Welcome, and thank you for your interest in receiving therapeutic services! Therapy is a commitment of time, money and energy, so it is important to choose a therapist thoughtfully. It is a joint process and I want you to feel completely comfortable with your choice to work with me.

Attached you will find a New Client Registration Form that I ask you to completely fill out to the best of your ability as well as a copy of the Notice of Privacy Practices for you to read and sign the last page indicating you have read the policy. The Notice of Privacy Practices is yours to keep. Also included are my Practice Policies and Consent to Treatment form and a Crisis Information Sheet along with its signature page. The Crisis Information Sheet is also yours to keep as it contains vital telephone numbers should you ever require crisis intervention. You will also find some additional forms to complete if you will be using insurance to pay for services.

If using insurance, be sure to contact your insurance company about your "mental health" coverage. Ask if there is a deductible or co-payment, and if pre-certification is necessary. It is important that you specifically ask about your "**mental health**" benefits as these may be different from medical benefits; and/or may be managed by a completely, different insurance company; also, some services such as "family therapy", may not be available for your specific policy. Bring your insurance cards to each visit as I need a copy to file with your insurance company.

Please bring the completed forms with you to your first appointment as I will use this information in working with you to construct an individualized treatment plan for the problems we are going to work on and how they might be solved. I will invite you to discuss this treatment plan and collaborate with me as we work together, as you are the expert in your life!

Again, thank you for allowing me to work with you. At any time please do not hesitate to ask questions about these or other matters of concern.

Phyllis Nobles is a Licensed Clinical Social Worker working with individuals, groups, and families. She is a clinical psychotherapist and maintains full compliance with the regulations set forth by the TN Board of Social Work Certification and Licensure. More information can be obtained at: www.tn.gov, following the links to the Health Related Boards. She is also a member of the Nashville Psychotherapy Institute and the Association For Play Therapy

Phyllis Nobles, LCSW

New Client Registration Form

Today's Date: _____

Note: *Only list phone numbers or addresses that are safe for me or office staff to call or to send mail*

Client Last Name:	First:	Middle:	Birth Date:	Age:	Gender: M F	Marital Status:
Guardian (if applicable)				Best phone # to reach you: ( )		
Client Street Address (mailing) :	City:			State:	ZIP Code:	
Client Occupation:	Client Employer:			Client Phone #: ( )		
Email Address:	Other Phone # (work, cell): ( ) Specify:					
Referred by:	Client School (if applicable):				Grade:	

PARENT/LEGAL GUARDIAN INFORMATION (if applicable)

Mother/Legal Guardian:	DOB:	Guardian SS#	
Legal Guardian's relationship to the minor:	Employer:	Phone# ( )	
Father/Legal Guardian:	DOB:	Guardian SS#	
Legal Guardian's relationship to the minor:	Employer:	Phone# ( )	

INSURANCE INFORMATION (if filing for insurance reimbursement)

Primary Insurance Company/HMO:	Policy Member ID#	Group ID#	Phone #: ( )	
Occupation:	Employer:	Employer address:	Employer Phone #: ( )	
Claims Address:			Claims Phone #: ( )	
Secondary Insurance:	Policy Member ID#	Group ID#	Claims Phone #: ( )	
Occupation:	Employer:	Employer address:	Employer phone #: ( )	
Claims Address:			Claims Phone #: ( )	

Please provide primary subscriber information if the insurance is carried by someone other than the patient.
(Please provide a copy of your insurance card – front and back)

Subscriber's full name:	Subscriber's S.S. #:	Birth date:	Group #:	Policy #:
Subscriber's relationship to the patient:				

IN CASE OF EMERGENCY

Primary Care Physician:	Address:	Phone # ( )	Date of last Physical Exam:
Emergency Contact (other than above)	Relationship to patient:	Phone # ( )	Work phone #: ( )

The above information is true to the best of my knowledge. If using insurance I authorize my insurance benefits to be paid directly to Phyllis Nobles, LCSW. I understand that I am financially responsible for any balance. If I choose to use insurance, I also authorize Phyllis Nobles LCSW, her billing business associates, or the insurance company to release any information required to process my claims.

