NOLENSVILLE PSYCHIATRY

7175 Nolensville Road
Suite 200
Nolensville, TN 37135
Phone: (615) 671-7258
Fax: (615) 235-1186
www.NolensvillePsychiatry.com
Email: drvanschenck@proton.me

Please complete this paperwork (except the Medicare Contract at the end) before your first appointment and bring it to your appointment. If the patient is under the age of 18 years it could help my assessment if parent(s)/guardian would also bring the completed **SCARED forms (child and parent)** on the website and either the **DEPRESSION SELF-RATING SCALE FOR CHILDREN** if patient is below age 11 years and **PHQ-9 Adolescent** if patient is 11-17 years old.

Directions:

From Nashville and North:

Take 31A/41A (Also known as Nolensville Rd) SOUTH towards Nolensville

Pass Concord Rd and Burkitt Rd

Turn RIGHT into Brittain Plaza

Park in the back, enter Suite 200 and wait in the reception area. At the time of your appointment Dr. Van Schenck will call your first name.

Directions:

From Triune and South:

Take 31A/41A (Also known as Nolensville Rd) NORTH towards Nolensville;

Pass Clovercroft Rd through Old Town Nolensville

Pass Sunset Rd on the left

Turn LEFT into Brittain Plaza

Park in the back, enter Suite 200 and wait in the reception area. At the time of your appointment Dr. Van Schenck will call your first name.

Patient Profile

Patient Name: _____

DOB:_____

Phone# (Primary number): _____ Other:_____

Address: _____ City: _____ State:_____ Zip:_____

I give permission for Dr. Van Schenck to leave psychiatric/medical information on your answering machine? _____

Emergency Contact

Name:_____Phone#:_____
Address:_____Relationship:_____

Office Policies

Office Hours: Monday through Friday 8:30 AM to 5:00 PM

Office hours are subject to change (holidays, vacation etc.).

Any changes to normal office hours will be available on the Nolensville Psychiatry answering message and discussed personally with patients.

Telemedicine: For your safety during inclement weather or due to physical and travel difficulties I offer telehealth services for follow up visits. If you would like Telemedicine please let me know at your first appointment or request telehealth over the phone at least 48 hours prior to your appointment. I will call you to arrange.

1.) I do not see patients for disability evaluations.
2.) I do not use a patient portal. All outside office communication is by the Nolensville Psychiatry phone # (615) 671-7258
3.) All patients under 18 years of age need to have a parent or guardian present at the first appointment. Both parents of a patient (under the age of 18) must to consent to the treatment of their child if both parents have a legal right to consent. Patients who can drive (16 years old) can come to their own follow up appointments without a parent or guardian.
4.) Phone calls of existing patients will be returned within 24 hours and usually within 12 hours excepting Sundays. I check messages M-F from 12:00pm-12:30 and 5:00pm-6:00pm
5.) I do not normally refill medication between appointments. At the time of your appointment, you will be supplied with enough refills to last until your next appointment.
6.) All patients on medication must have a primary care provider (doctor or NP) they see regularly. Because I am a specialist in Psychiatry, If I am prescribing you any medication, I will need to follow up with you at a minimum of every 3 months. If you desire to be seen less frequently than this for a prescription, I will advise you to return to your PCP for that prescription.
7.) Any medication adjustment in type/dose or a refill between appointments due to change in symptoms (ex: new onset panic attacks) may require an appointment to be scheduled within 7 days.
8.) If your medication is lost/stolen, you are required to file a police report, then provide a copy to me before I will refill the script.
9.) Note: All appointments are pre-paid by major credit card and non-refundable except through the cancellation policy.

Cancellation Policy

Once you register for your appointment it is your responsibility to remember your appointment and arrive on time. All appointments are non-refundable except through proper cancellation through phone message on the Nolensville Psychiatry phone number three days prior to your scheduled appointment (Ex: If cancelling a Thursday appointment, you must cancel by 12pm on Monday). If you cannot attend your appointment, please notify Dr. Van Schenck by voice message with details of the cancellation. Two cancellations may be grounds for dismissal. I appreciate your understanding and cooperation as this advance notice allows me to offer the appointment time to another patient in need. Although I do send appointment reminders, Nolensville Psychiatry is not responsible for last-minute work-related issues or transportation issues. If you arrive more than 15 minutes late for an initial appointment, I still may be able to spend time with you but will not be able to complete your initial evaluation that day unless there is another New Evaluation opening later that day and you are willing to wait. If you arrive more than 10 minutes late for a follow up appointment then it will be considered a no show unless I have another opening later in the day and you are willing to wait.

Please sign below that you have reviewed and will comply with office policies.

Signature:_____ Date:_____

Printed name:_____

Emergencies

Psychiatric Emergencies are:

1.) Suicidal thoughts or thoughts of harming others
2.) An unexpected medication reaction with serious symptoms
3.) Any unusual behavior that your fear may lead to physical harm.

