John Lambert, 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: _________________________
* Please indicate if you do not want us to leave voice mail on the phone numbers listed.

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

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

Who referred you to Dr. Lambert? ____

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 expected at the time of service. Payment may be made by cash, check or credit card.

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. Patients will also be charged the full session rate if they fail to keep their appointment on the day it is scheduled. Insurance does not cover missed or cancelled appointments. 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.

* For your convenience we are able to keep a credit card on file to charge at your appointments. If you would like to use this service please fill in the information below.

Credit/Debit Card Payment for appointments:

_____ Visa _____ Master Card _____ Discover ______ AMEX

Security Code: ________

Name as it appears on Card: _________________________ **Billing Zip Code** ___________

Credit/Debit Card #: _________________________________ **Exp. Date** ________________

I/we authorize John Lambert, M.D. to bill the above credit/debit card for professional services at the time of service. I will notify John Lambert, 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 John Lambert, 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: _______________________

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Insurance Policy:

All of our providers are out of network with insurance. We are happy to file your insurance for you; however, our filing your insurance does not guarantee payment from them. Payment is due at the time of service regardless of your insurance.

At your request we will file each visit with your primary insurance company. Please provide us with a copy of your insurance card. It is the patient's responsibility to make sure we have current and correct information at all times. It is up to you to update insurance information with us as it changes. Regardless of the status of your insurance, you are responsible for payment at the time of service. In the event we receive reimbursement from your insurance company your account will be credited.

Office Hours:

Dr. Lambert'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 24 hours 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.

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.

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Consent to Treatment and Patient Responsibility:

- I have read the policies listed above and I understand and agree to them. I agree to be treated by John Lambert, M.D., and when necessary, any doctors covering in his absence.
- If I choose to have my insurance filed for me I hereby authorize payment by my insurance company directly to John Lambert, M.D.
- I hereby authorize John Lambert, M.D. to release any information my insurance company may require concerning patient care in regards to billing or prescription needs.

Patient's Signature (Parent or Guardian, if under 18): ________________________________

Date: ________________________________

Financial Responsibility Agreement:

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.

Signature: ______________________________ **Date**: __________________________

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.

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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#: __________________________