The Northshore Group

Date ______________________ Clinician: ______________________

Patient Information

Name ______________________ Age ________ Birth date ______________ Sex ☐ M ☐ F

Address ____
(STREET) (APT #) (CITY & STATE) (ZIP CODE)

Home Phone* ______________________ Office Phone* ______________________

Cell/Pager ______________________ Email address ______________________

Social Security No. _______ - _____ - _______ Religion ______________ Education ______________

Occupation ______________________ Employer ______________________

Marital Status ☐ S ☐ M ☐ W ☐ D ☐ Sep Date: ______________ Previous Marriages ______________

*** Only list numbers where it is ok for you to receive phone calls.**

Spouse/Partner Information

Name ______________________ Age ________ Birth date ______________ Sex ☐ M ☐ F

Home Phone ______________ Office Phone______________ Cell/Pager ______________

Social Security No. _______ - _____ - _______ Religion ______________ Education ______________

Occupation ______________________ Employer ______________________

Is it ok to release information such as billing inquiries or appointment times to your spouse / partner? ☐ Yes ☐ No

Emergency Contacts

Name ______________ Relationship ______________ Phone ______________

Name ______________ Relationship ______________ Phone ______________

Parents, Siblings, and Children

Name	Relationship	Age/DOB	Education	Occupation	Residence

Referral Information

Source of Referral ____

Previous Psychiatric Sources Used ____

Family Physician ______________________ Phone No ______________

Would you like us to bill your insurance for you? ☐ Yes ☐ No If yes, please make sure we have a copy of your card.

Have you called your insurance company for authorization (if required)? ☐ Yes ☐ No

Does your employer provide Employee Assistance Program (EAP) benefits? ☐ Yes ☐ No

If so, have you obtained an EAP referral for this visit? ☐ Yes ☐ No

OFFICE USE ONLY:
Dx: ______________
CPT: ______________
Charge: ______________

THE NORTHSHORE GROUP
1111 NORTHSHORE DRIVE – SUITE SOUTH 490
KNOXVILLE, TN 37919-4054
VOICE – (865)584-0171 FAX – (865)584-0174

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Communication between your clinician here at The Northshore Group and other healthcare providers (i.e. primary care physician and other mental health providers) is important to make sure all care is complete, comprehensive, and well-coordinated. No information will be released without your signed authorization.

- Name of patient: ______________________________ DOB: ___ /___ /___ SSN: _____-____-_____
- I authorize The Northshore Group / ____ to disclose protected health information about [myself / my minor child / my legal charge] (circle one):
- This information should only be released to:

  PCP / Clinician:____ Phone / Fax _________________

  Address: ____

- I am requesting the release / communication of this information to the above provider to ensure the quality and coordination of care.
- Any applicable behavioral health information, including diagnosis, treatment plan, prognosis, and medication(s) will be communicated between healthcare providers.
- This authorization shall remain in effect until ________________________ (fill in a date or an event).
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address above. I also understand that my revocation will not be effective to the extent that action has already been taken in reliance on the authorization.
- I understand that a mental health professional generally may not condition services upon my signing an authorization such as this.
- I understand that information used or disclosed according to the authorization may be re-disclosed by the recipient and may no longer be protected by the HIPAA Privacy Rule.

_______________________________________ _______________________________________
Signature of patient (or parent or legal guardian) Relationship to patient

____
Date

THE NORTHSHORE GROUP
An Association of Independent Practitioners

Patient's Rights and Responsibilities Statement

Statement of Patient's Rights

Patients have the right to:

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept private. Only where permitted by law may records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Patient's Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Patient's Responsibilities

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and the provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon as they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of the care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

____
Patient Signature Date

____
Provider Signature Date

Landmark Center – South Tower
1111 Northshore Drive Suite South 490 Knoxville, TN 37919-4054
Voice: (865) 584-0171 Fax: (865) 584-0174