

David C. Mathis, Ed.D.

1134 Dow Street
Murfreesboro, TN 37130

Counseling and Consulting Psychology

Phone (615) 624-4494 Fax (615) 823-2879
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PATIENT INFORMATION

Child's Name: _____ SS#: _____ - _____ - _____

Nickname: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

FAMILY INFORMATION *(check each method of contact that can be used)*

Mother's Name: _____ Date of Birth: _____

Phone: (_____) _____ - _____ SS#: _____ - _____ - _____

Employer: _____ Phone: (_____) _____ - _____

Mother's Email: _____

Father's Name: _____ Date of Birth: _____

Phone: (_____) _____ - _____ SS#: _____ - _____ - _____

Employer: _____ Phone: (_____) _____ - _____

Father's Email: _____

Name and ages of others who reside with you: *(use the back if necessary)*

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Relationship to you: _____ Phone: (_____) _____ - _____

MEDICAL INFORMATION

Have you ever consulted a mental health professional? If so, whom and when:

Specify medication and dosages currently taken: *(use the back if necessary)*

Your Physician: _____ Phone: (____) _____ - _____

Last physical exam date: _____ Height: _____ Weight: _____

If a professional referred you, may we send them a confirmation of your appointment? _____

If yes, Provider name and location: _____

Circle any condition you have ever been treated for OR have indications of:

1. High blood pressure, anemia, hypoglycemia, diabetes, any blood disorder
2. Epilepsy, memory loss, migraine headaches, paralysis, any brain disorder

Please list any other relevant medical condition not already indicated: *(use the back if necessary)*

Circle any recent changes (last six months) in your:

1. Vision, hearing, coordination, balance, strength, speech, memory
2. Energy, sleeping, eating, elimination, menstrual cycle, sexual activity

Check all that apply:	Current	Past		Current	Past
Appetite change	_____	_____	Eating disorder	_____	_____
Weight Loss	_____	_____	Weight Gain	_____	_____
Difficulty concentrating	_____	_____	Confusion	_____	_____
Memory Loss	_____	_____	Seizures	_____	_____
Head Injury	_____	_____	Chronic Pain	_____	_____
Anxiety	_____	_____	Depressed mood	_____	_____
Irritability	_____	_____	Mood Swings	_____	_____
Excessive worrying	_____	_____	Withdrawal	_____	_____
Arguments	_____	_____	Anger	_____	_____
Physical Abuse	_____	_____	Sexual Abuse	_____	_____
Sexual Problems	_____	_____	Sexual functioning	_____	_____
Suicidal Thoughts	_____	_____	Suicidal actions	_____	_____
Thoughts to harm others	_____	_____	Harm toward others	_____	_____
Suffered from trauma	_____	_____	Sleep problems	_____	_____

This section relates to behaviors associated with possible addiction issues:

	Current	Past		Current	Past
Alcohol consumption	_____	_____	Alcohol Abuse	_____	_____
Abuse of illicit drugs	_____	_____	Abuse of prescriptions	_____	_____
Blackouts	_____	_____	Consequences from A/D	_____	_____
DUI or PD Charge	_____	_____	Arrested for Drugs	_____	_____
Tobacco Use	_____	_____	Food misuse	_____	_____
Sexual	_____	_____	Pornography	_____	_____

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PERSONAL INFORMATION

Do you have any special needs or concerns (e.g., language barriers, disabilities):

Briefly describe in reasons for seeking help at this time:

Print Name: _____

Signature

Date

PRACTICE POLICIES

As you enter into these services, it is important to me that you understand the policies of this practice so that you can make informed choices and we can minimize any misunderstandings.

BENEFITS AND RISKS OF PSYCHOTHERAPY

Psychotherapy is not easily reduced to a simple description. It varies depending upon the personality of both the therapist and the client as well as the particular issues for which the client seeks consultation. Individuals contemplating psychotherapy should realize that clients may make significant changes in their lives. People often modify their behaviors, emotional responses and attitudes during the course of therapy. In addition, it is possible that people will begin to feel differently about themselves and possibly alter significant aspects of their lives. Clients may make changes in employment, relationships, marriages, or familial relationships. It is not unusual for clients to feel some discomfort and distress before improvement is felt. If you have any questions about the process or my approach, we should discuss them if and when they arise.