***In case of emergency please call 911 or go to the emergency department. *Prescription refills are not considered an emergency.**

Payment

I understand that Dr. Van Schenck is not a contracted provider with my insurance. I understand that Dr. Van Schenck has also formally opted out of Medicare. I understand that all of Dr. Van Schenck's patients who are Medicare beneficiaries enter into a private contract with Dr. Van Schenck before treatment. I understand that I am financially responsible for all charges for appointments. I understand that I must submit my own insurance claims (unless I have Medicare and then I will not do this) and have my insurance (again, unless it is Medicare) reimburse me directly for services rendered. I will not file a claim with Medicare for services done by Dr. Van Schenck. The initial appointment is $325 for a 45minute new patient appointment with Dr. Van Schenck and $200 for a 20 minute follow up appointment. I understand that if I request paperwork (including medical records) the fee is $50 per request.

Signature:_____ Date:_____

Printed name:_____

Confidentiality

My practice is designed to be as confidential as possible. My scheduling system is HIPAA compliant. I have a private medical record. I also use a HIPAA compliant electronic prescribing program to send your prescriptions to the pharmacy. Other than this, no-one else will have access to your protected health information (unless subpoena by court order) other than another treatment provider or person/group included in the HIPAA Privacy Rule 45 C.F.R. §160.103 (see below).

Notice of Privacy Practices

Nolensville Psychiatry, LLC keeps your personal health information confidential. You must give Dr. Van Schenck your written authorization for him to release your personal health information to anyone other than another treatment provider or person/group included in the HIPAA Privacy Rule 45 C.F.R. §160.103. You have a right to reasonable requests to receive confidential communications of protected health information from me by alternative means. You have a right to request a copy of your protected health information. You have a right to amend your protected health information if it is in error. Please allow for 30 days for processing medical records requests. You have the right to receive an accounting of disclosures of protected health information. Please be advised that my records of your treatment are my property. You have a right to a copy of this authorization after you sign it.

Dr. Van Schenck will not condition any provision of treatment on your signing of this authorization. Unless otherwise limited by state or federal regulations (ex: court mandate) you may cancel this consent (in written form to Dr. Van Schenck), at any time; except for action which has already been taken. Your 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. Van Schenck is not responsible for any alterations made on its medical record copies, which have been released to any party. Any release which has been made prior to your revocation and which was made on the basis of this authorization shall not constitute a breach of your Right of Confidentiality.

This notice is effective as of April 1st, 2024 and I am required to abide by its terms. I reserve the right to change the terms of my Notice of Privacy Practices and make new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with me and/or with the Department of Health and Human Services, Office of Civil Rights, about violations of this notice. I will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services Office of Civil Rights

200 Independence Avenue, S.W.

Washington, DC 20201

(202) 619-0257 (877) 696-6775 (toll free)

Please feel free to ask any questions that you may have about this information. By signing below you are confirming that you have read and agree to everything in this notice.

Signature:_____ Date:_____

Printed name:_____

HIPAA ROI (Release of Information)

Authorization to Obtain and/or Release Information:

I, _____, hereby authorize Nolensville Psychiatry to obtain/release information.

The information to be released includes some/all of the following: Psychiatric Evaluation, Progress Notes, Medications, Psychosocial History, Hospitalization Course, Discharge Summary, Psychological Testing, Labs; Other: _____

Release/Obtain Information to/from: (please circle options) Name: _____ Address: _____ Telephone and Fax:

_____ PLEASE FORWARD INFORMATION TO NOLESNVILLE PSYCHIATRY

Treatment Agreement

I consent to participate in the psychiatric care offered by Dr. Van Schenck. I understand that all medication can have side effects including, but not limited to: headaches, weight gain, rashes, visual problems, dry mouth/throat, dizziness, cardiac side effects (including high blood pressure, risk of strokes etc.), thyroid abnormalities, blood chemistry changes, blood count changes, risk of abuse, genital-urinary difficulties, pain issues, sleep problems, kidney and liver problems, movement disorders, risk of drug interactions and in rare cases even death. I understand that it is my responsibility to relay any possible pregnancy status to Dr. Van Schenck prior to addition or stopping of medications. I understand that with medication there is a risk of risk of malformations in the fetus during pregnancy. I also understand that obtaining appropriate laboratory investigations and relaying those results when recommended by Dr. Van Schenck is my sole responsibility. I understand that when starting a medication, I will need to follow up in person with Dr. Van Schenck at least twice within the first two months. I understand that all patients on medication must be under the care of a primary care doctor or NP. I understand that if Dr. Van Schenck is prescribing medication, I will follow up with him at least every 3 months. If I desire to be seen less frequently than this, I will return to my PCP for that prescription but can continue to see Dr. Van Schenck at less frequent intervals. I understand that I am responsible for not mixing illicit street drugs and/or alcohol along with medication. I understand that Dr. Van Schenck recommends dialing 911 or visiting the nearest emergency room during life-threatening emergencies (listed above under ‘Emergencies’).

I understand that Dr. Van Schenck requires both parents of a patient (under the age of 18) to consent to the treatment of their child if both parents have a legal right to consent. I also require the consent of the patient under the age of 18. If I am a parent(s)/legal guardian, I understand that this agreement is true regarding my child-adolescent and I am responsible for all the information I provide to Dr. Van Schenck regarding the care of my child/adolescent. 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.

If pt is an adult (18 years or above)

Signature:_____ Date:_____

Printed name:_____

If patient is below age 18 years.

Parent # 1 Consent: Signature _____ Relationship to Patient:_____ Date: _____

Responsible Party Printed Name: _____

Parent # 2 Consent: Signature _____ Relationship to Patient:_____ Date: _____

Responsible Party Printed Name: _____

Is a Parenting Plan in place: _____ (If a parenting plan is in place, please provide documentation)

Patient Consent: _____ Date: _____

Medicare Contract (for all patients who have Medicare)

If you have Medicare then this is the contract that must be signed between Dr. Van Schenck and yourself before treatment begins. Please WAIT TO SIGN this portion with Dr. Van Schenck.

This agreement is between Dr. _____ ("Physician"), whose principal place of business is 7175 Nolensville Rd Suite 200, Nolensville TN 37135 and patient _____ ("Patient"), who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program. The expected or known effective date and expected or known expiration date of the current opt-out period is _____ (effective date) and _____ (expiration date). The Physician's opt out status auto-renews every two years unless terminated prior to the renewal date.

The Physician is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"): Psychiatric care

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule.
Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.
- Dr. Van Schenck has provided patient a copy of this contract.

Executed on (date)_____

by (Patient name) _____and [Physician name]
_____

[Patient signature] _____ [Physician signature]
_____

Buprenorphine Maintenance Treatment Agreement

Please read and sign if you would like stabilization/maintenance buprenorphine treatment.

Dr. Van Schenck helps with buprenorphine stabilization and maintenance (continuing treatment for those on buprenorphine), not induction (starting buprenorphine). He requires all patients seeking buprenorphine stabilization or maintenance to bring their induction paperwork/discharge paperwork (from the hospital or clinic that performed induction) to their first appointment. Buprenorphine is an FDA approved medication for the treatment of opioid use disorder. It is a partial agonist at the opiate receptor. The tablets/film must be held under the tongue until they completely dissolve. Other medical treatments for opiate addiction include methadone and naltrexone. Withdrawal symptoms (from stopping or weaning buprenorphine) are generally less intense than heroine or methadone. Buprenorphine can cause drowsiness, so Dr. Van Schenck recommends you should not drive or operate machinery until you are accustomed to its effects. Combining buprenorphine with other substances like benzodiazepines (Xanax, Ativan, Klonopin, Valium) can be dangerous and buprenorphine should never be mixed with alcohol. Dr. Van Schenck only treats people with buprenorphine who are not using any illicit substances. Side effects of buprenorphine can include: Tooth decay/loss, tooth infections, cracked teeth, cavities, root canal problems, CNS depression, hypotension, QT prolongation, lower seizure threshold, nausea, vomiting, dizziness, headache, memory loss, sweating, drowsiness, dry mouth, miosis, orthostatic hypotension, sexual adverse effects, urinary retention, Hypersensitivity reactions ranging from rash, hives, pruritus, and bronchospasm to anaphylactic shock, Hepatitis and liver impairment, ranging from transient, asymptomatic transaminase elevations to liver failure, may occur, particularly in patients with preexisting hepatic impairment. Buprenorphine may significantly lower blood pressure levels, which can result in orthostatic hypotension or syncope. Accidental exposure to even a single dose of buprenorphine buccal film or transdermal patch, especially in children, can result in a fatal buprenorphine overdose. Using buprenorphine in various forms, including buccal film, transdermal patch, and immediate-release injection, for an extended period during pregnancy can cause neonatal opioid withdrawal syndrome. If left unrecognized and untreated, this condition can be life-threatening to the newborn. If a pregnant woman needs to use opioids for an extended period, she should be informed of the risk of neonatal opioid withdrawal syndrome, and appropriate treatment should be made available.

Buprenorphine can cause withdrawal symptoms if you take it when other opiates are still in your system. Normally buprenorphine is combined with naloxone to discourage injecting or snorting – because the naloxone is an opiate antagonist which will cause withdrawal if abused in this way. In case of opiate relapse, Dr. Van Schenck advises you to enter inpatient detox treatment ASAP and he will no longer provide you buprenorphine until you have completed inpatient detox and re-induction on buprenorphine.

Dr. Van Schenck requires a specific visit frequency for stabilization and maintenance on buprenorphine. After the initial New Patient Appointment, the follow up frequency is: 1 week, then every 2 weeks for 6 months and then (if stable) at least monthly follow up visits for those on buprenorphine maintenance treatment. After one year of stable monthly visits patients can follow up every 3 months. Dr. Van Schenck does not refill buprenorphine without an appointment. Early refills due to overuse will not be given. Your medication should be kept in a safe and secure place out of reach of children. Buprenorphine patients will be financially responsible for obtaining drug testing to Dr Van Schenck. This includes routine and random monitoring for all patients on long-term opioid therapy with initiation and throughout duration of therapy.

Violation of this agreement will result in treatment with buprenorphine stabilization/maintenance being terminated. Please sign below if you consent to the above agreement.

Signature:___________________________________ Date:________________

Printed name:________________________________