_____ _____

Client signature Date

_____ _____

Parent/Guardian signature (if applicable) Date

MEDICAL HISTORY

Current Medications (use back of form if necessary)			
Doctor prescribing medication	Date of ***initial*** prescription/refills	Medication Name	Dosage and Frequency

All Hospitalizations/Surgeries		
Date	Reason	Outcome/Complications

Major medical conditions (Diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc.)	
Condition	Date/Length of Time

Past Psychiatric History (Mental health and chemical dependency diagnosis or problem areas – use back of form if needed)	
Problem or Condition	Dates of Service

Prior Psychiatric Treatment (Outpatient Psychiatric Therapy and/or Hospitalizations – use back of form if needed)			
Previous Clinicians/Hospitals/Addresses	Dates of Treatment	Previous treatment interventions and response	Response to treatment

Prior Psychological Testing (School, Psychologist, or Other Special Testing)		
Date	Reason	Outcome

Children and Adolescents	
Developmental History (As a child the client's developmental milestones met early, late or normal; any concerns):	
Details of problems during client's pregnancy and/or labor/delivery:	
School Behavior and Academic Achievement/Performance:	Can client read and write? Yes ☐ No ☐

Who has legal custody of the client? (Please note in some cases a valid custody agreement will be requested)
Family Mental Health or Chemical Dependency History (Please note **ANY suicidal attempts by relatives** - example: Mother – depression; Father – alcoholism)
Social History/Current Functioning (example: "has few friends")
Support Systems (family members etc) _____ School/Work/Social_____ Marital History_____ Legal History _____ Military History _____ Spiritual Beliefs _____ Other Special Needs/Culture? _____
Allergies
Allergies to Medications:
Allergies to Foods/etc:

Substance Use History

Substance	Amount	Duration	Age of First Use	Last Time Used
Caffeine (tea, etc.)				
Tobacco				
Alcohol				
Marijuana				
Opioids/Narcotics				
Amphetamines				
Cocaine				
Hallucinogens				
Inhalants/Other				

Why are you seeking therapy at this time? _____

_____

_____

_____

How long has this been going on? _____

How much sleep does the client routinely get each night? _____

In the past 6 months, the client has experienced problems in the following areas:

___ Concentration	___ Problems at work/school	____ Relationship Problems
___ Memory	___ Eating	____ Leisure Activities
___ Depression	___ Sexual Interest	____ Body Image Problems
___ Financial	___ Addiction (alcohol, drugs, internet, gambling, sex, etc.)	
___ Sleep	___ Energy	____ Anxiety/Fears
___ Hopelessness	___ Thoughts/Actions of Suicide	____ Self-injury
___ Aggression or Violence	___ Thoughts/Actions of Homicide	
___ Racing Thoughts	___ Domestic Violence	

___ Unusual Experiences (specify: _____)

Other: _____

Please list the members of your household(s) and their ages: _____

_____

_____

What other systems are currently involved in your family? (Legal, Child Protective Services, Home Health Services, etc.) _____

_____

Has the client ever been physically or sexually abused: **YES** **NO**

Has the client ever attempted suicide: **YES** **NO**

What other information would you want the therapist to know? _____

_____

_____

_____

Do I have permission to leave messages via telephone, for instance on your voice mail?

YES **NO** If Yes, which number? _____

If No, please give specific instructions: _____

_____

Please list any individuals I may need to speak with as a Release of Information needs to be done (ex: grandparents, teachers, school counselors, etc.)

_____

_____

_____

The above information is true to the best of my knowledge.

_x_____ _____

Client Signature (mandatory if over 15 years of age) Date

_ x_____, _____ _____

Legal Guardian/Guarantor (if applicable), Relationship Date

Notification of Privacy Policy

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

Preamble

Mandated law provides extremely strong privileged communication protections for conversations between your therapist and you in the context of your established professional relationship with your therapist. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very carefully defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which are not accessible to insurance companies and other 3rd party reviewers and in some cases, not to the client him/herself.

HIPAA provides privacy protections about your personal health information, which is called "Protected Health Information" (PHI), which could personally identify you. PHI consists of 3 components: *treatment*, *payment*, and *health care operations*.

