A Word of Welcome:

As the Medical Director for Bell Psychiatric, I wanted to thank you for your interest in scheduling an appointment with us. I have been providing psychiatric care for over 30 years. I have had the privilege of providing care for families in Cool Springs for almost 20 years. As a psychiatric physician I seek to evaluate my patients through a holistic perspective which includes biological, psychological, social and spiritual components. My evaluation process leads to recommendations that may include medication management, education and psychotherapy. Often my treatment is designed to integrate with a patient's current counseling treatment.

To expedite the scheduling process, **please complete all of the enclosed forms.**

We must receive these forms via email or fax prior to scheduling your first appointment.

Please also include:

- a list of ALL of your medications including all vitamins, and supplements that you take daily
- any relevant discharge paperwork (from previous clinics, hospitals, or treatment programs, if applicable)
- any other relevant documents: Psychological, Educational testing results, Laboratory reports, Genesight/Genomind results, Neuropsychological testing results, Individual Education Plans (IEPs), etc.

All patients under 18 years of age, need to have a parent or guardian present at the appointment as we will include them in the evaluation process.

If at all possible, please arrive 15 minutes early so that we can make sure all the necessary forms have been completed.

Once completed you may email or fax the forms to my office at:

Support@BellPsychiatric.com or Fax to (615) 567-3381

Once we receive all your completed forms we will call you to schedule your appointment. Please note that we will require you to pay for your New Patient Appointment in full to hold the appointment. Thank you for understanding. I look forward to serving your psychiatric needs.

Kindest Regards,

William Bryan Bell, MD

William Bryan Bell, M.D.

2001 Mallory Lane, Suite 303 Franklin, TN 37067
Office: 615-567-7881 Fax: 615-567-3381
Email us at Support@BellPsychiatric.com

PATIENT INFORMATION FORM

PATIENT DATA Date: _____

Patient Name: _____ Patient Birth Date: _____ Gender: ____

Patient E-mail Address:_____@_____

Patient Address: _____
Home City State Zip Code

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Emergency Contact: Name: _____ Phone: (_____) _____-_____

Credit Card information: CC number: _____ _____ _____ _____ Exp ____/____ CCV: ____
Name on Credit Card: _____
Address for CC: _____
Home City State Zip Code

PRIMARY INSURANCE DATA for OUTPATIENT MENTAL HEALTH:

Dr. Bell is IN-NETWORK with BCBS (mental health/behavioral health benefits) only. We only file BCBS claims. We can provide OUT-OF-NETWORK policy holder's an appointment receipt which can be used to file for OUT-OF-NETWORK benefits.

It is the responsibility of the guarantor to know their own mental health coverage and benefits information at the time of each appointment.

Primary Insured Name: *(GUARANTOR NAME)* _____

Insured Birth Date: _____ Age: _____ Gender: ____

Insured Address: _____
(If different from patient) Home City State Zip Code

Insured Phone(_____) _____-_____ Insured Email Address: _____@_____

Primary Insured Employer: _____

Insured Identification Number: _____ Group Number: _____

Primary Insurance Company:_____ Effective Date:_____

Please note: MENTAL HEALTH (MH) coverage and benefits may be provided by an Insurance Company which is different than the Insurance Company providing general medical coverage and benefits.

MH PLAN NAME:_____Mental Health Benefits Phone: (_____) _____-_____

Mental Health Deductible: _____ Amt. Met: _____ Co-Pay: _____

Bell Psychiatric Office Policies

Office Hours:
Monday, Wednesday and Thursday 8:00 AM to 5:00 PM
Tuesday 8:30 AM to 5:00 PM
Friday 8:00 AM to 12 PM

Office hours are subject to change (holidays, vacation etc.). Any changes to normal office hours will be noted on the voice messaging and email system.

Cancellation Policy

The time for your sessions is reserved specifically for you. If you cannot attend your appointment, **PLEASE NOTIFY THE OFFICE AT LEAST 48 HOURS IN ADVANCE** to avoid being charged for an appointment. The fee for a missed appointment or late cancellation is the full private pay price for the appointment (even if you have BCBS insurance). Insurance will not cover the cost for a missed appointment.

Phone / Email Contact

Dr. Bell's administrative staff is usually available to answer calls during office hours. If staff is assisting other patients or you are calling after office hours, your call will be directed to voicemail. Please leave a detailed message. Dr. Bell's staff check and respond to your voice mail messages throughout the day. Most of the time staff will be able to respond to you the same day, however, we ask that you please allow us a minimum of 48 hours (not including weekend or holidays) to respond to your request. If you have an emergency situation during office hours please follow the prompts for leaving an emergency message.

