Jack L. Koch Jr., MD, PLLC
Board Certified in Child, Adolescent, & Adult Psychiatry
1507 16th Avenue South, Nashville, TN 37212
o: 615.515.7775 f: 615.523.1483
DrJackKoch@GMail.com
www.drjackkoch.com

Patient Care

Thank you for choosing me to provide your psychiatric care. I strive to provide outpatient mental health services; including evaluation, diagnosis, education, and treatment; for children, adolescents, and adults. My treatment approach is individualized for each patient in order to address psychoeducational, psychotherapeutic, and/or pharmacologic management needs.

Although I do not have an inpatient practice, should you require admission to a hospital or residential setting, I will assist you in making appropriate arrangements, readily communicate with inpatient providers, and resume outpatient treatment at the time of discharge.

Appointments

The nature of outpatient psychiatric care requires an initial evaluation and subsequent follow-up visits as scheduled appointments. Follow up appointments are typically 25 or 45 minutes in duration and a full business day (24 hours Monday through Friday) notice of cancellation is required. Appointments that are missed or are canceled less than one business day in advance charge will be charged the full appointment charge.

If you anticipate not being able to make it to your scheduled appointment, please notify the office with as much advanced notice as possible. Please note: appointments scheduled and not kept will be billed to you and insurance companies will not reimburse for any portion of missed appointments.

If you have a regularly scheduled appointment and must cancel, I will assume that you intend to keep your next regularly scheduled appointment unless you notify the office otherwise

Fees & Insurance

Although I am not a participating provider for any insurance networks, I am happy to provide a statement of service that you may file with your insurance provider. Please remember that your insurance is to reimburse you directly for the services provided. The fee for your child's initial evaluation is $400 and is due at the time of service. Payment may be made by cash, check, or credit card (Visa or Mastercard).

Statements are generally sent out at the end of each week. If you will be submitting the visits to your insurance provider for reimbursement, please let the office know in order to make sure the statements will contain the information needed to submit the claim. Insurance forms are generally available from your health insurance carrier or employer.

Prescriptions

New prescriptions and refills should be obtained at the time of regularly scheduled visit. If you do require a refill between sessions, please check with your pharmacy to see if refills have already been authorized. If no refills are available, please call the office Monday through Friday from 9:00am to 4:00pm. As Dr. Koch is not always in the office to provide refills, please know that it may be **three or four days** before the requested prescriptions are available. The office will notify you when the prescription is ready and there is a $10 charge for refills provided outside of regularly scheduled follow-up visits.

As some pharmacies fax automated refill requests, please request your pharmacy disable these automated reminders. In order to avoid inadvertent charges for refill requests, faxed prescription refill authorizations

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received from pharmacies are generally ignored unless the office has received advanced notification from you that the refill is, indeed, needed.

Emergencies

In the event of an emergency (a situation which requiring immediate attention due to concerns of for an imminent danger to self or others), please call 911 or go to your local emergency room/department. Please ask the physician to contact me directly as appropriate. NOTE: after 4pm Monday through Friday and on weekends, there are no staff to accept telephone calls. Messages can be left on my emergency voicemail that will attempt to page me directly. If for any reason during an emergency situation you are unable to reach me, you should go directly to the nearest emergency room. Hospitals providing emergency psychiatric assessment:

Vanderbilt (Respond): (615) 327-7000
Parthenon Pavilion (Options): (615) 342-1400
Rolling Hills Hospital (Respond): (800) 832-0388

Non-urgent Communication

If you need to speak with me between appointments, please leave a message with the office at (615) 515-7775. As I may not be immediately available, please leave both daytime and nighttime numbers so that I may best return your call. I will make every effort to return calls on the same day that messages are left.

Confidentiality

With your consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:
Staff obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor may determine that you need an EKG, medical procedure, laboratory test, or emergency evaluation. He/she will share information with the doctor, or assistant, in order to get your tests completed or to permit emergency care in the case of an emergency assessment.

Examples of uses of your health information for payment purposes:
Submission of information for payment to your health insurance company. The health insurance company or business associate helping us obtains payment requests information from us regarding your medical care given. We will provide information to them about you and the care given.

Examples of uses of your health information for health care operations:
We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, billing services, mailing services, and insurance.

Additional information is available on the website: www.drjackkoch.com and in the office policies.

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Administrative & Billing

Person Responsible for Payment: _____

Social Security Number of Person Responsible for Payment: _____

Relationship to Patient:_____

Address: _____
(Street) (City) (State) (Zip)

I, _____, hereby authorize Jack L. Koch Jr., M.D. to provide treatment for my child and agree to assume full responsibility for fees for these services.

Should it become necessary, I authorize Jack L. Koch Jr., M.D. to release and exchange in verbal and/or written form any information necessary for the payment of fees, and/or the provision of my medical care. This may include information related to alcohol or substance abuse.

