MUSIC CITY PEDS
Developmental & Behavioral Medicine

Client Care Form

Client Information

Client First Name _____

Client Last Name _____

Client DOB _____ Other Sex/Gender Info?

Legal Sex _____ _____

Full Address _____

Preferred Name _____

Client Phone ☐ _____

Email Client ☐ _____

Client School _____ Grade? _____

Communication Preferences

We may use all of the following to contact you. Please indicate i**f you would like to opt OUT** of one of the following methods by crossing it out.

Phone Call / Email / Text Message

Preferred method of contact?: _____

Additional Information? _____

Payment Information

Our office requires a credit card to be placed on file at the time of scheduling. Please be prepared to give this information to our clinic coordinator at the time of scheduling, thank you.

Guarantor for Payment

☐ *Guarantor Same as Client?*

Relationship to Client

Guarantor First Name _____

Guarantor Last Name _____

☐ *Address Same as Client?*

Address _____

City _____

State Zip _____

Guarantor Phone _____

Guarantor Email

Parent (1) Info Relationship to Client _____

Full Name _____

Phone _____

Email _____

Parent (2) Info Relationship to Client _____

Full Name _____

Phone _____

Email _____

Emergency Contact (if other than parent)

Relationship to Client _____

Contact Full Name _____

Contact Phone Number _____

Custody/Legal Agreement?

☐ Not Applicable

☐ Yes*

Medical Decision-Making Rights?

☐ Not Applicable?

❑Full* ❑Joint*

**NOTE: If you marked yes or full/joint to either question above, we require documentation of arrangements prior to your appointment.*

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Printed Client Name Date of Birth

I understand that by signing this document, I agree to become a client of Music City Peds (either me or a minor member of my family). As an MCP client, I am eligible to receive a range of services, the type and extent of which will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me or my family member. I understand that typically treatment is provided over the course of several weeks or months. If I agree to allow Music City Peds to manage the medicine for me or my family member, I am aware that I will pay for follow-up appointments at the frequency recommended by my clinician, at least every 3 months (for maintenance dosing). _____

I understand that all information shared with clinicians at Music City Peds is confidential and no information will be released without my consent. During the course of treatment at Music City Peds, it may be recommended for my provider to communicate with other providers involved client's care. In this case, consent to release information is given through written authorization.
Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is a risk of imminent danger to me or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or disabled adult is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or disabled adult and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at Music City Peds, I may discuss them with my provider. I have read and understand the above and I consent to participate in the evaluation and treatment offered to me by Music City Peds. I understand that I may stop treatment at any time.

ACKNOWLEDGEMENT OF NOTICE OF POLICIES AND PRACTICES

My signature below indicates that I have read and understood the **Business Policies** of Music City Peds. My signature below also indicates that I have been provided an opportunity to review the **Notice of Policies and Practices to Protect the Privacy of Your Health Information** and have been offered a copy to keep*(For example, in the Business Policies, it states that to avoid being charged a $100 late cancellation or no-show fee, you must contact us 24 hours prior to your scheduled appointment to make changes.)*

Parent/Guardian Signature Parent/Guardian Printed Name Date

Client Signature (only necessary if over 18) Date

Provider Signature Date

MUSIC CITY PEDS
Developmental & Behavioral Medicine

RELEASE OF INFORMATION FORM
Authorization for Disclosure

This form, when competed and signed, provides authorization for **Music City Peds** to release and/or receive protected health information (PHI) from your clinical record to/from the person(s) designated within this document.

*Client Name*_____ *Client Date of Birth* _____

Please check the box(es) indicating what can be **released to** OR **received from** the following parties:

PRIMARY CARE PROVIDER	**REFERRING CLINICIAN**
Name: _____	Name: _____
Company: _____	Company: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
☐ ALL ☐ Evaluations/Office Visit Notes ☐ Lab Results ☐ Educational Info ☐ Former Records/Testing	☐ ALL ☐ Evaluations/Office Visit Notes ☐ Lab Results ☐ Educational Info ☐ Former Records/Testing
OTHER	**OTHER**
Name: _____	Name: _____
Company: _____	Company: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
☐ ALL ☐ Evaluations/Office Visit Notes ☐ Lab Results ☐ Educational Info ☐ Former Records/Testing	☐ ALL ☐ Evaluations/Office Visit Notes ☐ Lab Results ☐ Educational Info ☐ Former Records/Testing

- I understand the purpose of this authorization of information is to improve planning for treatment.
- I understand this release form covers the period from: *Specific Date(s)*:_____to_____**OR** (initial here)_____*All past, present and future encounters/visits*
- I understand that I have the right to revoke this authorization by providing written notification to the **Music City Peds** office address listed below. However, this authorization may not be revoked if **Music City Peds** has taken action on this authorization prior to receiving my written notice.
- I further understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.
- I understand that any personal health information or other information released to **Music City Peds** may be subject to re-disclosure by **Music City Peds** and may no longer be protected by applicable federal and state privacylaws.

Parent/Guardian *Signature* Parent/Guardian Printed Name Date

Client *Signature* (only if over 18) Date

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