IMPORTANT – PLEASE READ

GUIDELINES FOR NEW PATIENTS

COOL SPRINGS PSYCHIATRIC GROUP

354 COOL SPRINGS BLVD., SUITE 105, FRANKLIN, TN 37067

615-771-1100

You have made an appointment for a psychiatric evaluation with Cool Springs Psychiatric Group.

Appointment Guidelines:

- **Must arrive 15 min's before your appointment to check-in**
- Bring your insurance card, if applicable with photo ID.
- Be prepared to pay at time of appointment.
- You will see provider by yourself. Please don't bring children.

History Forms:

- You have received by email Cool Springs Psychiatric Group 17 page Psychiatric Evaluation & Diagnostic Packet.
- Please have it completed before you arrive for your appt. **They will not see you if the forms are not completed at the time of your appointment.**

Broken Appointment Fee:

- **You will be charged $100 broken appt., fee if you arrive without the paperwork completed.**
- Please give a 24-hour notice if you are going to **CANCEL** your appointment, to avoid a broken appointment fee.

Forms of Payment Accepted:

- All Credit Cards, Cash, **NO CHECKS!**

Cool Springs Psychiatric Group

PATIENT HISTORY

Patient Name ______________________________ Date of Birth________

Date form completed: ______________________

Please arrive on time and bring this form completed to your appointment to avoid any delay in seeing the doctor or cancellation of appointment.

1. What is prompting you to seek help? What do you want to change?

____
____
____

2. Why are you here now at this time in your life?

____
____
____

3. What is troubling you the most? (Please describe in detail)

____
____
____
____

4. What makes your problems/symptoms better?

____
____
____

5. What makes your problems/symptoms worse?

____
____
____

PSYCHIATRIC HISTORY

6. Are you currently seeing a therapist? (Name, address & phone#)______________________________

____

7. Have you ever seen a psychiatrist, psychotherapist, marriage counselor or family therapist for outpatient treatment? List provider's name, approximate duration of therapy, your age at that time and how benefical was it to you.

____
____
____
____
____

Patient Name:______________________________

8. Previous history: Have you ever been treated for any of the following (circle all that apply).
   Depression ADD/ADHD Bipolar (Manic/Depressive) Disorder
   Anxiety OCD Schizophrenia Panic Attacks Phobias
   Alcohol Problems (including AA) Anorexia/Bulimia Binge-eating PTSD
   Social Anxiety Drug Problems ECT treatment

9. Please list in chronological order all prior psychiatric hospitalizations (if any) below: None

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

10. Have you ever attempted to harm/kill yourself? If so, please list the occurrences below: Never

Approximate date of attempt	How did you attempt (method)

11. Prior drug related problems (circle all that apply):
    Tobacco marijuana cocaine opiates amphetamines/stimulants Valium
    hallucinogens Xanax others:______________________________

12. How much tobacco do you use now? ______________________________

13. Prior suicidal, dangerous and impulsive/compulsive behavior (check all that apply):
    ______ hallucinations commanding suicide
    ______ self-injurious behavior, i.e., cutting, burning
    ______ harm to others
    ______ gambling problems
    ______ impulsive/compulsive shopping
    ______ impulsive/compulsive sexual behavior

14. Prior alcohol related problems (check all that apply):
    ______ ever felt or been told you drink too much?
    ______ ever drink or use first thing in the morning?
    ______ ever experience alcohol or drug withdrawal?
    ______ ever gone through alcohol/drug detoxification?
    ______ ever been in an alcohol or drug rehabilitation program?

Patient Name____

15. Review the following list of medications. If you have taken any of these medications prescribed by any healthcare provider, please fill out the specific boxes related to that medication.