CONFIDENTIALITY

Tennessee law states: “The confidentiality relationship and communications between licensed psychologist . . . and client are placed upon the same basis as those provided by law between attorney and client . . .” This means that the confidential information is controlled by the client or legal representative. In addition, psychologists have ethical and moral obligation to keep confidential information which is revealed in sessions.

There are two exceptions to this law. First, in the case of an emergency when there is imminent danger to the client or another person, the psychologist can breach the confidentiality. Second, Tennessee law requires that child abuse be reported to the Department of Children Services. These situations have rarely arisen in my practice. Should such a situation occur, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult with other professionals. In these consultations, I make every effort to avoid revealing the identity of my client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important for our work together.

I practice in a building in which others also conduct professional services. However, all client records and calendars are separated so that confidentiality is maintained. I am not legally associated with any other professional who shares space. I operate as an independent practitioner and thus am not liable for or responsible for the action of any other professional. I

will do my utmost to ensure the professionalism of the office environment and the confidentiality of my client's information.

If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is highly unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider(s). In other words, if you choose to use email as a way to make contact with me, I cannot ensure the same level of confidentiality or HIPPA compliance. Thus, it is best to limit the use of personal, health information when using email.

EMERGENCY SITUATIONS

If an emergency arises after normal business hours, you should call 911 or go to the nearest emergency room for assistance.

FINANCIAL CONSIDERATIONS

You are asking that we enter into relationship for my services. Just as with any other service provider, whether it is an attorney or an accountant, there are fees for the services that you need. However, different from many service providers, because many of my services are health services that may be covered under your respective insurance plan, some fees may be paid for by your insurance. When your insurance pays for the services, you will not be billed for any more than what your plan allows. For example, if your plan reimburses for \$80 for a 50 minute psychotherapy session and your co-payment is \$25, then I will accept that amount and you will not have any additional charges for that one service. There are some services which you may request which are not covered by insurance benefits. In addition, you may prefer to pay for services yourself rather than submit claims to insurance.

In examining your needs, we will work together to develop plans based on your needs. These services will usually include psychotherapy but may also involve assessment and psychological testing. In addition, you may require additional time for ancillary services such as supplying documents or completing paperwork for employment related needs, e.g., short-term disability, or legal needs, etc. These services are not covered by insurance plans and will be your responsibility to pay (and in some cases, PRIOR to the services being performed).

Time that is spent in ancillary services will be billed on 15 minute increments. It is normally my practice to charge for other professional services you may require including such services as (1) assessment reports, correspondence, telephone conversations, (2) attendance at meetings, (3) preparation of records or treatment summaries for special requests, or (4) any extra services that you may request. I am also available for telephone appointments.

The use of personality inventories or other types of psychological testing is important in assessment and treatment planning. Fees for these tests range from \$40 to \$95, depending

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upon the tests that are selected. In most instances, charges for these psychological tests are billed separately to you and are not billed to your insurance due to additional case management requirements, authorization forms and procedures.

There may be times that you may become involved or either are involved in litigation which may require my participation. You will be expected to pay for my professional time even if I am compelled to testify by another party. Because of the complexity of legal involvement, I charge on a different rate for preparation for and attendance at any legal proceeding.

MANAGED CARE AND PRIVACY

The escalation of cost of health care has resulted in an increasing level of complexity about insurance benefits. Managed care plans often require advance authorization for behavioral health services. You should also be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary. This information is part of the insurance company's records. Privately paying for services is another means of protecting your privacy.

APPOINTMENTS

I accept appointments during the week from 8 am until the last appointment starting at 4 pm. I will occasionally take evening and weekend appointments but only on a limited basis. In addition, I reserve evening or weekend time for those who are privately responsible for the fees rather than using insurance.

PROFESSIONAL ETHICS

I adhere to the statues of the State of Tennessee, the Ethical Principles of Psychologists and the Ethical Principles of the American Psychological Association. Client records are my responsibility and are securely maintained to protect confidentiality.

Your signature below indicates that you agree to abide by these terms of our professional contract.

Signature of client

Signature of responsible party (if not client)

I agree to pay for appointments that are missed when not canceled with a 24-hour notice.

Signature of client

Date

Revised: May 18, 2017

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law”, HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can do protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.



David C. Mathis, Ed.D., Licensed Psychologist

I, _____, understand and have been provided a copy of Dr. Mathis' Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

Signature of client or Parent if client is a minor or legal charge _____
Date

If Legal Charge, describe representative authority: _____

Name of person signing for: _____