# PATIENT INFORMATION
## Provider: Andrea Belt, APRN, PMHNP-BC

Today's Date: _____

Full Name (First, M.I., Last): _____

Street Address: _____

City/State/Zip _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Which phone is your preferred contact? Home Cell Work

Age: _____ Birthdate: _____ Sex: _____ Social Security #: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse/Partner's Name: _____

Are you experiencing any legal problems? Y N If yes, please explain: _____

_____

Briefly describe your reason for seeking services: _____

_____

_____

_____

**Emergency Contact Information**:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

**Medical Information**:

Primary Care Provider: _____

Office Location: _____ Phone:_____

Pharmacy Name: _____

Location: _____ Phone number:_____

Please list all **medications** and the **instructions from the prescription bottle**:

| Medication | Instructions |
| --- | --- |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

List all over the counter medications and how you take them (amount, how often):

_____

_____

_____

**Allergies** to Medication/Reaction:

| Medication | Reaction |
| --- | --- |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Food/Environmental Allergies:

_____

Medical Conditions:

_____

_____

_____

Surgeries (with date):

_____

_____

_____

Seizure? Y N If Yes, date of last seizure: _____

Diabetes? Y N If Yes, are you insulin dependent? _____

Cardiac issues? Y N If Yes, please explain: _____

_____

Has anyone in your family died suddenly from a heart condition before the age of 40? Y N

If Yes, please explain:

_____

Do you want Andrea Belt Mental Health Services, LLC to file insurance claims for you? Y N

If "Yes," complete this section. If "NO," skip this section.

*Patients with Medicare/Medicare HMO can skip this section.

Primary Insurance: _____

Policy Holder: _____

Relationship to Policyholder: _____

Policyholder DOB: _____ Policy holder SS#: _____

Policy ID#: _____ Group #: _____

Claims Address & Phone #: _____

_____

Secondary Insurance: _____

Policy Holder: _____

Relationship to Policyholder: _____

Policyholder DOB: _____ Policy holder SS#: _____

Policy ID#: _____ Group #: _____

Claims Address & Phone #: _____

_____

*Andrea Belt, APRN, PMHNP-BC*
*665 Emory Valley Rd., Suite B*
*Oak Ridge, TN 37830*
*865-296-9210*

## AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Andrea Belt, APRN, to release to my insurance company and/or insurance plan management company information requested on the HCFA-1500 claim form and/or the plan management company's outpatient treatment report for the purpose of pre-authorizing services and/or processing claims for reimbursement of services rendered by above-named provider. I also authorize above-named provider to release the information necessary to secure full payment of my account through other parties, such as a collection agency/credit bureau of court of law, if my account becomes delinquent.

_____ _____

Signature of Patient or Guardian Date

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and direct my insurance company and/or insurance plan management company to pay Andrea Belt, APRN such amount as may be payable pursuant to the provision of my contract.
I also authorize above-named provider to initiate a complaint to the insurance commissioner on my behalf if my insurance company fails to respond to a claim or to pay a claim in a timely fashion.

_____ _____

Signature of Patient or Guardian Date

## PAYMENT AGREEMENT

I accept responsibility for payment of fees for services provided to myself and /or my dependent by Andrea Belt, APRN. I understand and agree that having health insurance coverage does not relieve me of full responsibility for all charges, even when the therapist agrees to accept direct payment of benefits from the insurance and/or the plan management company. I understand that my insurance benefits may not pay for all charges incurred by my dependent or myself. I understand that I may be charged for appointments not cancelled 24 hours in advance and agree to pay those charges. I further agree to pay all charges (such as collection agency commissions, attorney's fees, court costs, returned check charges) incurred by above-named provider in the pursuit of payment for my delinquent account balance in addition to the full balance of my account. I also understand that interest charges may accrue on delinquent account balances and agree to pay such charges if my account becomes delinquent.

_____ _____

Signature of Patient or Guardian Date

# *Andrea Belt, APRN, PMHNP-BC*

## Acknowledgement of Receipt of Notice of Privacy Practices

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 ("transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("security rules"). HIPAA applies to all healthcare providers, including mental health care. Providers and health care agencies throughout the country are now required to provide patients with 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 ***Notice of Privacy Practices*** is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read ***Notice of Privacy Practices*** as it is important that 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 I will do all I can to protect the privacy of your mental health records. If you have questions about any of the matters discussed in this document, please do not hesitate to ask me for clarification.

By law, I am required to secure your signature indicating that you have received the ***Notice of Privacy Practices*** document.

Sincerely, Andrea Belt, APRN

I, _____, understand and have been provided a copy of Andrea Belt's ***Notice of Privacy Practices*** 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 the document before signing this acknowledgement form.

_____ _____

Signature of Patient or Guardian Date

If Legal Charge, describe representative authority:

_____

**Andrea Belt, APRN, PMHNP-BC**
**Substance Use Assessment**

Name: _____ Date: _____

Please note any use of the following:

| | | | How much? | How often? | Age at First Use |
|---|---|---|---|---|---|
| Caffeine products | Y | N | _____ | _____ | _____ |
| Tobacco products | Y | N | _____ | _____ | _____ |
| Alcohol | Y | N | _____ | _____ | _____ |
| Marijuana | Y | N | _____ | _____ | _____ |
| Prescription drugs not prescribed for you | Y | N | _____ | _____ | _____ |
| Amphetamines | Y | N | _____ | _____ | _____ |
| Cocaine | Y | N | _____ | _____ | _____ |
| Barbiturates | Y | N | _____ | _____ | _____ |
| Heroin | Y | N | _____ | _____ | _____ |

Any prior substance abuse treatment? Y N

If "yes," please provide name and location of treatment facility, as well as dates of treatment

and result (time clean/sober after discharge): _____

_____

_____

Have you ever felt you should cut down on your drinking or substance use? Y N

Have you ever felt guilty about your drinking or substance use? Y N

Have friends or relatives expressed concern about your drinking or substance use? Y N

Have you ever felt annoyed by criticism of your drinking or substance use? Y N

Have you ever felt the need to drink or use to keep functioning or to cope? Y N