Treatment refers to activities which I provide, coordinate, or manage in your mental health care or other services related to your mental health care. Examples include psychotherapy sessions, psychological testing, or talking to your primary care physician about your medication or overall medical condition. I will strive to obtain your authorization before making any disclosure of your protected health information. Obtaining your authorization may not always be possible in emergency circumstances or if the disclosure is otherwise allowed by state law or federal regulations

Payment is when I obtain reimbursement for your mental health care. An example would be if filing insurance on a client's behalf.

Health Care Operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example is when utilization review occurs, a process in which insurance companies review the therapist's work to determine "medical necessity".

The *use* of your protected health information refers to activities my office conducts for filing claims, scheduling appointments, keeping records, and other tasks *within* my office related to client care. *Disclosure* refers to activities a client may authorize which occurs *outside* my office such as sending protected health information to other parties (i.e. Primary care physician, schools).

Uses and Disclosures of Protected Health Information Requiring Authorization

Tennessee requires authorization and consent for treatment, payment, and health care operations. HIPAA does nothing to change this requirement by law in TN. I may disclose PHI for the purposes of treatment, payment, and health care operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct the administrative steps associated with your care.

Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization is available upon request. The requirement of you signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of the conversations between therapist-client in treatment settings, HIPAA permits keeping "psychotherapy notes" separate from the overall "designated medical record". "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services. "Psychotherapy notes" are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, or joint family counseling session and that are separated from the rest of the individual's medical record". "Psychotherapy notes" are necessarily more private and contain much more personal information about you, hence the need for increased security. "Psychotherapy notes" are not the same as your "progress notes" which provide the following about your care each time you have an appointment at my office*: medication prescriptions and monitoring, assessment/treatment start and stop times, the modality of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.*

Certain payers of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time, I will be able to limit reviews of your protected health information to only your "designated record set" which includes the following: all identifying paperwork you completed when your first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use are not part of your "designated mental health record".

Individuals Involved in Your Care or Payment for Your Care: I may release overall health information about you, without clinical data, to a friend or family member who is involved in your care, and may also give information to someone who helps pay for your care, unless you object in whole or in part.

You may, in writing, revoke all authorizations, to disclosure of protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and TN law provides the insurer the right to contest under the policy.

Business Associates Disclosures

HIPPA requires that I train and/or monitor the conduct of those performing ancillary administrative services for my practice and refers to these people as "Business Associates". Presently, in my practice, I and my business associates do all my billing and record keeping, and no other individuals have access to these records. Both I and my business associates maintain strict HIPAA compliance. In the event I must cancel an appointment and can not do so personally due to illness or other

catastrophic event, an office staff member will contact you with a cancellation message.

Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization in the following case: 1) **suspected** child abuse, neglect, physical or sexual, 2) elder and domestic abuse or violence, 3) Health Oversight Activities (i.e. licensing board for psychology in TN), 4) Judicial or administrative proceedings (e.g. if you are ordered here by the court), 5) serious threat to health or safety (e.g. threat of suicide, "duty to warn" law, to prevent a serious threat to your health and safety or the health and safety of the public or another person, national security threats) 6) Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s), 7) When required to do so by federal, state or local law (e.g. in response to a court or administrative order), 8) To prevent or control disease, injury or disability.

I never release any information of any sort for marketing purposes.

Patients Rights and Therapist's Duties

You have a right to the following:

-The right to request restrictions on certain uses and disclosures of your protected health information which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing.

-The right to receive confidential communications by alternative means and at alternative locations.

-The right to inspect and have a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the record.

-The right to amend material in your protected health record, although I may deny an improper request and/or respond to any amendments you make to your record of care. To request an amendment, your request must be made in writing and submitted to Phyllis Nobles LCSW, P.O. Box 682648, Franklin, Tennessee 37068-2648. In addition, you must provide a reason that supports your request. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that: was not created by me; is not part of the information kept by me; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

-The right to an accounting of non-authorized disclosures of your protected health information

-The right to a paper-copy of notices/information from me, even if you have previously requested electronic transmission of notice/information. Please be advised that electronic transmission of PHI can be risky.

