Ben Frock, M.D.
30 Burton Hills Blvd., Suite 375
Nashville, TN 37215
Phone 615-327-4877 Fax 615-327-4881
http://healthymindsnashville.com

Patient Information:

Last Name: _____ First: _____ MI: _____

Prefers to be called (if different from legal name): _____

Address: _____

City: _____ State: _____ Zipcode: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _______________ Age: _____ Sex: MALE / FEMALE

Social Security #: _____-_____-_____ (not required for minors)

Who referred you to Dr. Frock? _____

Personal Information:
Spouse's Name: _____ Phone: _____

Patient Employer/Occupation: _____Phone: _____

Emergency Contact: _____ Phone: _____

Electronic Mail (EMAIL) Policy:

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). We cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we will save email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature and please contact the office if you have not received a reply within 24 hours.

*I have read and agree to the terms of the email policy X_____

Email address: _____

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Payment Policy:

Payment is required in full at the time of service. We accept credit/debit/checks/cash (please note we do not keep change in the office for cash payments but are happy to put a credit on your account if you do not have exact cash).

***** For your convenience we can keep a credit card on file to charge at your appointments.

Credit/Debit Card Payment for appointments:

I/we authorize Ben Frock, M.D. to bill the above credit/debit card for professional services at the time of service. I will notify Ben Frock, M.D. in writing if I no longer want my credit/debit card billed. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature: _____ Date: _____

Credit/Debit Card Payment for missed or cancelled appointments:

I authorize Ben Frock, M.D. to charge the above credit/debit card when the patient does not give advance notice for a late-cancellation or no-show, as per the policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature: _____ Date: _____

_____ Visa _____ Master Card _____ Discover _____ AMEX

Name on Card: _____ **Security Code**: _____
Billing Zip Code _____

Card #: _____
Exp. Date _____

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Insurance Policy:

As an out of network provider we are not contracted with any insurance companies and we do not accept payment from insurance companies. You can request a statement of service and payment that you can use to file insurance for yourself. Dr. Frock has opted out of Medicare. Please notify the office if you have Medicare insurance, you will need to sign an additional form and this insurance cannot be filed by Dr Frock or by the patient.

Appointment Charges / Cancellation Policy:

We do not overbook appointments and appointments made are reserved for the patient. We require a **24-hour cancellation notice**. Patients will be charged the full session rate if they do not cancel an appointment within the 24-hour time frame or if they fail to keep their appointment on the day it is scheduled. If you need to change or reschedule an appointment, please call our office as soon as you can so we can accommodate other patients who wish to be seen.

Paperwork Policy

Requests to complete forms or any other paperwork (such as FMLA or disability) may result in additional charges that reflect existing rates. Fee will depend on time needed to complete forms appropriately and this may include writing, chart review for supporting clinical documentation, preparing/sending faxes, and other administrative business tasks.

Office Hours:

Dr. Frock's office hours are by appointment Monday through Friday. The front office is open Monday through Thursday 9am – 4pm and Friday 9am – 2pm. If you need to contact the office regarding an appointment, billing questions or for general needs please call during these hours.

If you need to speak with your doctor between office visits, please call the office 9am-4pm. We will be able to get a message to your doctor asking him to call you back.

Medication refill policy:

Medication refill requests require a 24-hour notice. If medication refills are required between appointments, please have your pharmacy fax us a refill request. If you need to call for a refill you can do so Monday through Thursday 9am-4pm and Friday 9am-12 noon. Refills will be communicated to your pharmacy within 24 hours during regular business hours. After hours and weekend requests may not be called in until the next business day. Please call with your prescription information and dosage as well as your pharmacy name, location and phone number. We will need this information to complete your refill request.

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After Hour Emergencies:

To reach your doctor after office hours call the main office at 615-327-4877 and press 0 to be connected to our answering service. You may hear silence while the line connects. They will page your doctor or the on-call doctor for any urgent needs you may have after hours. If you are experiencing an emergency and cannot wait, please call 911.

Consent to Treatment and Patient Financial Responsibility:

- I have read the policies listed above and I understand and agree to them. I agree to be treated by Ben Frock, M.D., and when necessary, any doctors covering in his absence.

- I authorize Ben Frock, M.D. to release any information my insurance company requests or requires concerning patient care regarding billing or prescription needs.

I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges for services rendered. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days may be subject to a late fee. I understand that unpaid balances over 90 days are past due and may be referred to a collection agency.

Termination of Treatment:

Patients are not obligated to continue treatment. If you decide to terminate at any time, you are encouraged to discuss your decision to terminate care with your doctor.

Patient's Signature: _____

Date: _____

Person Responsible for Payment - (complete only if the patient is NOT paying for the bill):

Name of person responsible for bill: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____

Date of Birth: _______________ SS#: _____

HIPAA Privacy Rule
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.

- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness_____

Printed Name of Individual or Legal Representative _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign

- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Others (please specify)

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