You may also contact us through our office email service at support@BellPsychiatric.com. Please note that email messaging may not be secure and that you accept the inherent Privacy risks involved. Emails should only be used for non-urgent administrative purposes such as billing, scheduling, refill requests and any other general administrative question

EMAIL IS NOT TO BE USED FOR EMERGENCIES OR URGENT MATTERS.

Emergencies

During office hours you should call the office at (615) 567-7881 and follow the prompts for a psychiatric emergency. Please leave a detailed voice message about your emergency and include your name and phone number. Dr. Bell will triage your emergent situation then he or his staff will respond as quickly as possible. **If you cannot await a response, please call 911 or go to your nearest emergency room.**

After office hours you should call the office at (615) 567-7881 and follow the prompts for a psychiatric emergency. Please leave a detailed voice message about your emergency and include your name and phone number. Under most circumstances, Dr. Bell should be able to respond to your emergency within 30 minutes. **If you cannot await a response, please call 911 or go to your nearest emergency room.**

Psychiatric Emergencies are defined as:

- Suicidal thoughts or thoughts of harming others,
- An unexpected medication reaction with serious symptoms, or
- Any unusual behavior that your fear may lead to physical harm of yourself or others.

The Fee for an emergency phone consultation depends upon of the time spent in consultation with Dr. Bell. Insurance does not cover the cost for the emergency phone consultation.

PRESCRIPTION REFILLS ARE NOT CONSIDERED EMERGENCIES (please see prescription refill policy).

Prescription Refill Policy

NO REFILLS WILL BE GIVEN IF YOU HAVE AN OUTSTANDING BALANCE ON YOUR ACCOUNT. In general, all refill requests should be made **during** your appointment times. At the time of your appointment, you should be supplied with enough refills to last until your next appointment. Refill requests outside of visits are **only** for unusual/extenuating circumstances.

Prescription refills may incur a **$30** refill fee **FOR ALL REFILLS** requested outside of an appointment time.

If your prescription is a controlled substance (as is the case for most medications for ADHD), please see the "Controlled Medications" section as there are special policies for these prescriptions.

Prescription Refills for Non-Controlled Medications

If a refill is needed for a non-controlled medication outside of an appointment, call our office, make sure you have a scheduled follow-up appointment and let us know the medication name, dose and how you are taking it. Please include your pharmacy name and phone number as well. Allow at least 48 hours (business days) for this request to be completed. Contact your pharmacy to see know if and when your prescription will be available for pick up. Remember, you must first have a scheduled appointment with Dr. Bell or no refills will be given.

Prescription Refills for Controlled Medications

As with non-controlled medications, in general, all refill requests should be made **during** appointment times. Exceptions are made for changes to your medication between appointments or the unforeseen need for refills/rescheduling issues beyond your control.

Stimulants (most medications for ADHD, including Ritalin, Adzenys, Adderall, Focalin, Concerta, Vyvanse, etc.), many sleep medications (Ambien, Lunesta, etc.) and benzodiazepines (alprazolam, lorazepam, diazepam, clonazepam, etc.), are controlled substances. Since these medications are easily abused and there is an illegal market for these medications, the DEA and the State of Tennessee monitor prescribing and refill practices for these medications. If you are prescribed one of these medications, it is critical that you follow the controlled medication policy. The policy is as follows:

- You MUST take these medications as directed.
- If you feel you need to adjust your dose to a higher dose of the medication, you must call the office and consult with Dr. Bell prior to making any adjustments to your dose.
- You must be responsible with your medication and take measures to ensure that your medication is not lost or stolen.

If you require an early refill of your medication because you have adjusted your dose without consulting Dr. Bell or because your medication was lost/stolen you are in violation of the controlled medication policy. Dr. Bell understands that unexpected circumstances, out of your control, may result in your needing an early refill for your medication and will allow ONE violation of the controlled medication policy to allow for these circumstances. If your controlled medication was lost/stolen medications, you will be required to file a police report and present this report to Dr. Bell prior to any refill. You will be charged $100 fee for an early refill of your controlled medication. Any subsequent violations of the policy will result in your termination as a patient with Dr. Bell. While this policy may seem harsh, due to the nature of these medications, Dr. Bell must be able to manage these prescriptions responsibly and in a manner to minimize any potential abuse.

