

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.**

****General Consent for Treatment**

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.

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

****Privacy Policy**

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.

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 _____

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.

Patient Signature

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.

Notifications and Releases for "Minors"

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Date:

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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

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Patient

Counseling Intake Form

1100 E. Third St. * Suite G-100 * Chattanooga, TN 37403

Tel: (423) 643-2246 * FAX: (423) 643-2030

Client's name: _____ **Date:** _____

Primary reason(s) for seeking services today:

Please check behaviors and symptoms that occur more often than you would like them to:

- | | | |
|---|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Phobias/Fears |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Grief | <input type="checkbox"/> Poor judgment |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Self-Esteem Problems |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sexual Difficulties |
| <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Social Withdrawal |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Irritability | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Unresolved Trauma |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Obsessive Thoughts | _____ |

Marital Status/Current Living Situation

Single Married Living with significant Other Separated Divorced Widowed

Assessment of current relationship (if applicable): Good Fair Poor

Relationship	Name	Age	<i>Living?</i>		<i>Living with you?</i>	
			Yes	No	Yes	No
Spouse/Partner	_____	_____	___	___	___	___
Children	_____	_____	___	___	___	___
	_____	_____	___	___	___	___
	_____	_____	___	___	___	___

Employment

Please check employment status:

employed full-time employed part-time unemployed disabled retired

If currently employed, please list job information below:

Employer	Job Title	How long there?
_____	_____	_____

Counseling/Prior Treatment History

Have you had any prior professional counseling or psychiatric treatment? Yes No

If yes, please list most recent treatment episodes, who treated you, and outcome below:

<i>Approximate Treatment Dates</i>	<i>Treatment Provider/Facility</i>	<i>Outcome</i>
_____	_____	_____
_____	_____	_____

Medication and Chemical Use History

Current Prescribed Medications	Dose	Frequency	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever been treated for alcohol or drug dependence/abuse? Yes No

Have you ever felt like you should cut down on alcohol or other drug use? Yes No

Has a friend or relative ever discussed concerns about your drug use? Yes No

Have you ever felt guilty about your drinking or drug use? Yes No

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes No

Is there a history of problems with alcohol or drug use in your family? Yes No

Please note any current or past use of the following substances:

	<i>Amount</i>	<i>Frequency of use</i>	<i>Age of First Use</i>	<i>Age of Last Use</i>	<i>Used in last 48 hours?</i>		<i>Used in last 30 days?</i>	
					Yes	No	Yes	No
					_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____	_____	_____
Opioids/Narcotics	_____	_____	_____	_____	_____	_____	_____	_____
Amphetamines	_____	_____	_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____	_____	_____
LSD/Shrooms/PCP	_____	_____	_____	_____	_____	_____	_____	_____
Other drugs	_____	_____	_____	_____	_____	_____	_____	_____

Medical/Physical Health

List any current health concerns: _____

Primary Care Physician's Name and Phone Number: _____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____

Family History/Development

List any pertinent family history of medical, mental health, or substance abuse problems: _____

Significant Family Members (e.g., parents, siblings, step-relatives, half-relatives.)

Relationship	Name	Age	Living?		Living with you?	
			Yes	No	Yes	No
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Are there unusual or traumatic circumstances that affected your development? Yes No

If Yes, please describe: _____

Have you ever been a victim of sexual, physical, emotional, or verbal abuse? Yes No

Education

Fill in all that apply:

High school grad/GED

Vocational: Number of years: Graduated: Yes No Major: _____

College: Number of years: Graduated: Yes No Major: _____

Graduate: Number of years: Graduated: Yes No Major: _____

Other training: _____

Currently enrolled in school? Yes No (If yes, where? _____)

Special circumstances (e.g., learning disabilities, gifted): _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

Affectionate Aggressive Avoidant Fight/argue often Follower

Friendly Leader Outgoing Shy/withdrawn Submissive

Other (specify): _____

Spiritual/Religious

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group? Yes No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No

If Yes, describe: _____

Military

Military experience? Yes No

Combat experience? Yes No

Where: _____

Branch: _____ Discharge date: _____

Date enlisted: _____ Type of discharge: _____

Legal

Current Status

Are you involved in any active cases (civil, criminal)? Yes No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

For Staff Use

Therapist's signature/credentials: _____ Date: ___/___/___

Additional Comments/Information pertinent to treatment:

