

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

I do not accept new patients with MEDICARE. 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 9:00 AM (except Monday and Thursday open 10AM) to 5:30 PM (Friday closes at 3:30PM) and Saturday 10:00 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 can email the date range for you to make your next appointment in order for you to not run out of medication.
- 2.) I don't refill medications outside of an appointment.
- 3.) **Do not communicate with me through email for anything requiring less than 24 hours notice.** 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.
- 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.) I usually need to follow up with patients twice in the first two months after an initial visit. Stable patients can eventually be seen every 3 months (seasonally).
- 7.) All controlled medication should be securely stored in a safe: If your medication is stolen I reserve the right to not refill your medication early.
- 8.) I do not see patients for the purpose of disability evaluations.
- 9.) 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

If you need to cancel your appointment **let me know the details (by phone or text) do not email me and I can help you reschedule.** All appointments missed without canceling are non-refundable and all appointments rescheduled for another day with less notice than 12pm the day prior and for a reason other than physical inability are non-refundable. This allows me to make room for patients in need. If you arrive more than 15 minutes late for an initial visit then it will be considered a no show unless I have another opening later in the 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 I am financially responsible for all charges for appointments. The initial appointment is \$325 for a 60 minute New Patient Appointment and \$200 for a 30 minute follow up Medication Management/Therapy appointment. I also offer a 60 minute follow up Couples Counseling appointment for \$250 for any established patient who would like couples counseling with their partner. **I reserve the right to not do paperwork outside of scheduled appointment times.** The minimal fee for any 'paperwork' (medical records/letters/other paperwork) done outside of an appointment is \$50 for each item. Medical Records processing is \$50 per request. The fee for letters and other paperwork depends on the time required to process. I charge \$400 per hour of time spent (minimal charge \$50) calculated to the nearest minute (I use a timer) when doing letters or other paperwork. Please allow for 30 days for processing all paperwork. I will send you an invoice(s) for the paperwork. Once the invoice is paid I will release the paperwork. I reserve the right to cancel the cost of a letter or paperwork if written or done during an appointment.

Signature: _____ Date: _____

Printed name: _____

Confidentiality

My practice is designed to be as confidential as possible. My scheduling system is HIPAA compliant. My iPlum phone system is HIPAA compliant. Patients who would like secure texting should complete the registration information consent on the website under "Text Messaging" section and I can send you a secure texting link with instructions on how to download the free iPlum app for secure texting. 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 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 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: _____