To make a refill request for controlled medications, leave Dr. Bell a message on his voicemail (615-567-7881) with your exact medication request.

Email and Cell Phone/Texting Policy

For reasons of privacy/confidentiality, Dr. Bell does not conduct treatment through email or texting. Conducting treatment via email violates Dr. Bell's commitment to privacy and confidentiality, lacks the back and forth of natural conversation, and is fraught with the opportunity for misunderstanding. Dr. Bell's policy is to meet to discuss things or at least have a telephone conversation. Dr. Bell will use email only if he has specifically requested you send him specific information by email and he is expecting it. All email messages sent to Dr. Bell at his request should be accompanied with voicemail messages asking him to look for the email message.

Fees and Payment

Please contact the office for a schedule of current fees. Your fee for your appointment as well as any account balance is due in full **at the time of service**. This includes expected copayment, coinsurance, deductibles, and other charges which are not covered by insurance. For our private pay and out of network patient's this includes the full price for the appointment and any other miscellaneous charges incurred in between appointments. Payment may be made by cash, check or major credit card. We do not accept partial payments nor payment plans. If you are unable to pay in full at the time of your appointment, your appointment will be rescheduled and no prescription refills will be given until full payment is received.

Disclaimer about mental health coverage and benefits: We do our best to obtain the most current mental health coverage and benefits information from the Blue Cross Blue Shield website. The explanation of benefits and insurance payment after your claim is processed will determine the final cost of the appointment.

Outstanding Balance Policy: While most office charges are paid in full at your appointment, at times you may incur charges for emergency calls, prescription refills outside of appointment, no-show charges, reports, and / or letters, etc. In the event you incur a charge outside of your appointment, we request your authorization to run your credit card at the time the charge is incurred. We will notify you of the charge and credit card payment. It is our office policy to keep your credit card information securely on file at our office.

There will be a monthly billing charge of $25 for patients who have forgotten to pay their bills. If three months pass without payment of the bill, Dr. Bell will be required to terminate you from his care and send your bill to the collections agency. I acknowledge that if my account is sent to collections for my failure to pay, I will be need to pay any balance, a 35% of balance collection fee, and any legal fees associated with the collections process.

DR. BELL WILL NOT PROVIDE APPOINTMENTS NOR PROVIDE PRESCRIPTION REFILLS for patients with outstanding balances.

Release of Private Healthcare Information (PHI)

Because of the laws governing the release of Private Healthcare Information, we will be unable to release information pertaining to your healthcare without a completed and signed Release of Information form. Once this is obtained we can forward patient records or a summary of treatment to licensed professionals at no charge as a professional courtesy. Request to release this information to non-healthcare providers including attorneys, underwriting companies, etc., will be billed at cost for supplies, mailing and administrative processing time. It is our policy to not release records directly to a patient without first reviewing the record together. Any request for release of records must allow at least 3 weeks preparation time.

ASSIGNMENT AND RELEASE

OFFICE POLICY AGREEMENT

I, the undersigned, certify that I have read the OFFICE POLICIES above and am willing to abide by them.

For IN NETWORK Mental health coverage and Benefits with BCBS.

I acknowledge that I (or my dependent) have insurance coverage (as noted above). If Dr. Bell is a contracted provider with my insurance, I am assigning directly to William Bryan Bell, MD all insurance benefits, if any, otherwise payable to me for services rendered. If my insurance company fails to reimburse Dr. Bell, I recognize that I am still financially responsible for all charges. I, hereby, authorize Dr. Bell to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

For OUT OF NETWORK and PRIVATE PAY.

Since Dr. Bell is not a contracted provider with my insurance, I understand that I am financially responsible for all charges for services rendered. I understand that I must submit my own insurance claims and have my insurance reimburse me directly for services rendered.

Further, I consent to leaving my credit card information on file to be kept securely for payment only on my account. I will allow Dr. Bell or his staff to run my credit card for charges incurred for services (which cannot be billed to my insurance) rendered in between appointments and / or any balance left after a BCBS claim is filed.

I acknowledge that if my account is sent to collections for my failure to pay, I will be need to pay any balance, a 35% of balance surcharged fee and any legal fees associated with the collections process.

Finally, please note that your attendance at each appointment helps facilitate the healing process. With this in mind the automated system will attempt to email and/or call/text to remind you of your appointment. Ultimately, it is your responsibility to keep your appointments even if the reminder message fails. It is our expectation that you will attend your appointment if at all possible, therefore, failure to cancel your appointment without at least 48 hours notice in advance of your scheduled appointment date will result in a charge for the full private pay price of the appointment. (Voice message will be accepted 48 hours prior to date). Thank you for your understanding.

