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

Patient Information:

Last Name:_____________________________ First:_________________________ MI:______

Preferred name (if different from legal name):____

Date of Birth: ______________________ Age: _________ Gender: ____________________

Preferred Phone Number:__________________ Email:_________________________________

Address:____

City: ____________________________ State: _______________ Zip Code: ________________

Patient Employer/Occupation: ___________________________ Phone: __________________

Preferred Pharmacy: __________________________________ Phone: __________________

Pharmacy Address/Neighborhood:____

Who referred you to Dr. Frock? ____

Emergency Contact Information:

Name: ____________________________________ Relationship to patient: _________________

Phone: ________________________ Email: ____

Electronic Mail (EMAIL) Policy:

By agreeing to communicate via email, you assume 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. These communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and 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

Signature: ____ Date:__________________

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Insurance Policy:

As an out-of-network provider, Benjamin D. Frock, M.D. is not contracted with nor will accept payment from insurance companies. You can request a statement of service and payment to file insurance for yourself (aka “superbill”). Additionally, Benjamin D. Frock, M.D. opted out of Medicare. Please notify the office if you have Medicare insurance; you will need to sign an additional form, as Dr. Frock or the patient cannot file this insurance.

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). We can keep a credit card on file to charge at your appointments for your convenience.

Credit/Debit Card Payment for Appointments:

I/we authorize Benjamin D. Frock, M.D. to bill the below credit/debit card for professional services at the time of my appointment. If a credit card is used, I understand there may be an additional credit processing fee. I will notify Benjamin D. 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:_________________

Payment Information:

_____ Visa _____ Master Card _____ Discover _____ AMEX

Name on Card: ____________________________ **Card #**: ____________________________

Exp. Date: _____ / _______ **Security Code**: _______ **Billing Zip Code** ___________

Credit/Debit Card Payment for Missed or Cancelled Appointments:

I authorize Benjamin D. Frock, M.D. to charge the above card when I do not give advance notice for a late cancellation or no-show, as per the policies below. 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:_________________

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Appointment Charges / Cancellation Policy:

We do not overbook appointments; therefore, all slots are explicitly reserved for the patient. If you need to change or reschedule an appointment, please call our office as soon as possible so we can accommodate other patients who wish to be seen.

All rates are established before your appointment is scheduled. If you have questions about appointment fees, please feel free to discuss these with Dr. Frock. Rates are based on a 45-minute or a 25-minute appointment time frame. If sessions go beyond your scheduled time, additional fees may apply.

We require a 24-hour cancellation notice. Patients will be charged the full session rate if they cancel an appointment within the 24-hour time frame or fail to keep their appointment on the scheduled day.

Paperwork Policy:

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

Office Hours:

Dr. Frock's schedules patients by appointment only. The front office is open:

Monday to Thursday: 9:00 AM – 12:00 PM & 1:00 PM – 4:00 PM
Friday: 9:00AM – 2:00PM
Closed Saturday & Sunday

If you need to contact the office regarding an appointment, billing questions, or general needs, please call during these hours.

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; please wait on the line. The answering service will page your doctor or the on-call doctor for any urgent needs. If you are experiencing an emergency and cannot wait, please call 911.

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Medication Refill Policy:

Medication refill requests require 24-hour notice. If medication refills are required between appointments, please have your pharmacy send us a refill request. If you need to call for a refill, you can do so during posted business hours. 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 and your pharmacy name, location, and phone number. We will need this information to complete your refill request.

Patient Medication Agreement:

Prescription fraud, diversion, and misuse are known challenges facing the healthcare industry. As a result, some clinics refuse to write certain controlled medications or those carrying some abuse potential.

While this effort may be helpful in some instances, we feel that omitting certain medications outright limits the overall effectiveness of the care we aim to provide. To provide optimal care while prioritizing patient safety, we will take many measures as detailed below.

Please read, review, and sign to demonstrate understanding of the Patient Medication Agreement.

- I understand that prescriptions for controlled medications will always include database monitoring and may include urine drug testing as appropriate.
- I agree to receive any prescribed or controlled substances from Benjamin D. Frock, M.D., and will not seek duplicate prescriptions from other providers
- I understand that it is a felony to obtain medications by fraudulent means, possess medications without a legitimate prescription, or sell/give medication to others
- I understand that lost or stolen medications will not be refilled early.
- If appointments are not kept or scheduled, I understand that certain prescriptions will not be refilled.

We hope there is a limited negative impact from the above measures and that you understand the actions taken to safeguard against fraud and misuse.

Signature: ____ Date:_________________

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Consent to Treatment and Patient Financial Responsibility:

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

- I authorize Benjamin D. Frock, M.D. to release any information requested by my insurance company or pharmacy 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 outstanding balances over 90 days are past due and may be referred to a collection agency.

Person Responsible for Payment
(complete only if the patient is <u>NOT</u> paying the bill):

Name of person responsible for bill: ____

Date of Birth: _____________________

Preferred Phone Number:__________________ Email:________________________________

Address:____

City: _____________________________ State: ______________ Zip Code: ______________

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 with your doctor.

Signature: ____ Date:_________________

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

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

I, ________________________________, (patient's name) understand that 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 before signing this acknowledgment.
- This facility reserves the right to change its Notice of Privacy Practices, and before 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 acknowledgment of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Others (please specify)

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Treatment Overview

Have you ever seen a psychiatrist? If yes, who provided treatment/what was your diagnosis?

Are you currently or have you previously been in therapy? If yes, with who and for how long?

Current medication regimen (including supplements):

Previous psychiatric medication trials:

Current medical providers (please include primary care, specialists, or other relevant info):

Provider	Role	Phone