-The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your privacy rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for future appointments. My duties as a therapist on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and privacy practices with respect to your PHI, and to abide by the terms of this notice

unless it is changes and you are so notified. If for some reason you desire a copy of my internal policies for executing privacy practices, please let me know, and I will get you a copy of these documents I keep on file for auditing purposes.

Complaints

I am the appointed "privacy officer" for my practice per HIPAA regulations. If you have concerns of any sort that my office may have somehow compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected health information. You may also send a written complaint to the secretary of the U.S. Department of Health and Human Services.

This notice shall go into effect 4/14/2003 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

HIPAA

I have read and have been given a copy of the HIPPA Notification of Privacy Policy for the offices of Phyllis Nobles LCSW and I acknowledge receipt of these documents. I further understand I may review the Practice Policies and Consent to Treatment for HIPAA compliance to protect my confidential medical information and all processing necessary for my care; at any time.

Client Name:_____
(Please print)

_**x**_____ _____
Client Signature (mandatory if over 15 years of age) Date

_ **x**_____, _____ _____
Legal Guardian/Guarantor (if applicable), Relationship Date

Phyllis Nobles, LCSW
Practice Policies and Consent to Treatment

Welcome and thank you for your interest in receiving therapeutic services! I appreciate your trust and opportunity to work with you. Therapy is a commitment of time, money and energy, so it is important to choose a therapist thoughtfully. To be informed and consent to treatment, please take this time to review some of the policies and practices that guide a client/therapist partnership with me.

I am a Licensed Clinical Social Worker working with individuals, couples, and families. I am a clinical psychotherapist and maintain full compliance with the regulations set forth by the TN Board of Social Work Certification and Licensure. More information can be obtained at: www.tn.gov, following the links to the Health Related Boards. My experience includes treating individuals with problems related to emotional, behavioral and relationship problems as well as experience in addiction counseling and specialized training in treating trauma, OCD, and early childhood issues.

Patient Agreement with Policies and Procedures & Consent to Treatment

The following information is provided to my clients to assist you in understanding policies and procedures in my practice. I strive to provide you with care which is both comfortable and of the highest quality. Please do not hesitate to ask questions about these matters.

Confidentiality: I have given you a copy of the **Notification of Privacy Policy** document now required with the passage of the federal "medical records privacy law" known as **HIPAA** (Health Insurance Portability and Accountability Act). I am required by law to give you a copy of this document and to secure your signature indicating you have received a copy of it. Laws such as these are important, but also complex, and in my **Notification of Privacy Policy** document, I have attempted to inform you of your rights in plain, simple language. Please read the contract, and do not hesitate to ask me any questions you may have.

There are exceptions to confidentiality which are legally mandated and of which you should be aware. These exceptions include, but not limited to: 1) if the client is in danger of harming themselves, 2) if the client is a danger to others, 3) report of suspected child abuse and/or neglect (including Statutory Rape - other individuals at least 4 years older than victim), and 4) report of suspected adult/elder abuse and/or neglect. In the latter three instances, therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken.

If you choose to contact me using email, texting, or other electronic means, be aware that electronic transmissions are not tamper proof. I prefer you communicate confidential information either in person or via the U.S. Mail. If you should choose to communicate using electronic means (email, text, fax, telephone, etc.) I can not be responsible for the security of these transmissions. I am not available through email or the internet, more broadly, for psychotherapy, professional consultation or emergencies.

In addition, if you participate in group therapy all members are mandated to keep information shared during group sessions confidential and the client will be required to sign a confidentiality agreement to other group members.

Appointments: I, or my business associate office or staff, may schedule appointments for my clients. Since clients are seen by appointment only, the appointment time given is reserved for you. Please give at least twenty-four (24) hours notice if you must cancel your reserved time. You will be charged for appointments that are not cancelled 24 hours in advance. Please understand that you are fully responsible for any charge due to a missed appointment. Note also, that if you are filing insurance the insurance company will not reimburse you for missed appointments. As therapy takes time and commitment, I ask that you follow my recommendations regarding frequency of appointments, which are usually on a weekly basis. If for some reason you should be unable to contact me during an emergency, you may obtain assistance by calling the Crisis Help Line at (615)

244-7444, the Community Assistance Program (CAPS) at (615) 342-1450, or by going to your local hospital emergency room.