_____ _____ _____

Responsible Party Signature Relationship to Patient Date

_____

Responsible Party Printed Name

OFFICE TREATMENT AGREEMENT

I agree and consent to participate in the psychiatric / behavioral health care services offered and provided by William Bryan Bell, MD. If the Patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____ _____

Responsible Party Signature Relationship to Patient Date

_____

Responsible Party Printed Name

PERSONAL HISTORY QUESTIONNAIRE

Child and Adolescent Version

DATE: _____

By completing this questionnaire as fully and accurately as possible, you will be helping us to provide you the most timely and appropriate treatment. If you do not want to answer a question, write, "Do not care to answer" in the space provided. Thank you!

Client's Name: _____ Date of birth: _____

By whom were you referred to our clinic?

_____

Name of Referral Person Profession

_____

Referral Address City State Zip

Please describe the primary problem/concern for which you or your child have come to our clinic:

_____

_____

When did your / your child's problem(s) begin (give approximate dates)?_____

_____

_____

What triggers or stressful life events play a role in the level of distress you / your child have been experiencing? _____

_____

_____

Any other treatment (therapy, hospitalization, IOP, PHP, new medication, medication dosage changes, changes in therapy) to address your /your child's problem? _____

_____

_____

What led to your decision to seek psychiatric help, now?

_____

_____

PERSONAL AND FAMILY MENTAL HEALTH HISTORY

Current Therapists/Counselor: _____

_____

Previous Psychiatrists: _____

_____

Previous Therapists/Counselors: _____

_____

If you / your child have been in therapy before or received psychiatric assistance for your problems, what was the outcome of your treatment? _____
_____
_____

Have you / your child ever been hospitalized for mental or emotional problems? YES NO If YES, when, where, and how many times?
_____
_____

Have you / your child ever attempted suicide / homicide? YES NO If YES please describe: _____
_____

Do you / your child have thoughts of suicide / homicide now? YES NO If YES please explain:_____
_____

If you are actively suicidal, Please call 911 or go to your nearest emergency room.

Have you / your child ever been arrested or had legal problems? YES NO If YES please explain :_____
_____

Does or has any member of your family ever suffered from an addiction, emotional / mental health problem or any problem that you would have considered a mental disorder? YES NO If YES please explain: _____
_____

Has any member of your family ever committed suicide or homicide? YES NO If YES please explain:_____
_____

MEDICAL HISTORY

Primary Care Physician, Pediatrician, Any other physician care:
(Please include name, address and phone numbers,) _____
_____
_____

Current/past medical illnesses (asthma, diabetes, thyroid, seizures, head injuries, heart disease, etc)
_____
_____

Past Surgical History
_____
_____

Do you have any concerns about your physical health and/or chronic health problems? YES NO If YES please describe:
_____
_____

Have you lost or gained weight within the past few weeks without planning to do so? YES NO If YES describe: _____
_____

Current Height: _____ Current Weight: _____

CURRENT MEDICATIONS: Please list your CURRENT prescription and non-prescription medications; please include vitamins, home remedies, birth control pills, and herbal supplements. USE the back of this form if you need more room.

Please tell me what the medication is used to treat and current dose and when you take it. _____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any known **MEDICATION ALLERGIES**: _____

SUBSTANCE USE HISTORY

Please include whether use is in the past and/or present. What is the frequency of use? When did you / you child last use. Have you / you child had any legal trouble because of use?

Alcohol: _____

Marijuana: _____

CBD Oil: _____

Cocaine/Methamphetamines: _____

Opiate/Narcotic pain medication: _____

Anxiety Medications (Benzodiazepines): _____

Stimulant medications: _____

Caffeine: _____

Tobacco (cigs, dip, vape): _____

Other: _____

_____

_____

_____

Please circle any medical condition which applies to **YOUR Family or BLOOD RELATIVES**:

Brain condition	Breathing problem	Diabetes	High blood pressure	Kidney problem
Bowel condition	Cancer / tumors	Heart condition	Hormonal problem	Thyroid problem

PERSONAL DEVELOPMENTAL AND SOCIAL HISTORY

Circle any of the follow as they apply to your / your child's childhood:

