consent.

_____ _____
Signature Date

If not signed by client, state relationship to the client: _____

_____ _____
Witness Signature Date

This information has been disclosed to you from records that are confidential. Federal law protects this confidentiality. Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information without the specific 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 <u>not</u> sufficient for this purpose.