NOLENSVILLE PSYCHIATRY

Office in the back of building for your privacy
7175 Nolensville Road
Suite 200
Nolensville, TN 37135
Phone: (615) 671-7258
Fax: (615) 235-1186
www.NolensvillePsychiatry.com
Email: drvanschenck@proton.me

If you have MEDICARE you must schedule your first appointment over the phone.
At Nolensville Psychiatry patients otherwise schedule and pre-pay for appointments on the website through the 'Book Now' button (on the 'Book Appointment' Tab).

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:_____

Address: _____

City: _____ State:_____ Zip:_____

Phone# (Primary number): _____

Email: _____

Drug Allergies:

_____

Pharmacy Name and City (my program will help find the rest):

_____

Emergency Contact

Name:_____Phone#:_____

Address:_____Relationship:_____

Office Policies

Office Hours: Monday through Thursday 8:30 AM to 5:00 PM (Friday closes at 4:30PM) and Saturday 9:30 AM to 2:00 PM

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

Any changes to normal office hours can be discussed personally with patients.

1.) Patients book and pre-pay for all appointments on the website www.nolensvillepsychiatry.com. At the end of your appointment, I will write down the dates for you to make your next appointment in order for you to not run out of medication.
2.) I do not refill medications outside of an appointment.
3.) All patients can communicate with me through the Nolensville Psychiatry phone # (615) 671-7258. Please see the website tab 'Text messaging' for information on iPlum secure texting for patients who would like to be able to text message with me.
4.) Phone calls and texts of existing patients will be returned within 24 hours and usually within 12 hours excepting Sundays. I check messages and respond Mon-Fri 8-8:30AM/12-12:30pm/5-6pm.
5.) 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.
6.) My standard schedule for patients seeking stabilization is explained below, as I will need to monitor your condition.
    - Initial evaluation
    - Follow up in 10 days
    - 3 weeks
    - 5 weeks
    - 7 weeks
    - 11 weeks
    - At this point, if you are stable, you can continue to follow up with me every 11 months.
    - Note: All patients on medication must have a primary care doctor or NP they see regularly.
    - Patients on multiple controlled substances are seen weekly to monthly.
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.) I do not see patients for the purpose of disability evaluations. I do not do disability paperwork.

10.) For your safety during inclement weather or due to physical and travel difficulties I offer telehealth services. I must see you in office before prescribing controlled medication. I will email you the Telehealth Link before your appointment on the day of your appointment.

Cancellation Policy

All appointments missed without canceling are non-refundable. If you need to cancel your appointment simply let me know the details (by phone or text) and I can help you reschedule. If you arrive more than 15 minutes late for an initial appointment, I still may be able to see you but will not be able to complete your initial evaluation that day unless there is another initial evaluation opening later that day and you are willing to wait. If you arrive more than 15 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 60 minute New Patient Appointment and $200 for a 30 minute follow up Medication Management/Therapy appointment. The fee for paperwork (letters/medical records) is the following: $50 for a letter, $50 for medical records (Please allow for 30 days for processing paperwork). The paperwork/letters or medical records can be paid for and picked up at a mutually scheduled time. If you require me to release it to a source other than yourself, I require payment before I release the document. In that case I can send you an invoice for the paperwork which must be paid before I release the documents.

Signature:_____ Date:_____

Printed name:_____

Confidentiality

My practice is designed to be as confidential as possible. My scheduling system is HIPAA compliant. My iPlum phone and text 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).

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, dysgeusia, neuralgia, blood count changes, risk of abuse, genital-urinary difficulties, pain issues, sleep problems, kidney and liver problems, movement disorders, suicidal thoughts, 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. Patients on controlled substances may need to be seen weekly to monthly.
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 and I am psychiatrically stable I will follow up with him at least every 11 weeks unless Dr. Van Schenck determines I need to be seen more frequently. 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').

Signature:_____ Date:_____

Printed name:_____

If patient is below age 18 years.

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.

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:

_____

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. Dr. Van Schenck uses iPlum for phone communication and iPlum for text communication for those patient's who chose to do this. iPlum has an encryption policy that keeps the data secure. It provides secure texting channels for HIPAA-compliant messaging. 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 March 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:_____