Brand Name	Generic Name	check if YES	How long taken?	Dosage Mg/d	Did it help Yes/No	Any Side effects?
Selective Serotonin Reuptake Inhabitors (SSRIs)						
Luvox	Fluvoxamine					
Paxil	Paroxetine					
Paxil CR	Paroxetine					
Celexa	Citalopram					
Lexapro	Escitalopram					
Zoloft	Sertreline					
Prozac	Fluoxetine					
Serotonin Norepinephrine Reuptake Inhabitors (SNRIs)						
Effexor	Venlafaxine					
EffexorXR	Venlafaxine XR					
Pristiq	Desvenlafaxin					
Cymbalta	Duloxetine					
Other Antidepressants						
Desyrel	Trazodone					
Serzone	Nefazodine					
Wellburtin	Bupropion					
Remeron	Mirtazapine					
Viibryd	Vilazodone					
Tricyclic Antiodepressants						
Adapin	Doxepin					
Anafranil	Clomipramine					
Asendin	Amoxapine					
Elavil	Amitriptyline					
Ludiomil	Maprotiline					
Norpramin	Desipramine					
Pamelor	Nortriptyline					
Sinequan	Doxepin					
Surmontil	Trimipramine					
Tofranil	Imipramine					
Vivactil	Protriptyline					

Other Psychotropics (Have you taken any of these?) Please circle

Abilify	Buprenorphin	Dexedrine	Ambien	Klonopin	Emsam	Provigil	Thorazine	Cialis
Risperdal	Campral	Adderall	Buspar	Ativan	Nardil	Depakote	Dalmane	Viagra
Invega	Antabuse	Vyvanse	Restoril	Xanax	Parnate	Lithium	Orap	Levitra
Geodon	Suboxone	Strattera	Sonata	Hydroxyzine	Halcion	Lamictal	Navane	Stendra
Zyprexa	Naltrexone	Concerta	Vistaril	Valium	Niravam	Phemtermine	Trilafon	Rexulti
Seroquel	Ambien CR	Dexedrine	Atarax	Tranxene	Tegretol	Mobane		Adzenus
Symbyax	Valproic Acid	Focalin	Librium	Methadone	Cylert	Topamax	Stelazine	Vraylar
Clozapine	Adderall XR	Ritalin	Saphris	Synthoid	Mellaril	Haldol	metadate	
Daytrana	Lunesta	Meridia		Loxitane	Prolixin	Latuda	Nuvigil	
Trintellix (vortroxetine)		Fanapt (Ileoperidone)						

Patient Name:___________________________________

SOCIAL HISTORY

16. Race/Ethnicity (check one or more):
    ___ American Indian/Alaskan Native
    ___ African American
    ___ Hispanic
    ___ Caucasian
    ___ Other

17. Current marital status (check one):
    ___Single, never married ___Married, living together ___Separated
    ___Widowed ___Cohabiting with partner ___Divorced
    ___ Married, not living together

18. If you are married or cohabitating with partner, how long has this been? _____Yrs. _______Mos.

19. Total number of marriages: ________ Your age when married______
    Your age when divorced_______

20. How many children do you have? _____ Ages:_________________________

21. *Females Only:* Your age when your children were born?________________________
    Did you ever experience post-partum problems (treated or untreated)?________
    If yes, what was your age?________
    Are you pregnant or plan to become pregnant with the next 6 months?_______

22. Spouse's/Partner's Name:____

23. Who else lives with you?____

24. How many years of formal education have you completed? _______ years

25. Highest degree obtained: (check only one)
    ___High school graduate ___G.E.D. ___4 year college degree ___MBA/MA/MS/MPH
    ___M.D. ___Junior college degree or technical school diploma ___JD/LLB
    ___Ph.D ___Other___________________________

26. What best describes your current employment status? (check one from each category a,b & c_)

    a. Employment Status
    __Unemployed, not looking for employment
    __ Unemployed, looking for employment
    __Full-time employed
    __Part-time employed
    __On welfare __Social security disability

    b. Student
    __Part-time
    __Full-time
    __Not a student

    c. Volunteer Status
    __Part-time
    __Full-time
    __No Volunteer work

27. What is your occupation?_____________________________ Employer:________________
    How long have you been employed there?___________

