

**Notifications and Releases**

We want to make your experience with every aspect of our service, meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians.

Listed below are several notices that outline certain responsibilities of ours, and yours. ***Please read them carefully and sign where indicated that you have read each statement.***

*We look forward to treating you as a patient, however, we need your permission for our physicians to examine you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.*

**\*\*General Consent for Treatment**

**I give general consent to be treated.**

Date: \_\_\_\_\_

**Patient / Patient's representative**

**\*\*Financial Policy / Assignment of Benefits**

*As a courtesy to our patients, the practice accepts assignment from most commercial insurance programs. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment of our services.*

***A 24-hour notification is required for cancelled/rescheduled appointments, or you will be subject to a fee.*** \_\_\_\_\_ (patient initial)

If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. Balances not paid within 30 days after your first treatment will be subject to a 1½% service charge per month. In addition, if the fees for our services are not paid, we may turn the account to a collection agency. Attorney's fees and court costs will also be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

**I acknowledge it is my responsibility to ensure payment of fees for services provided by the practice and authorize the practice to release any medical information, if necessary, to my insurance company.**

Date: \_\_\_\_\_

Patient / Patient's representative

*New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will keep your record as long as you are a patient of the practice and seven years after your last visit.*

**\*\*Privacy Policy**

**I acknowledge that I have been informed about the privacy of my medical record, and the practice's Privacy Policy has been made available to me.**

Date: \_\_\_\_\_

Patient / Patient's representative

**CENTER FOR INTEGRATIVE MEDICINE**

PATIENT DEMOGRAPHIC FORM

**(PLEASE PRINT)**

Primary Provider seen in our office: \_\_\_\_\_

**PATIENT INFORMATION**

Legal First Name: \_\_\_\_\_ Legal Last Name: \_\_\_\_\_

Middle Name \_\_\_\_\_ Name you prefer to go by \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: (please circle) Male Female

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone (\_\_\_\_\_) \_\_\_\_\_ (please circle) home cell work

Secondary Phone (\_\_\_\_\_) \_\_\_\_\_ (please circle) home cell work

SS# \_\_\_\_\_ Email Address \_\_\_\_\_

Would you like to receive a copy of our monthly newsletter via email? YES NO

Marital Status: S M D W Spouses Full Legal Name \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact (someone not living in your household)

Contact Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary phone \_\_\_\_\_

Person responsible for bill if patient is a minor: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (if different): \_\_\_\_\_

**INSURANCE INFORMATION: (Please complete this section in full. Info needed may not appear on card)**

**PRIMARY INSURANCE**

Insurance Company \_\_\_\_\_

Primary Cardholder's Information: **please check box if information is the same as above**

Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Relation to Primary Cardholder \_\_\_\_\_

**Secondary Insurance**

Insurance Company \_\_\_\_\_

Primary Cardholder's Information: **please check box if information is the same as above**

Name \_\_\_\_\_ SSN#: \_\_\_\_\_ DOB \_\_\_\_\_

Relation to Primary Cardholder \_\_\_\_\_

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I, THE UNDERSIGNED, GIVE AUTHORIZATION TO TREAT AND ASSIGN DIRECTLY TO THE CENTER FOR INTEGRATIVE MEDICINE, ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS AND AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

CENTER FOR INTEGRATIVE MEDICINE  
Jeffrey S. Jump. M.D.  
1100 E. Third Street. Suite G-100  
Chattanooga, TN 37403 Phone: (423) 643-2246 Fax:  
(423) 643-2030

## PRIVACY RESTRICTION

As your healthcare provider, I want you to understand that everything you tell me is confidential. New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will not discuss your condition with anyone else (i.e., parents/guardians, spouses) without your approval in writing.

**I understand the above statement and (check one box below):**

- I do not mind that my medical information is shared with my parent/guardian or spouse at anytime.
- I want my medical information to remain confidential. My protected health information should *NOT* be shared with any other individual. I realize that unless I pay cash for all services provided, there is a chance that an insurance company may release information to the person(s) paying for my medical insurance. I also realize that this restriction must be approved by Center for Integrative Medicine Privacy Officer, who may deny my request.