Fees and Payment: The fee for the initial 60-90 minute clinical assessment is $175. Subsequent sessions are billed at $125. for each 45-minute appointment. Group and family therapy fees vary based on type of group and materials required. Fees, deductibles, or co-payments, are due at the time services are rendered. If a co-payment is not paid at the time of service I do have the right to refuse service. If requested, clients will be provided a receipt for payment, and this may be submitted to your insurance company for reimbursement if you are filing for out-of-network provisions, though no responsibility for reimbursement is held by therapist. At this office, if the service is not covered by the insurance carrier at the time of service, you the patient/guarantor accept all financial responsibility. Fees are subject to change. No shows or late cancellations (not 24 hour notice) will be charged $80.00.

Non-traditional Services such as telephone and email consultations requiring more than 15 minutes will be billed at the customary rate plus additional costs incurred. Any legal services, paperwork and letters requested by the patient outside of the appointment will be charged at a rate of $250 per hour with a **six hour minimum** deposit. If travel is required, reimbursement for travel, lodging, meals, etc. is necessary. Your insurance company will generally not pay for these services.

Insurance: I am on some insurance panels and I/we may be able to file with your insurance company. My office does file insurance claims. If you plan to submit a request for reimbursement to your insurance company, you must first verify that your insurance will pay for the psychotherapy services of this provider which may include family therapy. Please note that your insurance will only pay for services medically necessary to treat a specific mental disorder. Insurance will generally not cover services specifically sought for purposes of coaching, personal development, or relationship enhancement. I must inform your insurance company of a mental health diagnosis in order for you to file your insurance. Please also note, that if you file with your insurance company the insurance company may request information related to your case. In such cases, I often have to release a significant amount of information regarding your case. You need to be aware that I am releasing this information to your insurance company and cannot be responsible for the insurance company's use of, or disclosure of, this information. Your insurance company may further "manage" your care. This means that sessions may have to be approved in advance in order to be paid. It is your responsibility to have your initial session approved. Insurance companies may further have their own definition of medical need for treatment, which may differ with our opinion, or your opinion, of the situation. In the event that you continue treatment beyond that which has been approved by your insurance, you will be responsible for charges. Please also know, that in some cases, clients may be denied private health insurance in the future if they have ever received treatment for a mental illness. Please inform me if you have any questions regarding my, or your, agreement with your insurance carrier and method of payments.

Insurance Changes: If the insurance coverage for the patient changes, a copy of the insurance card (Front & Back) will be presented to the office either in person or by fax to prevent charges from being denied. If a charge denies for failure to be submitted to a correct insurance carrier within a timely manner, the guarantor/patient/financial responsibly party will be responsible for the charges.

Payment Plans/Financial Hardships: Please inform me if you are financially unable to pay for your sessions as you go. I will attempt to offer other therapeutic or payment options that will allow you to continue to receive counseling and reduce financial stressors associated with services.

Returned Checks: There is a $35.00 fee for all checks returned due to insufficient funds.

Delinquent Accounts: If the financial portion of the account with the clinician becomes delinquent and the account is turned over to a collection agency there is a 30% balance markup placed on the account to cover the collection agency's fee. This amount will be added to the account balance at the time the account is turned over. This does not include costs if the account is perused in court.

Termination: Termination of therapy may occur at any time and may be initiated by either the client or myself. It is requested that if a decision to terminate is being made, there be a minimum of seven days notices in order that a final termination session be planned. Termination can be constructive, and processing to explore the reasons for termination is healthy. If any referral is warranted, it will be made at that time. Clients with outstanding fees beyond 120 days will be terminated or suspended until fees are collected. Psychiatric emergencies will be referred to your nearest emergency room or you may dial 911.

