KEVIN B. COLLEN, MD PLLC
2011 Ashwood Avenue
Nashville, TN 37212
(615) 383-4694
Fax (615) 383-0228

NEW PATIENT DEMOGRAPHIC INFORMATION

Name:______________________________________Nickname:_____________

Street Address:____

City:________________________________ State:_______ Zip Code:__________

SSN:______-____-________ Gender:_____ Date of Birth______________ Age:______

Phone#:___________________________ Cell Phone #:___________________________

Employer:____

Work Phone #:______________________________ Position:____________________

INSURANCE INFORMATION

Insurance Company/HMO:____

Insurance Company Phone #:___________________ Group/Plan Number:__________

Member ID #:______________________ Policy Holder's Name:_________________

Policy Holder's SSN:_______-______-_________ Policy Holder's DOB_____________

Policy Holder's Employer:____

OTHER INFORMATION

Primary Care Physician:_____________________________ Phone #:_____________

Emergency Contact Person:____________________ Relation:___________________

Phone #:________________________ Alternate Phone #:_________________________

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BOARD CERTIFIED GENERAL PSYCHIATRY

MEDICAL HISTORY

Please describe any **Medical** conditions or disease that you currently have or had:

___

___

___

Please describe any **Hospitalizations** that you have had including the hospital name:

___

___

Please describe any **Pain** that you have including where it is, how long you have had it and what helps it:

___

___

Please describe any **Surgeries** that you have had including dates:

___

___

Please list any **Medications**, including doses that you are now taking:

___

___

___

Please list any **Allergies** that you have to medications or food:

___

___

PSYCHIATRIC AND FAMILY HISTORY

Please list any **Psychiatric** care with dates that you have had, including psychiatrists, psychologists, therapists:

____

____

____

Please list any **Inpatient** or **Residential** care that you have had including the dates:

____

____

Please list any other **Treatment** that you have had:

____

Please list any **Suicide** attempts you have had including the dates:

____

____

Does any **Family** member (mother, father, sister, brother, aunt, uncle, cousin) have mental illness now or in the past?

____

____

Please list any **Family** members that have attempted or completed **Suicide** including dates if applicable.

____

____

Please give the date(s) of your **Marriage(s)** if applicable:

____

____

Please list your **Children** with ages if applicable:

____

____

SOCIAL HISTORY

Are you a **Veteran,** if so, what branch of the military were you in? Were you exposed to combat?

____

____

Please list any **Legal** problems that you have or had including dates:

____

____

SUBSTANCE USE HISTORY

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Cocaine					
Hallucinogens					
Others					

Have you ever had any **Withdrawal** symptoms from alcohol or any other drugs including seizures?

____

Patient's Name: ____, Date: ______/_______/_______

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OFFICE POLICIES

Attendance and Cancellation: Compliance with the individualized treatment plan includes attending regularly scheduled appointments. Appointments will be scheduled at the frequency that is deemed clinically appropriate. Failure to attend scheduled appointments, without adequate notice to the office, is interpreted as non-compliance with the treatment plan. Adequate notice is considered to be 24 hours in advance of the appointment time. ***If cancellations are not made at least 24 hours in advance of your scheduled appointment time, you will be charged a no-show fee of $60.00 for follow-up appointments and $160.00 for new patient evaluation appointments*** for which insurance does not cover and is your responsibility. If you have multiple cancellations or multiple missed appointments your care at this office will be terminated.

Insurance Changes: Please provide a copy of your insurance card to the office at the time of your first appointment and at the beginning of the calendar year and when there is a change of insurance. If a charge is denied because the insurance information is wrong then you are responsible for the charges.

Medication and Medication Refills: Please call the office at the above number at least two business days prior to needing a refill of your medication. Controlled substances will not be filled, renewed, or called-in by phone between appointments. ***There will be a charge of $25.00 associated with a prescription if the medication was to be refilled during an appointment that was cancelled or missed by you.***

Delinquent Accounts: If your account becomes delinquent, then a 30% markup will be added to the account to cover the collection agency's fee. Further fees will be added to the account to cover court costs if needed. These added costs are your responsibility.

Patient's Name: ______________________________, Date: _____/_____/_____

Patient's Signature: ____

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CONSENT FOR TREATMENT WITH PSYCHOTROPIC MEDICATION

I agree to participate in behavioral care services offered and provided by Dr. Collen, licensed and Board Certified in General Psychiatry. I understand that I am consenting and agreeing only to those services that Dr. Collen is qualified to provide within the scope of his license, certifications, and training.

I understand that medication may be prescribed as part of my treatment program. I authorize Dr. Collen to prescribe this medication and agree to come for scheduled follow-up appointments on a regular basis. I understand that I may be placed at risk for serious side effects if my prescription runs out and the medication is discontinued.

Dr. Collen will inform me of the diagnosis, and will discuss with me the risks and benefits of treatment with medications, if alternative medications are an option, as well as the risks of no treatment. Upon asking, I can receive written information explaining the more common side effects of the medications, but understand that there may be other side effects that are much less common. I agree to inform Dr. Collen if there are any changes or side effects that I experience. I understand that the medications are expected to be helpful, but there is no guarantee as to the results.