28. What is your spouse's occupation?____

29. Current Residence: __own home/condo __Retirement/Senior housing __Renting

Patient Name:______________________________________

30. Family History: Has anyone in your family ever been treated for any of the following: (please check all that apply and when appropriate indicate paternal or maternal)

	Father	Mother	Brother	Sister	Children	Aunt	Uncle	Grandparent
Depression								
Anxiety								
Panic Attacks								
Post Traumatic Stress								
Bipolar/Manic depression								
Schizophrenia								
Alcohol Problems								
Drug Problems								
ADHD								
Suicide attempts								
Suicide completed								
Psychiatric hospital stay								

31. **Medical History:** Do you have or have you ever had any of the following (please check all that apply)? Please write in your medical problems in each category.

___High Blood Pressure

___Lung Disease

___Diabetes

___Heart Disease

___Thyroid Disease

___Anemia

___Asthma

___Skin Disease

___Seizures

___High Cholesterol

___Cancer

___Eating Disorder

___Chronic pain

___HIV Positive or AIDS

___Other medical issues

___Gastrointestinal Problems (ulcers,pancreatitis, irritable bowel, colitis)

___Arthritis or Rheumatoid problems

___Liver Damage or Hepatitis

___Other Endocrine? Hormone Problems

___Neurological Problems (stroke, brain tumor nerve damage)

___Gynecological/Hysterectomy

___Urinary Tract or Kidney Problems

___Migraine or Cluster Headaches

___Ear/Nose/Throat Problems

___Viral Illness (herpes, Epstein-Barr, Chronic Hepatitis)

___Genital Problems

___Eye Problems

___Fibromyalgia

___Sleep apnea

Patient Name:____

32. Primary care physician: Name, address & phone#: ____

____

*If you do not have primary care physician, it is advisable to contact your insurance to locate a physician.

33. List names of any specialists: ____

34. List any drug allergies: ____

35. Current/recent stresses (check all that apply with a brief explanation):

___Break up of relationship:____

___Serious argument: ____

___Child/other left home: ____

___Death of spouse/other: ____

___Health of family member: ____

___Behavior of family member: ____

___Personal injury or illness: ____

___Retired: ____

___Loss of job: ____

___Change of residence: ____

___Legal difficulty: ____

___Financial problems: ____

___Other: ____

Patient Name: ____

36. Has there ever been a period of time when you were not your usual self? Check all that apply:

a. ___ you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?
b. ___you were so irritable that you shouted at people or started fights or arguments?
c. ___you felt much more self-confident than usual?
d. ___you got much less sleep than usual and found you did not really miss it?
e. ___you were much more talkative or spoke much faster than usual?
f. ___thoughts raced through your head or you could not slow your mind down?
g. ___you were so easily distracted by things around you that you had trouble concentrating or staying on track?
h. ___you had much more energy than usual?
i. ___you were much more active or did many more things than usual?
j. ___you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?
k. ___you were much more interested in sex than usual?
l. ___you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
m. ___spending money got you or your family into trouble?

37. If you checked more than one of the above, have several of these ever happened during the same period of time?

38. How much of a problem did any of these cause you -- being unable to work; having family; money, or legal troubles; getting into arguments or fights?
Please circle one (1) response only:
No problem   Minor problem   Moderate problem   Serious problem

39. Has a health professional ever told you that you have manic-depressive illness, bipolar disorder, adult ADD or ADHD? ____