Informed Consent to Treatment: I have provided this information to you in hope of fully informing you of policies of my office and parameters of care you will receive here, such as the importance of confidentiality. Psychiatric and psychological care, like other things in life, offer no absolute guarantee of success. While psychotherapy is a positive experience for many, it is not always helpful to everyone. There are risks and limitations to any form of care offered a client, and ultimately, clients are responsible for their own growth. Psychotherapy often generates intense emotional experiences including negative ones and could involve worsening of problems, strained or damaged relationships with others during treatment, and the uncovering of unexpected, disturbing issues. You or your loved ones participation may result in strong feelings of anxiety or emotional distress. I recommend each patient educate themselves on their particular issues and therapy which they receive.

If you are a parent, legal guardian or family member who is present during psychotherapy, please know you are not considered to be the client and are not the subject of the treatment. Psychotherapists have certain legal and ethical responsibilities to their clients. The privacy of this relationship is given legal protection. My primary responsibility is to my client and I must place their interests first. As a family member you have less privacy protection since you are not officially my client. By participating in psychotherapy with my client, you are voluntarily consenting to participate in the assessment and treatment that may be performed during this (series of) visit(s) with me.

After we have met to discuss your concerns, I will construct an individualized or family/group (when needed) treatment plan for the problems we are going to work on and how they might be solved. I invite you to discuss this treatment plan and collaborate with me to work towards your progress. You are the expert in your life so, please, ask lots of questions and be an active participant in your therapy.

I, or my office staff, may need to use your name, address, phone number, and your clinical records to contact you, leave a message on your telephone answering machine to return your call, or, provide you with appointment reminders, test results, or billing information. You have the right to revoke/refuse to give me authorization to contact you regarding your case at this office. Any restriction should be requested in writing. If you do not give authorization, it will not affect the treatment I provide to you or the methods I use to obtain reimbursement for your care including billing you by mail or collection proceedings. You may inspect or copy the information that I use to contact you regarding your care at any time (i.e. appointment reminders, care alternatives and etc.)

Please place your initials in the designated spaces below to indicate that you have read and understood each of these following conditions for treatment. Your signature is also required at the end of this form.

If applicable, I hereby authorize Phyllis Nobles, LCSW or designated staff to notify the referral source of my having made this appointment. This alone will be disclosed to the referring professional and is done as a professional courtesy. **Initial:** _____

I understand that I will be responsible for compensating Phyllis Nobles, LCSW at the rate of $240/hour for court related services, as well as travel and expenses, if she must prepare for and/or appear in court on behalf of the client or client family. **Initial:** _____

I understand that confidentiality may be compromised by contact with Phyllis Nobles, LCSW using electronic forms of communication such as unencrypted email, internet transmissions or cellular phone calls and text messaging. I understand that Phyllis Nobles, LCSW cannot guarantee confidentiality when communicating with her through these media. **Initial:** _____

I voluntarily consent to participation in the assessment and treatment that may be performed during this (series of) visit(s) with Phyllis Nobles, LCSW. **Initial:** _____

Older adolescents (16-17) are asked to confirm if I do/do not have permission to talk freely with parents or other family/guardian members. Restrictions must comply with higher local, state or federal laws and statutes. **Initial:** _____

Emergencies: In case of emergencies, you may contact your nearest hospital emergency room. Phyllis Nobles, LCSW is not available by email or the internet for emergencies.
Initial: _____

Consent for Treatment

I _____ have read the above information regarding services and fees
(Print Client Name Here)
for services and I agree and consent to participate in behavioral health care services offered and provided at/by Phyllis Nobles LCSW, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within:
1. The scope of the provider's license, certification, and training; or

2. The scope of the license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.

If the client is under the age eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am legally authorized to initiate and consent for treatment on behalf of this individual.

Please feel free to discuss any of these matters with me in more detail. By signing below, you acknowledge having read, understood, and agreeing to these policies and procedures and acknowledge your informed consent for treatment.

_____ _____
Client (mandatory if age 15 or older) Date

_____ _____
Legal guardian if client is under 18 years of age Date

Relationship to Patient (if applicable): _____

Crisis Information Sheet

In the event you or your loved one experience thoughts of harming self or others or have another crisis situation, I have listed below some crisis hotline numbers that you may call to receive help in the event I am not immediately available. Please place this list in an easy to find location.

