The Northshore Group

Date ______________________________ Clinician: ______________________________

Patient Information

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

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

*** Please list below only phone numbers our staff can use to call or text about appointments and the account.**

Home Phone* ____________________ Work Phone* ____________________ Cell*____________________

Email ____

Social Security No. ________ - ____ - ________ Religion ______________ Education ______________

Occupation ______________________________ Employer ______________________________

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

Spouse/Partner Information

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

Home Phone ____________________ Work Phone ____________________ Cell ____________________

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 Contact

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 ______________________________ Office Phone ____________________

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:______________

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

Patient Name: ____ Date of Birth:_____________________

____
(Name of PCP, Therapist, Psychiatrist)

____
(Phone number of above PCP, Therapist, Psychiatrist)

____City________________________________State________Zip______________
(Address of above PCP, Therapist, Psychiatrist)

I, the above named patient, authorize my provider at The Northshore Group, and the clinician listed above to exchange information regarding my mental health / substance abuse treatment and medical healthcare for coordination of care purposes, including information relating to diagnosis, testing or treatment. I understand that this authorization shall remain in effect for the duration of my treatment and that I may revoke this authorization at any time by written notice.

Please select one: _______ I authorize communication with my PCP and or other healthcare provider
_______ I do NOT authorize communication with my PCP and or other healthcare provider

Signature of Patient / Personal Representative: _________________________________Date:_______________

INFORMATION TO BE COMPLETED BY PROVIDER

Date of Initial Consult:__________________________**Date of Next Appointment:**______________________

Type of Service: _______**Individual Therapy**
_______**Group Therapy**
_______**Family Therapy**
_______**Medication Management**
_______**Other:**____

Diagnostic Impressions:____

____

Treatment Recommendations / Medications:____

____

____

Please call if further information would be helpful.

Provider:_____________________________________ Date:____

Date Sent: ___________________________________

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