Many of the medications we use are not safe or the effects are not known on human development. Therefore, it is very important that if you are pregnant or plan on becoming pregnant you let Dr. Collen know immediately. Also, please notify Dr. Collen immediately if your pregnancy status changes during the course of your treatment.

Patient's Name: ______________________________, Date: _____/_____/_____

Patient's Signature: ____

Consent for Release of Confidential Information to Primary Care Physician

Primary Care Physician Name: ______________________________

Patient Name: ____________________ Social Security Number: ________________

By initialing all information items I approve, I authorize release of the following medical information to the Health Care Practitioner named above. **Check and initial all that apply:**

☐ Mental Health Diagnosis ______________________________

☐ Medication Management Information ______________________________

☐ Other Mental Health Treatment Information ______________________________

☐ Other Information Specified here ______________________________

☐ Substance Abuse (SA) Information ______________________________

For SA Information, this authorization is:

☐ Limited to the following treatment ______________________________

☐ Limited to the following time period ______________________________

OR

☐ I do **NOT** wish to have information shared with my PCP/ Medical Practitioner

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

______________________________ ____________________
Signature of Patient or Legal Guardian Date

______________________________ ____________________
Witness Date

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HIPAA

I have read and will be given a copy, by request, of the Notice of Private Practices for the Middle Tennessee Psychiatric Clinic.

Patient's Name: ________________________________, Date: _____/_____/_____

I am a patient of Dr. Collen and I understand that I may review the Policies and Procedures Manual for HIPAA Compliance to protect my confidential Protected Health Information and all processing necessary for my care, at any time.

DISCLAIMER

Dr. Collen is the individual Psychiatrist treating you in these offices and is not employed in any manner by Middle Tennessee Psychiatric Clinic. Middle Tennessee Psychiatric Clinic does not oversee any care provided by your individual physician. Each and every physician who has an office in this building located at 2011 Ashwood Ave, Nashville, Tennessee is an independent private practitioner. Middle Tennessee Psychiatric Clinic does not evaluate, license or grant privileges to any practitioner to practice in these offices. If you have any questions please seek further clarification from your physician.

Patient's Name: ________________________________, Date: _____/_____/_____

Patient's Signature: ____

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USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form you are giving consent to use and disclose your protected health information for treatment, payment and healthcare operations. We will use or disclose your protected health information as described in this Section. Your protected health information may be used and disclosed by your clinician, the 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. Your protected health information may also be used and disclosed to process your health care charges. The following are examples of the types of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be all inclusive, but to describe the uses and disclosures that are made by our office.

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 that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency, that provides care to you. We may also disclose your health information to other health care providers who may be treating you. For example, your protected health information may be provided to a clinician to whom you have been referred to ensure that the clinician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed to obtain authorization and payment for your health care services. This may include certain activities that your health insurance may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility of coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to carry out the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign in sheet at the registration desk where you may be asked to sign your name when you come to our office for care. We may also call you by name in the waiting room to speak to a staff member or when your clinician is ready to see you.

Patient's Name: ______________________________, Date: _____/_____/_______

Patient's Signature: ____

MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

STATEMENT OF MEMBERS' RIGHTS

Members have the right to be treated with dignity and respect.

Members have the right to fair treatment; regardless of their race, gender, religion, ethnicity, age, disability or source of payment.

Members have the right to have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.

Members have the right to easy access, timely care in a timely fashion.

Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.

Members have the right to share in developing their plan of care.

Members have the right to information in a language they can understand.

Members have the right to have a clear explanation of their condition and treatment option.

Members have the right to information about their insurer, its practitioners, services and role in the treatment process.

Members have the right to information about clinical guidelines used in providing and managing their care.

Members have the right to ask their provider about their work history and training.

Members have the right to give input on the Members' Rights and Responsibilities policy.

Members have the right to know about advocacy and community groups and prevention services.

Members have the right to freely file a complaint or appeal and to learn how to do so.

Members have the right to know their rights and responsibilities in the treatment process.

Members have the right to receive services that will not jeopardize their employment.

Members have the right to list certain preferences in a provider.

STATEMENT OF MEMBERS' RESPONSIBILITIES

Members have the responsibility to treat those giving them care with dignity and respect.

Members have the responsibility to give providers information they need. This is so providers can deliver the best possible care.

Members have the responsibility to ask questions about their care. This is to help them understand their care.

Members have the responsibility to follow the treatment plan. The plan of care is to be agreed upon by the member and provider.

Members have the responsibility to tell their provider and primary care physician about medication changes, including medication given to them by others.

Members have the responsibility to follow the agreed upon medication plan.

Members have the responsibility to keep their appointments. Members should call their providers as soon as they know they need to cancel visits.

Members have the responsibility to let their providers know when the treatment plan isn't working for them.

Members have the responsibility to let their provider know about problems with paying fees.

Members have the responsibility to report abuse and fraud.

Members have the responsibility to openly report concerns about the quality of care they receive.

Patient's Signature: ______________________________

Date: _______/_______/_______