2210 Sutherland Ave., Suite 114
Knoxville, Tennessee 37919
(865) 556-8947
philip.axtell@easttnpt.com
easttennesseepsychologicaltesting.com

East Tennessee
Psychological Testing

Demographic Information—Adult

Please complete this form with all needed information. If you have any questions about this form, please ask us to explain.

Name: ______________________________ Today's Date: __________

Your Date of Birth: ________________ Your Age: ________

Phone Number: ____________________ Alternate Phone Number:____________________

Address: ____

City: ______________________ State: __________ Zip: ________

Your marital status: ______________

Social Security Number: ____________________

Employer: __________________________________

Person responsible for this account: ______________________________

Name of Insurance Carrier: ____

Name on Card (If different than above): ______________________________

Card Holder Date of birth:________________

Insurance Subscriber ID: ______________________ Group Number: ______________

Address of Insurance Carrier:______________________________________

City: ______________________ State: ______________ Zip:__________

Provider Service Number (on back of card): ________________________

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Consent to Treatment—Adult

I ____, ______________do
(Client Name) (Date of Birth)

hereby seek and consent to take part in the assessment and/or treatment provided by East Tennessee Psychological Testing (ETPT). I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of an assessment, treatment, or of any procedures provided to me by ETPT.

I am aware that I may stop the treatment or assessment at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that there may be consequences to terminating the assessment or treatment before it is completed.

I know that I must call to cancel an appointment at least 48 hours (2 days) before the time of the appointment. If I do not cancel and/or do not show up, I may be charged a no-show fee for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my assessment or treatment.

My signature below shows that I understand and agree with all of these statements.

______________________________ ____________________
Signature of client (or person acting for client) Date

______________________________ ____________________
Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Philip Axtell, Ph.D. ______________________________ ____________________
Signature of therapist Date

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Agreement to Pay for Professional Services

Adult

I request that East Tennessee Psychological Testing provide professional services to me ______________________________
(Print your name)
and I agree to pay this therapist's fee for these services.

I agree that this financial relationship with East Tennessee Psychological Testing (ETPT) will continue as long as services are provided or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping our sessions. I agree to pay for services provided to me up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by ETPT, although other persons or insurance companies may make payments on my account. I am also informed that my insurance may not cover the entire cost of the service(s) provided to me by ETPT. I understand that I will be billed for the remainder of the cost that is not paid by my insurance company. I also agree to pay the amount that is not paid by the insurance company. A written report will be provided following the completion of the evaluation **after all financial obligations have been met and your account has a zero balance.** If you have an outstanding balance, a final report will be sent when your balance is paid in full. If you have an outstanding balance, the final report will be sent when your balance is paid in full. Due to insurance policy, we cannot bill the testing until after the feedback session. It could take weeks after the feedback session for your insurance company to reimburse me for the testing services I provided to you. After we determine what you owe, after your insurance has paid, we will send you a final invoice. Once that final invoice is paid, I will send you the report of the results.

You understand that if your account is past due it may become necessary for our office to employ a collection agency. You agree to pay all costs including attorney's fees and court costs. **Any accounts placed with a collection agency will be charged an additional fee of 35% of the account balance.** All materials in your medical record remain the property of the psychologist. You realize that such action could require a release to the collection agency, attorneys, and/or the court, information which identifies the parties involved, give patient diagnoses, and describes the dates and nature of the charges as well as all other information contained on any claim filed.

I have read this information and agree to act according to everything stated here, as shown by my signature below.

______________________________ ______________________________
Signature of client (or person acting for client) Relation to client

______________________________ ______________________________
Printed name Date

I, the psychologist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Philip L Axtell, PhD ______________________________
Signature of psychologist Date

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Communication Agreement
Adult

In this agreement you are giving us permission and indicating the methods to contact you. Below you can specify the method(s) in which we can communicate information with you if we cannot talk with you directly. Please check the following statements allowing us way(s) to communicate with you.