Happy childhood	Behavioral problems	Family problems	Physical abuse
Unhappy childhood	Legal problems	Medical problems	Emotional abuse
Emotional problems	School problems	Drug or alcohol problems	Sexual abuse

Full Term / Born Early / Birth Problems _____

Pregnancy complications / exposures (stress, alcohol, drugs for example) _____

Developmental Milestones reached on time? (Walking, talking, toilet training, etc) _____

Status of Parents' Relationship: (Married, Divorced, Separated, Other):

Describe Parents' relationship to each other and to you / your child: _____
_____
_____

Current Grade and School: _____

Describe your Educational Goals (if applicable): _____
_____
_____

What is your Faith and would you consider your Faith important to your emotional health? _____
_____
_____

Do you have any other information that you feel would be helpful for your doctor to know? YES NO If YES please describe:
_____
_____
_____

TREATMENT GOALS

Please identify **three** of the most important **goals** you / you child have in coming to see us.

One: _____

Two: _____

Three: _____

Circle the Medications you have taken. If No medications ever taken please circle NONE

Generic Name of Medication	Common Brand Names	Dose	When taken and for how long? Note any side effects
Amphetamine	Evekeo		
Amfetamine + Dexamfetamine	Adderall, Adzenys, Dyanavel		
Dexamfetamine	Dexedrine, Dextrostat, Zenzedi		
Lisdexamfetamine	Vyvanse		
Methylphenidate	Ritalin, Concerta, Metadate, Daytrana Patch		
Dexmethylphenidate (XR)	Focalin, Focalin XR		
Atomoxetine	Strattera		
Clonidine	Kapvay		
Guanfacine	Intuniv, Tenex		
Alprazolam	Xanax		
Chlordiazepoxide	Librium		
Clonazepam	Klonopin		
Clorazepate	Tranxene		
Diazepam	Valium		
Lorazepam	Ativan,		
Oxazepam	Serax		
Buspirone	BuSpar,		
Hydroxyzine	Atarax, Vistaril		
Carbamazepine	Carbatrol, Equetro, Tegretol		
Gabapentin	Neurontin		
Lamotrigine	Lamictal		
Levetiracetam	Keppra		
Lithium salts	Eskalith, Lithobid, Sedalit		
Oxcarbazepine	Trileptal		
Topiramate	Topamax		
Sodium valproate	Depakene, Depakine Enteric		
Divalproex sodium	Depakote		
Amitriptyline	Elavil, Endep		
Amoxapine	Asendin		
Bupropion SR/XL	Wellbutrin, Wellbutrin SR, Wellbutrin XL		
Citalopram	Celexa		
Clomipramine	Anafranil		
Desipramine	Norpramin		
Desvenlafaxine	Pristiq		
Doxepin	Silenor, Sinequan		
Duloxetine	Cymbalta		
Escitalopram	Lexapro		
Fluoxetine	Prozac, Sarafem, Symbyax		
Fluvoxamine	Luvox		
Imipramine	Tofranil		
Levomilnacipran	Fetzima		
Mirtazapine	Remeron		
Nortriptyline	Aventyl, Pamelor		
Paroxetine	Paxil, Pexeva		
Phenelzine	Nardil		
Protriptyline	Vivactil		
Selegiline	Emsam		
Sertraline	Zoloft		
Tranylcypromine	Parnate		
Trazodone	Desyrel, Oleptro		
Venlafaxine	Effexor, Effexor XR		

Vilazodone	Viibryd		
Vortioxetine	Trintellix, Brintellix		
Eszopiclone	Lunesta		
Ramelteon	Rozerem		
Suvorexant	Belsomra		
Temazepam	Restoril		
Triazolam	Halcion		
Zaleplon	Sonata		
Zolpidem	Ambien CR, Intermezzo		
Aripiprazole	Abilify, Abilify Maintena		
Asenapine	Saphris		
Brexiprazole	Rexulti		
Cariprazine	Vraylar		
Chlorpromazine	Thorazine		
Clozapine	Clozaril		
Fluphenazine	Sinqualone		
Haloperidol	Haldol, Haldol Decanoate		
Iloperidone	Fanapt		
Lurasidone	Latuda		
Olanzapine	Zyprexa, Zyprexa Relprevv		
Olanzapine/Fluoxetine	Symbyax		
Paliperidone	Invega, Invega Sustenna		
Perphenazine	Trilafon		
Pimozide	Orap		
Promethazine	Neuraxph, Prothazin		
Quetiapine (ER)	Seroquel (XR)		
Risperidone	Risperdal, Risperdal Consta		
Thioridazine	Mellaril,		
Thiothixene	Navane		
Trifluoperazine	Stelazine		
Ziprasidone	Geodon		
Modafinil	Provigil		
Amodafinil	Nuvigil		
L-Methylfolate	Deplin		
Prazosin	Minipress		
Melatonin			
Cyproheptadine	Periactin,		
Diphenhydramine	Benadryl		
Hydroxyzine	Atarax, Vistaril		
Promethazine	Phenergan		
Propranolol	Inderal		
Varenicline	Chantix		
Acamprosate	Campral		
Buphrenorphine	Subutex		
Buphrenorphine / Naloxone	Suboxone		
Dislufiram	Antabuse		
Methadone	Dolophine		
Naltrexone	ReVia, Vivitrol		
			List any other psychiatric medications which you may have taken:

