Child/Adolescent Information Form

Patient Name *

Title | First Name | Middle Name | Last Name | Suffix

Preferred Name

Patient Gender *

Please Select

Address *

Street Address

Street Address Line 2

City | State

Zip Code

Home Phone

Work Phone

Cell Phone

Patient E-Mail *

example@example.com

Receive appointment reminders via e-mail? *

Please Select

Receive invoices/statements via e-mail? *

Please Select

e-mail for invoices (if different)

example@example.com

Dr. Koch does not directly bill insurance companies. Will you be submitting statements of service to your insurance for reimbursement?

Please Select

Are you a full-time student

Please Select

Name of school

Are you employed?

Please Select

Employer

Occupation (if applicable)

For patients 17 years of age and younger:

Relationship to patient

Please Select

List other relationship

Parent's/Guardian's Name

Title First Name Middle Name Last Name

Parent's/Gaurdian's e-Mail

example@example.com

Parent's/Guardian's Phone

Do you live with patient

Please Select

Address

Street Address

Street Address Line 2

City State

Zip Code

Relationship to patient

Please Select

List other relationship

2nd Parent's/2nd Guardian's Name

Title First Name Middle Name Last Name

2nd Parent's/2nd Guardian's e-Mail

example@example.com

2nd Parent's/2nd Guardian's Phone

Do you live with patient

Please Select

Address

Street Address

Street Address Line 2

State

City

Zip Code

Treatment Concerns and Goals

Current Concerns

Treatment Goals

What changes would you like to see in your life? What are your goals for treatment?

Previous Treatment

Have you previously been in therapy or seen a psychiatrist before? How successful was it or how satisfied with the services were you? How would you like this experience to be different?

General Background/Demographics

Where were you born?

How long have you lives in the Nashville area?

Who lives with you?

Legal History

Religious affiliation (if any)/Spiritual

Legal History

Additional Information

Medical History

Do you have a personal/primary care physician?

Please Select

Physician's Name

Practice/Group Name

Phone Number

Phone Number

Area Code

Date of Last Visit

Pharmacy *

Pharmacy Phone *

Area Code

Phone Number

Pharmacy Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Are you currently under the care of another physician?

Please Select

Name and reason/condition treated

Medical History

Current/Past Medical Illnesses (e.g. Asthma, Diabetes, Thyroid Problems, Migraines, Chronic Pain, etc.)

Head Injury/Loss of consciousness

Current Medications

Current Medications (including prescription and non-prescriptions meds, vitamins, supplements, herbs, including name, dose, times, reasons):

Do you have any medication allergies?

Please Select

Please list medication allergies and your body's response to them:

Do you have any of these conditions?

	Yes	No	Current	Past
Abnormal Bleeding/Bruising	☐	☐	☐	☐
Alcohol/Substance Abuse/Dependence	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Angina Pectoris	☐	☐	☐	☐
Artificial Heart Valve	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Congenital Heart Defect	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐

Fainting Spells	☐	☐	☐	☐
Frequent Headaches	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Heart Murmur	☐	☐	☐	☐
Heart Surgery	☐	☐	☐	☐
Hemophilia	☐	☐	☐	☐
Hepatitis A	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐
Low Blood Pressure	☐	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐	☐
Pace Maker	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐
Sexually Transmitted Disease	☐	☐	☐	☐
Shingles	☐	☐	☐	☐
Sickle Cell Disease	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐

For female patients only: do any of the following apply to you?

	Yes	No
Are you taking birth control pills?	☐	☐
Are you planning on becoming pregnant?	☐	☐
Are you pregnant?	☐	☐
Are you nursing?	☐	☐

Substance Use History

Past or Present Substance Use (age of first use, frequency of use, amount used, last use, etc.):

Do you drink caffeine?

Please Select

Pattern

Age of first use, frequency of use, amount used, etc.

Do you use tobacco/nicotine in any form?

Please Select

Pattern

Age of first use, frequency of use, amount used, etc.

Last use:

Do you drink alcohol?

Please Select

Pattern

Age of first use, frequency of use, amount used, etc.

Last use:

Do you use Marijuana?

Please Select

Pattern

Age of first use, frequency of use, amount used, etc.

Last use:

Do you use Cocaine, Methamphetamine, or other stimulants (not prescribed to you)?

Please Select

Pattern

Age of first use, frequency of use, amount used, etc.

Last use:

Do you use anti-anxiety medications (benzodiazepines, barbiturates, etc.)?

Please Select

Pattern

Prescribed to you or not? Age of first use, frequency of use, amount used, etc.

Last use:

Do you use narcotic/opiate pain medications?

Please Select

Pattern

Prescribed to you or not? Age of first use, frequency of use, amount used, etc.

Last use:

Do you use inhalants?

Please Select

Pattern

Last use:

Other Drug Use?

Please Select

Pattern

Age of first use, frequency of use, amount used, last use, etc.

Last use:

Family Psychiatric History

Family mental health history (who has had or is suspected of having had what illnesses and did they receive treatment? e.g.: grandmother with depression treated with Prozac):

Mother's side:

Father's side:

Siblings:

Children:

Family Medical History

List any significant family medical illnesses or history (including neurological illnesses like Parkinson's, seizures, diabetes, thyroid/endocrine, cardiac/heart attacks) in family members:

Patient Care

Thank you for choosing me to provide your psychiatric care. I strive to provide outpatient mental health services; including evaluation, diagnosis, education, and treatment; for children, adolescents, and adults. My treatment approach is individualized for each patient in order to address psychoeducational, psychotherapeutic, and/or pharmacologic management needs.

