VOGELFANGER AND STRUBLE CLINIC

NEW PATIENT INFORMATION

(Please Print)

Patient Name:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Date of birth:_____ Age:_____ Sex: ○ Male ○ Female Marital Status: **S M W D Sep**

SSN #:_____ Home phone:_____ Cell Phone:_____

Email:_____ Patient's employer/school:_____

Name of guardian (if applicable):_____

Allergies:_____

Emergency Contact's Name:_____ **Phone #:**_____

Emergency Contact's Relationship To Patient:_____

Insured's name:_____ Insured's Social Security#:_____

Insured's Address:_____ Insured's date of birth:_____

Insured's Employer:_____ Insured's phone #:_____

Insured's employer's address: _____ Insured's occupation:_____

Patient's relationship to insured party: **Self Spouse Child Other**:_____

Here due to related injury or illness?: ○YES ○NO Date of accident or occurrence:_____

Are you currently on disability or seeking disability? ○ YES ○ NO

Primary Pharmacy Name and Phone #:_____

Consent To Treatment

I do hereby seek and consent to assessment, examination, AND treatment by Vogelfanger and Struble Clinic and/or any of its associates. I understand that developing a treatment plan and regularly reviewing my progress toward meeting my treatment goals is in my best interest. I agree to participate actively in this process.

Assignment Of Benefits

I authorize payment directly to Vogelfanger and Struble Clinic PLLC of any benefits payable under my insurance policy for the indicated services.

Patient/Guardian Signature:_____ **Date:**_____

Vogelfanger and Struble Clinic

Patient Rights and Responsibilities Statement

PATIENT RIGHTS

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment regardless of race, religion, gender, sexual orientation, ethnicity, age, disability, or source of payment.
- Patients have the right to have their treatment and other patient information kept private. Only when required by law will information and records be released without patient permission.
- Patients have the right to access care in a timely fashion. Patients have the right to know about treatment options. This is regardless of cost or coverage by the patient's benefit plan.
- Patients have the right to participate in developing a plan of care.
- Patients have the right to get information about their insurance plan, in a language the patient can understand.
- Patients have a right to receive a clean explanation of their progress, condition, and treatment options.
- Patients have the right to get information about their insurance plan, practitioners available, services available, and the insurance company's role in the treatment process.
- Patients have the right to information about clinical guidelines used in providing and managing patient care.
- Patients have the right to ask the provider about provider's work history and training.
- Patients have the right to give input on the patients' rights and responsibility policy.
- Patients have the right to know about advocacy, community and prevention services.
- Patients have the right to freely file a complaint pr appeal To their insurance company and learn how to do so.
- Patients have the right to know their rights and responsibilities in the treatment process.
- Patients have the right to receive services that will not jeopardize employment.
- Patients have the right to identify certain preferences in selecting a provider.

PATIENT RESPONSIBILITIES

- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients have the responsibility to give the providers the information they need. This is so providers can deliver the best possible care.
- Patients have the responsibility to ask questions about their care. This is to help them understand their care.
- Patients have the responsibility to follow the treatment plan. The plan of care is to be developed and agreed upon by the patient and provider.
- Patients have the responsibility to follow the agreed upon therapy and medication plan.
- Patients have the responsibility to tell their provider and primary care physician about medication changes, including medication given to them by others.
- Patients have the responsibility to keep their appointments. Patients should call their provider as soon as they know they need to cancel appointments.
- Patients have the responsibility to let their provider know when the treatment plan is not working for them.
- Patients have the responsibility to let their provider know about problems paying fees.
- Patients have the responsibility to report abuse and fraud.
- Patients have the responsibility to openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, that I understand this information, and that I have received a copy if requested.

Patient/ Guardian Signature:_____ **Date:**_____

VOGELFANGER AND STRUBLE CLINIC

INTAKE INFORMATION

NOTICE OF PRIVACY PRACTICES

○ I have received a copy of this office's notice of privacy practice.

HELPFUL RECOURCES

○ I have received a list of helpful recourses.

MENTAL HEALTH ADVANCED DIRECTIVE

○ I currently have a mental health directive.
If you check here, please provide us with a copy.

○ I do not have a mental health advanced directive.
If you check here, you may request and develop one at any time.

Signature of Patient/Guardian:_____ **Date:**_____

Signature of Staff:_____ **Date:**_____

VOGELFANGER AND STRUBLE CLINIC

AUTHORIZATION TO DISCLOSE INFORMATION TO PRIMARY CARE PHYSICIAN

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been reliance on it. This release will automatically expire twelve months from the date signed.