40. Are you on a diet of any kind? _______ If yes, explain: ______________________________
____

42. When do you typically go to bed? ____

43. What are your weekly patterns of exercise? ____
____

44. List a few positive changes you would like to see in yourself over the next few months:
____
____
____
____

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date					
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.			Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?							
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?							
3. How often do you have problems remembering appointments or obligations?							
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?							
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?							
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?							
							Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?							
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?							
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?							
10. How often do you misplace or have difficulty finding things at home or at work?							
11. How often are you distracted by activity or noise around you?							
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?							
13. How often do you feel restless or fidgety?							
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?							
15. How often do you find yourself talking too much when you are in social situations?							
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?							
17. How often do you have difficulty waiting your turn in situations when turn taking is required?							
18. How often do you interrupt others when they are busy?							
							Part B

Mood Check

Part A. Please place a check after the statements below that *accurately describe you.*

During times when I am not using drugs or alcohol:	
I notice that my mood and/or energy levels shift drastically from time to time.	
At times, I am moody and/or energy level is very low, and at other times, and very high.	
During my "low" phases, I often feel a lack of energy, a need to stay in bed or get extra sleep, and little or no motivation to do things I need to do.	
I often put on weight during these periods.	
During my low phases, I often feel "blue," sad all the time, or depressed.	
Sometimes, during the low phases, I feel helpless or even suicidal.	
During the low phases, my ability to function at work or socially is impaired.	
Typically, the low phases last for a few weeks, but sometimes they last only a few days.	
I also experience a period of "normal" mood in between mood swings, during which my mood and energy level feels "right" and my ability to function is not disturbed.	
I then notice a marked shift or "switch" in the way I feel.	
My energy increases above what is normal for me, and I often get many things done I would not ordinarily be able to do.	
Sometimes during those "high" periods, I feel as if I have too much energy or feel "hyper".	
During these high periods, I may feel irritable, "on edge," or aggressive.	
During the high periods, I may take on too many activities at once.	
During the high periods, I may spend money in ways that cause me trouble.	
I may be more talkative, outgoing or sexual during these periods.	
Sometimes, my behavior during the high periods seems strange or annoying to others.	
Sometimes, I get into difficulty with co-workers or police during these high periods.	
Sometimes, I increase my alcohol or nonprescription drug use during the high periods.	
Total	

Part B. The statements in Part A (not just those checked) describe me (circle one of the answers below):

Not at all (0)	A little (2)	Fairly well (4)	Very well (6)

Add the number in parentheses in Part B to your checkmark total from Part A. _________

Part C. Please indicate whether any of your (blood) relatives have had any of these concerns:

	☐ Grandparents	☐ Parents	☐ Aunts/Uncles	☐ Brothers/Sisters	☐ Children
Suicide					
Alcohol/Drug Problems					
Mental Hospital					
Depression Problems					
Manic or Bipolar					

Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	Yes	No
Have you ever attempted suicide?	Yes	No

(please continue with part D, over)

MoodCheck

Part D.

Question						
How old were you when you first were depressed? *(circle one)*	As long as I can remember	Grade school	Middle school	High school	18-24	> 24
How many episodes of depression have you had?	One	2-4	5-6	>10		
Have antidepressants ever caused: *(circle all that apply)*	Excessive energy	Severe insomnia	Agitation	Irritability	Racing thoughts	Talking a lot
How many antidepressants have you tried, if any?	None	1	2	3	>3	
Has an antidepressant you took worked at first, then stopped working?	No	Yes				
Do your episodes *start* gradually, or suddenly?	Gradually	Can't say	Suddenly			
Do your episodes *stop* gradually, or suddenly?	Gradually	Can't say	Suddenly			
Did you have an episode after giving birth?	No	Within 6 months	Within 2 months	Within 2 weeks		
Are your moods much different at different times of year?	No effect of time of year	Yes, seasonal shifts				
When you are depressed, do you sleep differently?	No	Sleep less	Sleep more			
When you are depressed, do you eat differently?	No	Eat less	Eat more			
When you are depressed, what happens to your energy?	Nothing	It varies a lot	Very low	Extremely low, can hardly move		
In episodes, have you lost contact with reality? (delusions, voices, people thought you were odd)	No	Yes				

If your total score from Parts A and B is greater than 16; or if you have lots of circles in shaded boxes on this page, you may need to learn more about "mood swings without mania" or Bipolar II disorder.