Although I do not have an inpatient practice, should you require admission to a hospital or residential setting, I will assist you in making appropriate arrangements, readily communicate with inpatient providers, and resume outpatient treatment at the time of discharge.

Appointments

The nature of outpatient psychiatric care requires an initial evaluation and subsequent follow-up visits as scheduled appointments. Follow up appointments are typically 25 or 45 minutes in duration and a full business day (24 hours Monday through Friday) notice of cancellation is required. Appointments that are missed or are canceled less than one business day in advance charge will be charged the full appointment charge.

If you anticipate not being able to make it to your scheduled appointment, please notify the office with as much advanced notice as possible. Please note: appointments scheduled and not kept will be billed to you and insurance companies will not reimburse for any portion of missed appointments.

If you have a regularly scheduled appointment and must cancel, I will assume that you intend to keep your next regularly scheduled appointment unless you notify the office otherwise

Fees & Insurance

Although I am not a participating provider for any insurance networks, I am happy to provide a statement of service that you may file with your insurance provider. Please remember that your insurance is to reimburse you directly for the services provided. The fee for your child's initial evaluation is $350 and is due at the time of service. Payment may be made by cash, check, or credit card (Visa or Mastercard). Statements are generally sent out at the end of each week. If you will be submitting the visits to your insurance provider for reimbursement, please let the office know in order to make sure the statements will contain the information needed to submit the claim. Insurance forms are generally available from your health insurance carrier or employer.

Prescriptions
New prescriptions and refills should be obtained at the time of regularly scheduled visit. If you do require a refill between sessions, please check with your pharmacy to see if refills have already been authorized. If no refills are available, please call the office Monday through Friday from 9:00am to 4:00pm. As Dr. Koch is not always in the office to provide refills, please know that it may be three or four days before the requested prescriptions are available. The office will notify you when the prescription is ready and there is a $10 charge for refills provided outside of regularly scheduled follow-up visits.
As some pharmacies fax automated refill requests, please request your pharmacy disable these automated reminders. In order to avoid inadvertent charges for refill requests, faxed prescription refill authorizations received from pharmacies are generally ignored unless the office has received advanced notification from you that the refill is, indeed, needed.
Emergencies
In the event of an emergency (a situation which requiring immediate attention due to concerns of for an imminent danger to self or others), please call 911 or go to your local emergency room/department. Please ask the physician to contact me directly as appropriate. NOTE: after 4pm Monday through Friday and on weekends, there are no staff to accept telephone calls. Messages can be left on my emergency voicemail that will attempt to page me directly. If for any reason during an emergency situation you are unable to reach me, you should go directly to the nearest emergency room. Hospitals providing emergency psychiatric assessment:
Vanderbilt (Respond): (615) 327-7000
Parthenon Pavilion (Options): (615) 342-1400 Rolling Hills Hospital (Respond): (800) 832-0388
Non-urgent Communication
If you need to speak with me between appointments, please leave a message with the office at (615) 515-7775. As I may not be immediately available, please leave both daytime and nighttime numbers so that I may best return your call. I will make every effort to return calls on the same day that messages are left.
Confidentiality
With your consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.
Examples of uses of your health information for treatment purposes are:
Staff obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor may determine that you need an EKG, medical procedure, laboratory test, or emergency evaluation. He/she will share information with the doctor, or assistant, in order to get your tests completed or to permit emergency care in the case of an emergency assessment.
Examples of uses of your health information for payment purposes:
Submission of information for payment to your health insurance company. The health insurance company or business associate helping us obtains payment requests information from us regarding your medical care given. We will provide information to them about you and the care given.
Examples of uses of your health information for health care operations:
We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, billing services, mailing services, and insurance.
Additional information is available on the website:drjackkoch.com and in the office policies.

Assignment and Release

Person responsible for payment: *

Prefix	First Name	Middle Name	Last Name	Suffix

Relationship to patient:

E-mail *

example@example.com

Phone Number *

I hereby authorize Jack L. Koch Jr., M.D. to provide treatment for my child and agree to assume full responsibility for fees for these services.
Should it become necessary, I authorize Jack L. Koch Jr., M.D. to release and exchange in verbal and/or written form any information necessary for the payment of fees, and/or the provision of my medical care. This may include information related to alcohol or substance abuse.
By signing this form, you hereby agree to pay your account within 45 days following the date of the payment invoice. Should you fail to pay your account in a timely manner, you will also pay on demand late charges and any amount incurred in collecting, enforcing, or protecting the Provider's rights under this agreement. These expenses will bear interest from the date payment is due until paid in full at the interest rate permissible by Tennessee law in effect at the signing of this document. This amount may include, but is not limited to attorneys' fees, court costs, and other legal expenses incurred at all stages of collection.
If the person responsible for payment will not be present at the time of the initial visit, please have them provide credit card information to the receptionist prior to the initial evaluation date.
I have read this form in full and have received a copy of Jack L. Koch Jr., M.D.'s office policy. I agree to assume full responsibility for the fees for the services provided.

Responsible Party Signature (by entering my name and the date in the fields below, I agree to the above): *

First Name Middle Name Last Name

Date *

Month Day Year