*(Thank you for taking the time to fill out this questionnaire.)

HIPAA Notice of Privacy Practices Signature Page
for
William Bryan Bell, M.D.

Date: _____

**If asked, does our office have permission to give the appointment date/time to any member of your family? YES NO

If YES, Name:_____ Relationship: _____

PHONE NUMBER FOR REMINDER CALLS: _____

**I have read or am aware of the HIPPA Notice of Privacy Practices for Dr. Wm. Bryan Bell and ACCEPT the policy.

Client Name: _____ Signature: _____
(Client or Guardian)

* * * * *

I have read the HIPPA Notice of Privacy Practices for Dr. Wm. Bryan Bell and have the following **restrictions and / or amendments** to request. (Only complete if this section applies):

_____
_____
_____
_____

Signature: _____
(Client or Guardian)

* * * * *

Additionally, I agreed to authorize communication between Dr. Bell and/or his staff with my primary care physician, if needed: YES NO

NAME of Primary Care Physician: _____

Signature: _____
(Client or Guardian)

Authorization for Release of Information

Date: _____ Patient Phone Number: _____

Patient Name: _____ DOB: ____/____/____ SSN: _____-____-_____

Patient Address: _____

I hereby authorize the release of my protected health information

From/To: William Bryan Bell, M.D. / Anne R. Meade, APRN
2001 Mallory Lane, Suite 303
Franklin, TN 37067
Phone: (615) 567-7881
FAX: (615) 567-3381

From/To : _____
_____
_____
Phone: _____
FAX: _____

I hereby authorize the release of the following information: (check all that apply)

☐ Yes ☐ No HIV status and or related information including AIDS _____ initial
☐ Yes ☐ No Substance Abuse/Dual Diagnosis (including alcohol/drug abuse) _____ initial
☐ Yes ☐ No Medical History (Laboratory results, medications, treatment reports).
☐ Yes ☐ No Psychological test/psychiatric evaluation/neurological workup.
☐ Yes ☐ No Social history, including family, education, employment, arrest, and drug use information.
☐ Yes ☐ No Summary of previous mental health treatment.
☐ Yes ☐ No Periodic reports of treatment progress including attendance, participation and urine surveillance results.
☐ Yes ☐ No Other (specify)

_____

I understand that this information will be used for other following specific purposes: (Check Yes or No)

☐ Yes ☐ NO To develop a diagnosis, treatment and rehabilitation plan.
☐ Yes ☐ NO To coordinate medical, psychological and social rehabilitative process.
☐ Yes ☐ NO To determine present and future eligibility for probation, parole, bail bond, pre-trial release or other diversion process within the criminal justice system.
☐ Yes ☐ NO To process insurance claims for services provided (diagnosis, number of visits, modalities, and expected length of treatment.)
☐ Yes ☐ NO Other (specify)

_____

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to re-disclosure by the recipient and no longer protected by law. Dr. Bell is not responsible for any alterations made on its medical record copies, which have been released to any party. I understand that any release which has been made prior to my revocation and which was made on the basis of this authorization shall not constitute a breach of my Right of Confidentiality. I understand my records are protected under the federal regulation 42, CFR Part 2, HIPPA and TCA 33 and cannot be disclosed without my written consent unless otherwise provided for in these regulations.

- I understand that I have a right to a copy of this authorization after I sign it.
- I understand that Dr. Bell will not condition any provision of treatment on my signing this authorization.
- **This authorization automatically expires in one year and may be revoked at any time with my written statement.**

_____ _____
Signature of Client Date Signature of Parent / Guardian Date

_____
Signature of Witness Date

Please include a photo ID when requesting an electronic release of records