If your total score from Parts A and B is less than 10, and you have few circles in shaded boxes on this page, antidepressants are probably okay, if you and your doctor choose to use them. They can occasionally cause: unusual thoughts, including violent and suicidal ones; irritability; too much energy; and severe sleep problems. Contact your doctor if you think any of these might be happening to you.

Your Name ______________________ Date ____________

CAGE

Patient Name: ______________________________ Date:______________

Instructions: Answer *YES* or *NO* to each of the following questions.

1. Have you ever felt you ought to *cut* down on your drinking?

   ___ Yes (1)

   ___ No (0)

2. Have people *annoyed* you by criticizing your drinking?

   ___ Yes (1)

   ___ No (0)

3. Have you ever felt bad or *guilty* about your drinking?

   ___ Yes (1)

   ___ No (0)

4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

   ___ Yes (1)

   ___ No (0)

Please add the numerical value of each answer to get your score.

TOTAL SCORE: ________

A score of 2 or more may indicate clinically significant alcohol problems.

Burns Anxiety Inventory*

Name: ____________________ Date of Test: ____________________

DOB: ____________________

INSTRUCTIONS: Mark the appropriate box with an X to answer each question. Please be honest and be sure to answer all questions on the page. Indicate how much each of the following symptoms has been bothering you in the past several days.		0- Not at all	1- Somewhat	2- Moderately	3- A lot
CATEGORY I: ANXIOUS FEELINGS					
1	Anxiety, nervousness, worry or fear				
2	Feeling things around you are strange or foggy				
3	Feeling detached from all or part of your body				
4	Sudden unexpected panic spells				
5	Apprehension or a sense of impending doom				
6	Feeling tense, stress, "uptight" or on edge				
CATEGORY II: ANXIOUS THOUGHTS					
7	Difficulty concentrating				
8	Racing thoughts				
9	Frightening fantasies or daydreams				
10	Feeling on the verge of losing control				
11	Fears of cracking up or going crazy				
12	Fears of fainting or passing out				
13	Fears of illnesses, heart attacks, or dying				
14	Fears of looking foolish in front of others				
15	Fears of being alone, isolated or abandoned				
16	Fears of criticism or disapproval				
17	Fears that something terrible will happen				
CATEGORY II: PHYSICAL SYMPTOMS					
18	Skipping, racing or pounding of the heart				
19	Pain, pressure or tightness of the chest				
20	Tingling or numbness in the toes or fingers				
21	Butterflies or discomfort in the stomach				
22	Constipation or diarrhea				
23	Restlessness or jumpiness				
24	Tight, tense muscles				
25	Sweating not brought on by heat				
26	A lump in the throat				
27	Trembling or shaking				
28	Rubbery or "jelly" legs				
29	Feeling dizzy, lightheaded, or off balance				
30	Choking or smothering sensations or difficulty breathing				
31	Headaches or pains in the neck or back				
32	Hot flashes or cold chills				
33	Feeling tired, weak, or easily exhausted				

Office Use Only:
Score: ____________
Test #: ____________

*Copyright © 1984 by David D. Burns, MD (from *The Feeling Good Handbook*, Plume, 1990)