I____, hereby give my consent to allow
(Please print your name)

East Tennessee Psychological Testing to contact me in the following ways by checking the following:

○ I give my permission to have messages left on my landline answering machine or voice mail

○ I give my permission to have messages left on my cellular phone voicemail

○ I give my permission to have messages sent to me at my email address: (please print clearly)

____

○ I give permission to have text messages sent to the following number: ____________________

○ I give my permission to leave messages about me or my child with the following person(s) in the event you cannot contact me directly

____ __________________________
Name of person Relationship

____ __________________________
Name of person Relationship

If you have any special requests about our office contacting you please indicate that request below

____

____

____ ______________________
Print Name Date of Birth

____ ______________________
Signature Date

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Health History Form

Your Name: ______________________________ Date: ____________

Have you, or do you currently have, any of the following health conditions:

	During Childhood	Currently
Serious head injury		
Loss of consciousness		
Epilepsy or seizures		
Broken bones		
Thyroid condition		
Migraine headaches		
Diabetes		
Allergies		
Asthma		
Heart problems		
Lead poisoning		
Problems with hearing		
Problems with vision		

Any other serious medical conditions not addressed above either currently or in the past:

____

Please list all of the medications you are currently taking

Name	Dose	Reason for taking medication

Continue on next page if needed

Medications (continued)

Name	Dose	Reason for taking medication

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Policy Regarding Electronic Media

The following policy gives you information about our policies and procedures regarding our use of electronic media. Included in this policy is the use of cell phones, smart phones, email, and social media (Facebook, Linked In, Four Square, Twitter, and other forms of social internet sites). Our use of, and participation in, these forms of media is very limited as outlined below and serves to protect you and your confidentiality and that of your children. If you have any questions about this policy feel free to talk with me at any time. As technology develops and changes over time these policies will be reviewed, amended, and changed. When we make changes to this policy we will notify you in writing.

1. Contacting you: In providing you with services we will have the need to contact you. Typically, this is accomplished with a phone call. At the time of your initial appointment, we will get contact information, your permission and modes of contact, and how our office will be able to leave information for you in the event we do not talk with you directly. You will have the opportunity to grant, or restrict, the administrative information we send to your selected device(s); cell phone, voicemail, text message, or email. Our office will only send administrative information including such things as appointment reminders, changes in appointment, or other information regarding your appointment. To protect your privacy, we will not use text or email for treatment related conversations. You can change, grant, or deny our office the use of your selected means of contact at any time by completing and signing our Communication Agreement.

2. Social Media: Our practice does not have any presence in the social media realm. Some of our staff members have social media accounts and pages. To protect your privacy, we do not accept, invite, friend, or initiate contact requests of current and former clients and their parents. This allows us to have a professional therapeutic relationship that protects the privacy of both you and us.

3. Email: If you give us permission we may contact you via email to give you information about your appointment. However, it is important to understand that this form of communication is not secure and the privacy of our clients is our upmost concern. Any emails that we exchange will become part of your mental health record. Additionally, emails are logged with internet service providers (both mine and yours) and are potentially available to be read by these providers. If you give us permission on the Communication Agree Form, we will send the final report via email that is Encrypted and HIPAA compliant. We do not use email as a therapeutic, treatment, or recommendation tool.

4. Location and check-in services: Many social media sites and smart phones have check-in and location services. You should be aware that with the use of these services at our office others can know where you are while you are here. This potentially gives others information that may

compromise your privacy by alerting them that you are at a location that provides psychological services. Please be aware of this risk if you routinely use check-in services or have a passive location service app or enabled service on your device.

5. Internet Search Engines: Our office does not routinely search clients on Internet search engines. However, in rare cases if we feel you may be a danger to yourself, others, or your children we may make use of an internet search of you or your child's name. In the rare event that a provider here makes use of a search engine concerning you or your child we will document this in you or your child's record and discuss it fully the next time we meet.