I, _____, hereby authorize **VOGELFANGER AND STRUBLE CLINIC, PLLC**

(Please Check One)

- ○ To release any applicable information to my Primary Care Physician
- ○ To release medication information only to my Primary Care Physician
- ○ Not to release any information to my Primary Care Physician

Primary Care Physician:_____

Address:_____

Phone Number:_____

○ I do not have a Primary Care Physician (PCP)

Patient/Guardian Signature:_____

Please Print Name of Patient:_____

Date:_____

VOGELFANGER AND STRUBLE CLINIC
PATIENT HELATH QUESTIONNAIRE AND GENERAL ANXIETY DISORDER
(PHQ-9 AND GAD-7)

Date: _____ Patient Name: _____ Date of Birth: _____

Over the <u>last 2 weeks,</u> how often have you been bothered by any of the following problems?

Please circle your answers.

PHQ - 9	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get alone with other people? (Circle one)

Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

Over the <u>last 2 weeks,</u> how often have you been bothered by any of the following problems?

Please circle your answers.

GAD - 7	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get alone with other people? (Circle one)

Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

VOGELFANGER AND STRUBLE CLINIC

Patient Name:	DOB:	Age:

What is the chief complaint? Why is the patient here? _____

Psychiatric treatment history. Outpatient and inpatient. Include names/ dates; helpful/ not helpful.	List all current and previous psychiatric medicines and tell if they were helpful.	Family and patient history of psychiatric issues or alcohol/ drug abuse.	Medical Issues. Issues with pain. Allergies. All current medications for medical problems.

			If response is yes, briefly explain:
Physical Abuse	○ Yes	○ No	
Emotional Abuse	○ Yes	○ No	
Sexual Abuse	○ Yes	○ No	
Trauma	○ Yes	○ No	
Recent Deaths or Losses	○ Yes	○ No	
DCS Involvement with Family	○ Yes	○ No	
Disability	○ Yes	○ No	

Employer? Work Issues?	School name/ grade: School Issues?	Who lives in patient's home? Problems at home?
Hobbies/ community/ leisure activities? Problems in the community?	Religious and cultural affiliations?	Legal or financial issues?

Does the patient have problems making or keeping friends?	○ Yes	○ No
Any problems with memory?	○ Yes	○ No
Sees or hears things that others do not?	○ Yes	○ No
Nervous or upset often? Anxious?	○ Yes	○ No
Sleep problems?	○ Yes	○ No
Appetite problems or eating issues?	○ Yes	○ No
Depressed or "blue" for days in a row?	○ Yes	○ No
Suicidal thoughts or plans considered as a solution for problems?	○ Yes	○ No
Thoughts or plans to harm others?	○ Yes	○ No
Smoke or use tobacco? Frequency and rate:	○ Yes	○ No
Issues regarding sexuality, sexual behavior, pregnancy, menstrual cycle?	○ Yes	○ No

Was patient's birth planned?	○ Yes	○ No	Explain Complications:
Any complications with pregnancy or labor?	○ Yes	○ No	
At what age did patient walk and talk?	Age:		

VOGELFANGER AND STRUBLE CLINIC, PLLC

6005 PARK AVENUE

SUITE 630-B

MEMPHIS, TN 38119

(901) 767- 1136 phone

(901) 767- 0476 fax

CONSENT FOR E- MED REQUEST

I do hereby consent to Vogelfanger and Struble Clinic requesting my medication history from the pharmacy clearinghouse (E- Med Records).

Name of Patient

Signature of patient, parent, or legal guardian Date

E-med request Consent checkbox has been checked to indicate permission has been received from the patient to download their medication history.

Signature of staff checking box

VOGELFANGER AND STRUBLE CLINIC

TENNderCARE EPSDT INFORMATION, ASSESMENT, AND REFERRAL SCREENING

(Required for ALL TennCare Patients under 21 Years of Age)

Tennessee Medicaid Insurance coverage provides for the periodic diagnosis and treatment of dental, vision, and hearing problems for covered children and young adults under the age of 21 years.

Date of most recent **DENTAL** examination: _____	Referral provided for Doral Dental: 1-888-233-5935 ○ YES ○ NO
Date of most recent **VISION** examination: _____	Referral provided for VISION SERVICES:* ○ YES ○ NO
Date of most recent **HEARING** examination: _____	Referral provided for HEARING SERVICES:* ○ YES ○ NO

*for referrals for VISION and HEARING services: call for TENNCare Health Plan Customer Service Center

- United Health Care West TN: 1-800-690-1606
- BlueCare West TN: 1-800-999-1658
- WellPoint 1-800-438-8789

Patient Name: _____

Signature of patient if 18 years old or older/ guardian if under 18 years old:

_____ Date: _____

Copy given to patient/ guardian? ○ YES ○ NO

Staff Signature: _____ Date: _____