Burn's Depression Checklist

Name: ______________________ Date: ______________

Instructions: Put a check ☑ to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.		0 = Not At All	1 = Somewhat	2 = Moderately	3 = A Lot	4 = Extremely
Thoughts and Feelings						
1	Feeling sad or down in the dumps					
2	Feeling unhappy or blue					
3	Crying spells or tearfulness					
4	Feeling discouraged					
5	Feeling hopeless					
6	Low self-esteem					
7	Feeling worthless or inadequate					
8	Guilt or shame					
9	Criticizing yourself or blaming others					
10	Difficulty making decisions					
Activities and Personal Relationships						
11	Loss of interest in family, friends or colleagues					
12	Loneliness					
13	Spending less time with family or friends					
14	Loss of motivation					
15	Loss of interest in work or other activities					
16	Avoiding work or other activities					
17	Loss of pleasure or satisfaction in life					
Physical Symptoms						
18	Feeling tired					
19	Difficulty sleeping or sleeping too much					
20	Decreased or increased appetite					
21	Loss of interest in sex					
22	Worrying about your health					
Suicidal Urges						
23	Do you have any suicidal thoughts?					
24	Would you like to end your life?					
25	Do you have a plan for harming yourself?					
	Please Total Your Score on Items 1-25 Here:					

Total Score	Level of Depression
No Depression	0-5
Normal but unhappy	6-10
Mild depression	11-25
Moderate depression	26-50
Severe depression	51-75
Extreme depression	76-100

MEDICATION LIST

Date:________________

Patient Name:____________________________ Date of Birth:__________

Allergies:

Please List ALL *current* medications below (include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort, etc.)

Date	Name of Medication	Dosage	Times per day?	On this for how long?	Side Effects (if any)	Prescribing Physician

Cool Springs Psychiatric Group

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ____
First Middle Last

Date of Birth: _____/_____/_____

Phone # with area code: ________________________ Alternate Phone# ______________________

Home Address:____

City: ____________________________________ State:__________ Zip code:____________

By signing this form I am acknowledging that I received a copy of the "The Notice of Privacy Practices" for physicians at Cool Springs Psychiatric Group.

Signature of Patient:____ Date:_______________

_____You may communicate with my primary care physician. Please give us following information:

* Name: ______________________________________ Phone:____________________

* Address: ____

____You may NOT communicate with primary care physician.

_____I prefer to decide later.

1/11/17

Cool Springs Psychiatric Group
REGISTRATION FORM
(Please Print)

Today's date: | PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ☐ M ☐ F

Street address: | City & State: | Zip Code

Social Security# | Home Phone ( ) | Cell ( ) | Work ( )

Occupation: | Employer: | Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital
☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Email address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate **primary** insurance

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of **secondary** insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child | Subscriber's date of birth:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize practitioners at Cool Springs Psychiatric Group or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Cool Springs Psychiatric Group

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name:____
First Middle Last

Date of Birth: ____________________ Home Phone:________________ Cell:____________

Physical Address:____

City:__________________________________ State:__________ Zip:________________

Requested Information to be amended:

I give my permission for the following person(s) to make appointments and speak to office staff in case of emergency on my behalf. I also give permission for doctor or nurse practitioner to speak to this person if it is clinically necessary. Write "None" if you do not give anyone permission to speak on your behalf.

Name:____ Relationship to patient:____________

Name:____ Relationship to patient:____________

*Person(s) you *do not* want us to talk to: ______________________________________

Relationship to patient: ____________________________

I understand that by giving my permission for the above named person(s) to communicate on my behalf to the Cool Springs Psychiatric Group staff and doctor, it is for these two purposes only. We rely on you, as our patient, to represent yourself on issues related to your overall care. It is our policy to inform you if others contact us concerning you.

TO Our Patient: You have the right to request that we amend your protected health information. We do not have to agree with your determination that the information should be amended. If we do not agree to the amendment request and you do not agree with our decision, you may submit a written statement disagreeing with the denial of all or part of a requested amendment on the basis of such disagreement. We may reasonably limit the length of a statement of disagreement. Please send any correspondence to Cool Springs Psychiatric Group, Attention: HIPAA compliance Officer, 354 Cool Springs Blvd., Suite 105, Franklin, TN 37067.

Your signature indicates that you understand and agree to the above information.

Signature of Patients; ____________________________________ Date:______________

1/1/15