By signing this form, you hereby agree to pay your account within 45 days following the date of the payment invoice. Should you fail to pay your account in a timely manner, you will also pay on demand late charges and any amount incurred in collecting, enforcing, or protecting the Provider's rights under this agreement. These expenses will bear interest from the date payment is due until paid in full at the interest rate permissible by Tennessee law in effect at the signing of this document. This amount may include, but is not limited to attorneys' fees, court costs, and other legal expenses incurred at all stages of collection.

If the person responsible for payment will not be present at the time of the initial visit, please have them provide credit card information to the receptionist prior to the initial evaluation date.

I have read this form in full and have received a copy of Jack L. Koch Jr., M.D.'s office policy. I agree to assume full responsibility for the fees for the services provided.

Signature: _____Date: _____

Please remember that payment is requested at the time of the appointment.

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Patient Information Form

Child & Adolescent Patient Background

Date: _____

Client Name: _____ Date of Birth: _____Age:_____

Address: _____ City:_____ State:_____ Zip:_____

Patient's Social Security #: _____

Phone: ☐ Home: _____

(check preferred) ☐ Cell: _____

☐ Work: _____

e-mail: _____

May we send you appointment reminders via e-mail? ☐ Yes ☐ No
May we send invoices/statements via e-mail? ☐ Yes ☐ No

e-mail for invoices (if different): _____

By whom were you referred:_____

FOR CLIENTS 18 AND YOUNGER:

Legal Guardian's Name: _____

Address: _____ City:_____ State:_____ Zip:_____

Social Security # (of Legal Guardian):_____

School: _____ Grade: _____

Primary Care Provider: _____

Address/Name of Practice: _____ Phone: _____

DR. KOCH DOES NOT DIRECTLY BILL INSURANCE COMPANIES. PLEASE INDICATE IF YOU WILL BE SUBMITTING BILLING STATEMENTS TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT: ☐ Yes ☐ No

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Child & Adolescent Patient Background *(page 2)*

What concerns are you having currently? What brings you to the office now, rather than before?

_____

_____

_____

_____

_____

What would you like to change in your life? What are your goals with treatment (and life)?

_____

_____

_____

_____

_____

Have you been in therapy or seen a psychiatrist before? How successful was it or how satisfied with the services were you? How would you like this experience to be different?

_____

_____

_____

_____

_____

_____

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Child & Adolescent Patient Background *(page 3)*

GENERAL BACKGROUND & DEMOGRAPHICS

Where were you born?_____

How long have you lived in the Nashville area?_____

Marital / Relationship Status (how long?): _____

_____

Who Lives with You: _____

_____

_____

Any Children: _____

_____

Highest Education/ Grades/ Academic Strengths/ Areas of Concern: _____

_____

Occupation (longest employed): _____

_____

Religion/Spiritual: _____

_____

Legal Issues (past/present): _____

_____

Any additional Information: _____

_____

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Child & Adolescent Patient Background *(page 4)*

MEDICAL BACKGROUND

Current/Past medical illnesses (e.g. asthma, diabetes, thyroid, migraines, pains, etc): _____

_____

_____

_____

Have you ever had any head injury, loss of consciousness, sports injury to the head, falls, or concussion? If so, when, how many times, any noticeable after-effects (i.e. forgetful, difficulty concentrating, personality changes, hard to learn):

_____

_____

_____

Allergies to medications, foods or food sensitivities (please list offense and allergic response):

_____

_____

_____

Current Medications (including prescription and non-prescriptions meds, vitamins, supplements, herbs, including name, dose, times, reasons):

_____

_____

_____

_____

Name/Address/Phone Numbers of other health/therapy providers: _____

_____

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Child & Adolescent Patient Background *(page 5)*

FAMILY MEDICAL & PSYCHIATRIC HISTORY

Family mental health history (who has had or is suspected of having had what illnesses and did they receive treatment? e.g.: grandmother with depression treated with Prozac):

Mother's Side: _____

_____

_____

_____

Father's Side: _____

_____

_____

_____

Siblings: _____

_____

_____

Children: _____

_____

_____

List any significant family medical illnesses or history (including neurological illnesses like Parkinson's, seizures, diabetes, thyroid/endocrine, cardiac/heart attacks) in family members:

_____

_____

_____

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Child & Adolescent Patient Background *(page 6)*

SUBSTANCE USE HISTORY
Past or Present Substance Use (age of first use, frequency of use, amount used, last use, etc.):

Caffeine: _____

Tobacco: _____

Alcohol: _____

Marijuana: _____

Cocaine, Methamphetamine, or other stimulants: _____

_____

Anxiety Medications (benzodiazepines): _____

_____

Narcotic/Opiate Pain Medications: _____

_____

Inhalants: _____

Other: _____

_____

_____

_____

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Child & Adolescent Patient Background *(page 7)*

DEVELOPMENTAL HISTORY

Full Term/Early/Birth Weight: _____

Pregnancy complications/exposures (i.e. excessive stress, cigarettes, etc): _____

_____

_____

Delivery complications: _____

_____

_____

Developmental milestones reached on time? (Age at which first walked? spoke? toilet trained? Were any of these skills lost?)

_____

_____

_____