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Patient Signature

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Date

**Emergency Treatment EXCEPTION:** If the Privacy Office agrees to a restriction, HIPAA privacy regulations provide an exception in emergency treatment situations for a hospital or physician to use and disclose necessary information to treat the patient.

CENTER FOR INTEGRATIVE MEDICINE  
Jeffrey S. Jump, M.D.,  
1100 E. Third Street, Suite G-100  
Chattanooga, TN 37403  
Phone: (423) 643-2246 Fax: (423) 643-2030

## **Notifications and Releases for "Minors"**

We want to make your experience with every aspect of our service meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians.

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**I give general consent to be treated.**

\_\_\_\_\_  
Patient / Patient's representative

\_\_\_\_\_  
Date:

### **\*\*Financial Policy / Assignment of Benefits**

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**I acknowledge it is my responsibility to ensure payment of fees for services provided by the practice and authorize the practice to release any medical information, if necessary, to my insurance company.**

\_\_\_\_\_  
Patient / Patient's representative

\_\_\_\_\_  
Date

### **\*\*Privacy Policy**

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\_\_\_\_\_  
Patient

**Counseling Intake Form**  
**Confidential Information – Youth**  
**Brittney S. Smith, LPC-MHSP**

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_  
                    First                      Middle                      Last

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex:  Male  Female

Home Address \_\_\_\_\_  
  Street                                      City                                      State                                      Zip

Home phone \_\_\_\_\_ Cell \_\_\_\_\_ Work phone \_\_\_\_\_

Mother's name \_\_\_\_\_ Legal custody of youth? \_\_\_\_\_  
                                    First                      Middle or Maiden                      Last

Mother's address \_\_\_\_\_  
  Street                                      City                                      State                                      Zip

Mother's phone #: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Mother's occupation \_\_\_\_\_ Employer \_\_\_\_\_

Father's name \_\_\_\_\_ Legal custody of youth? \_\_\_\_\_  
                                    First                      Middle                      Last

Father's address \_\_\_\_\_  
  Street                                      City                                      State                                      Zip

Father's phone #: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Father's occupation \_\_\_\_\_ Employer \_\_\_\_\_

Name of other legal guardian \_\_\_\_\_ Home phone \_\_\_\_\_

Guardian's address \_\_\_\_\_ Cell phone \_\_\_\_\_

Guardian's relationship to youth \_\_\_\_\_ Work phone \_\_\_\_\_

Youth's immediate family (please include all members residing within home)

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Does person reside within home</u>
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Patient's Name \_\_\_\_\_

Youth's school \_\_\_\_\_ Teacher \_\_\_\_\_

Grade \_\_\_\_\_ Any additional needs classes \_\_\_\_\_

**Please complete the following medical information:**

**Youth's Physician**

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Years \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Medical issues or concerns:

**Does youth smoke?** \_\_\_ Yes \_\_\_ No If so, how much? \_\_\_\_\_ How long? \_\_\_\_\_

**Has youth ever been treated for drug/alcohol dependence or abuse?** \_\_\_ Yes \_\_\_ No

**Previous Mental Health Services:**

<u>Type of Services</u>	<u>Provider</u>	<u>Dates of Service</u>
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**Current or expected legal involvement?** \_\_\_ Yes \_\_\_ No If yes, please explain:

**Referred by:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

May we contact this person/agency to notify them of your follow through for an appointment? **Y N** Initials:

**Person to notify in case of emergency:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
street city state zip home work/cell

**Spiritual/Religious Affiliation (if any):** \_\_\_\_\_

How important are spiritual/religious matters to youth?

**List youth's leisure interests:**

Patient's name \_\_\_\_\_

**What do you consider to be youth's strengths?**

**Briefly describe the problems and reasons that brought you here:**

**Briefly list goals of your treatment here; that is, what you would like to achieve and/or see happen by coming here for care:**

**Additional Comments or Questions?**

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**Staff Use Only**

**Additional Comments/Information Pertinent to Treatment:**

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**Brittney S. Smith, LPC-MHSP**

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**Date**