- **Becoming upset to the point of harming self or others:**
    1. Call the **National Suicide Prevention Lifeline** at **(800) 273-TALK** or
    2. Call the **Nashville Area Crisis Line** at **(615-244-7444)**.
    3. **Go to my local Emergency Room immediately**
- **National Child Abuse Hotline**: 1-800-25-ABUSE
- **Domestic Violence Hotline**: (800) 334-4628
- **National Domestic Violence Hotline** at 1-800-799-SAFE(7233), /800-799-7233/800-787-3224 TDD, 800-942-6908 Spanish Speaking
  Help is available to callers 24 hours a day, 365 days a year. Hotline advocates are available for victims and anyone calling on their behalf to provide crisis intervention, safety planning, information and referrals to agencies in all 50 states, Puerto Rico and the U.S. Virgin Islands. Assistance is available in English and Spanish with access to more than 170 languages through interpreter services. If you or someone you know is frightened about something in your relationship, please call the National Domestic Violence Hotline at 1-800-799-SAFE (7233) or TTY 1-800-787-3224. SAFETY ALERT: Cell phones and computers can be monitored and impossible to completely clear. If you are afraid your phone, internet and/or computer usage might be monitored, please use a safer computer (library) or use a safe phone (pay phone).
- **Elder Abuse Hotline**: 800-252-8966
- **Poison Control:** 800-362-9922
- **National Drug Information Treatment and Referral Hotline: 800-662-HELP (4357)** Information, support, treatment options and referrals to local rehab centers for any drug or alcohol problem. Operates 24 hours, seven days a week.
- **Any Life threatening emergencies: 911**

Crisis Information Sheet

I am a client of Phyllis Nobles LCSW, and I acknowledge receiving the crisis hotline phone list and agree in time of crisis will call to request help.

_x_____ _____
Client Signature (mandatory if over 15 years of age) Date

_ x_____, _____ _____
Legal Guardian/Guarantor (if applicable), Relationship Date

IMPORTANT INFORMATION REGARDING INSURANCE AND COLLECTIONS

Phyllis Nobles, LCSW
106 Mission Court, Suite 601, Franklin, TN 37067

Professional services are rendered and charges to the patient and not to insurance companies. Even though I file your insurance claims, I cannot accept responsibility for collecting your claim or negotiating a settlement for a disputed claim. Be aware that in order for me to file your insurance claims, I often have to release a significant amount of information regarding your case. You need to be aware that I am releasing this information to your insurance company and cannot be responsible for the insurance company's use of or disclosure of this information. Your insurance company may further "manage" your care. This means that sessions may have to be approved in advance in order to be paid. It is your responsibility to have your initial session approved. I will assist in the process, if I can. Insurance companies may further have their own definition of medical need for treatment, which may differ with my opinion or your opinion of the situation. In the event that you continue treatment beyond that which has been approved by your insurance, you will be responsible for charges.

I authorize the payment of the insurance benefits directly to Phyllis Nobles, LCSW on my behalf. I understand I am responsible for all deductibles, co-insurance, and non-covered charges.

** COPY OF INSURANCE CARD IS REQUIRED TO FILE YOUR INSURANCE**
Name of Primary Insurance Company:_____
Name of Secondary Insurance Company:_____

POLICY REGARDING APPOINTMENTS and PRIVACY

It is your responsibility to keep the appointment/s you schedule with Phyllis Nobles, LCSW. Please be aware that I do not call and give appointment reminders. **If you are not able to make your appointment that you have scheduled, you will need to call 24 hours in advance to cancel or reschedule the appointment. If you fail to cancel your appointment 24 hours in advance you will be charged $80.00 for failure to show for the appointment.** This charge will not apply during inclement weather or other emergency situations.

I may need to use your name, address, phone number, and your clinical records to contact you to leave a message on your telephone voice mail to provide you with appointment changes or billing information. You agree that you have **only** given me or by business associate safe telephone numbers and mailing addresses to use.

By signing this statement,

I_____acknowledge that
(Please print) (Patient/Legal Guardian/Guarantor/Financial Responsible Party's Name)

I have read and fully understand all the information on this page.

_**x**_____ _____
Patient/Legal Guardian/Guarantor/Financial Responsible Party's Signature Date