Ginger Lovingood, MD, Allen Rigell, MD & Julia Wood, MD
Knoxville Psychiatry, PLLC
310 N. Forest Park Blvd. Suite 202
Knoxville, TN 37919

Welcome to Knoxville Psychiatry!

Please complete the accompanying forms and return to the office staff. We will need to receive these documents before we can schedule your initial appointment. These forms give your doctor an understanding of the your history and permission to treat you. Please bring a copy of any pertinent medical records along with your photo Identification and insurance card. If you have records that you would like us to review prior to your appointment, please bring or send these to the office at least 48 hours prior to your appointment. For your first appointment, it can be helpful to have a family member or someone to assist in providing additional history.

The charge for your initial appointment is $400.00. Full payment is due at the time of service. We do NOT participate in the Medicare program, TennCare or in any form of commercial insurance programs. We do not file insurance but we will give you the necessary forms to file your commercial insurance claims. If you have Medicare coverage, You will be required to sign a Medicare Opt-Out Private Pay Contract. Claims cannot be filed by our facility or by the patient, per Medicare. Should your insurance company require a prior authorization or referral for your visits with us, you must personally acquire this prior to your appointment. You, as the patient, are responsible for all charges.

We are located down from the Mayo Garden Center on North Forest Park Blvd. behind the Blair House Antiques and across from the Smoothie King. Should you have any questions, please do not hesitate to contact us. We look forward to meeting you. Thank you for allowing us to participate in your care.

Sincerely,

Dr. Ginger Lovingood
Dr. Allen Rigell
Dr. Julia Wood

Ginger Lovingood, MD, Allen Rigell, MD & Julia Wood, MD
Knoxville Psychiatry, PLLC
310 N. Forest Park Blvd. Suite 202
Knoxville, TN 37919
Phone: (865) 539-2221
Fax: (865) 539-5324

Welcome to Knoxville Psychiatry, PLLC. Your mental health is our primary concern and our goal is to provide you with the best care possible. The following information has been prepared for your benefit. Please read it carefully and ask any member of our staff if you have questions.

Clinical Care

At your initial evaluation, you consent to receive a comprehensive diagnostic assessment. All communication and clinical treatment will be documented in the patient chart. Both the law and the standards of the profession require such. You are entitled to receive a copy of these records, unless (as in rare circumstances) we believe that seeing these records would be emotionally damaging. The fee for records is $20.00 unless we are providing your records to another provider. If this is the case, we will be happy to provide the records to an appropriate mental health professional of your choice, or to prepare an appropriate summary instead.

Please note that we (Drs. Lovingood, Rigell and Wood) do NOT have admitting privileges, nor are we affiliated with or on staff at any hospital. Should we deem more intensive services are needed than we can provide, we will do our best to ensure safety and obtain the appropriate level of care, but we cannot provide that care directly nor can we guarantee the receipt or quality of care that others provide.

Confidentiality

While we believe that communication with other members of your treatment team as well as with family, where appropriate, helps to deliver the best clinical care, Knoxville Psychiatry will not release information without your written permission.

However, there is no guarantee of confidentiality under the following conditions:

- If we suspect you are in imminent danger of harm to yourself or another person, or if we suspect a child or elderly person is being abused or neglected (as we are mandated reporters)
- If a court orders a release of information
- If you initiate a malpractice lawsuit, or a billing dispute with a financial institution
- If your insurance company requests to review your case
- If you pay by credit card, our name will appear on your credit card statement (Knoxville Psychiatry)
- If you do not pay your bill, your balance due statement (including diagnostic and procedural codes) may be sent to a collection's agency or other responsible party
- Dr. Lovingood, Dr. Rigell & Dr. Lovingood and the administrative staff of Knoxville Psychiatry communicate with one another to provide clinical care
- More details about privacy practices can be found in our Notice of Privacy Practices

Appointments

Drs. Lovingood, Rigell and Wood see patients by appointment only, except in emergencies. Twenty-four-hour notice is required for canceled appointments. YOU WILL BE CHARGED $87.50 FOR MISSED APPOINTMENTS/ LATE CANCELLATIONS. You may leave a message after hours for canceled appointments. Your insurance will not reimburse you for missed appointment charges should you choose to file this claim.

Telemedicine

Drs. Lovingood, Rigell and Wood offer appointments both in person and by telemedicine (video). We require your first visit be conducted in person as our ability to provide proper care may be otherwise limited. Additionally, there may be circumstances in which we require follow up visits be conducted in person. Our office uses Spruce Health, a secure teleconferencing software, to conduct video appointments. We will provide you with instructions on how to access this application should you choose to use it. For an optimal visit, you should be connected to a secure internet connection and in a private area for the duration of your visit. At times, technology can fail. Your doctor may be willing to conduct the visit through a different platform such as FaceTime or Zoom. Please note, these platforms are not secure and while the likelihood of transmission being intercepted for viewed is small, we cannot be

responsible for the security of these visits. Alternately, if technology fails due to unforeseen circumstances your doctor may conduct the visit via telephone.

Fees, payment and insurance

You are required to pay at the time of service. We are out of network for all insurance plans including Medicare. If you have coverage through an insurance plan, we will give you the appropriate forms to file with your insurance plan. You may not file out of network claims with Medicare as this is not allowed by law. Claims filed to insurance will go to your out of network benefits. Fees for appointments are as follows: initial appointment 400 dollars, starting January 1, 2023 follow up appointments will be 175 dollars and prior to that it is 150 dollars. We accept cash, check, debit card and Visa/Mastercard. Regardless of insurance coverage or other circumstances, you are responsible for your account. All accounts are to carry a zero balance, no charges are allowed. You are financially responsible for all charges, whether or not insurance covers any services, whether we decide to proceed with treatment or whether treatment is successful, for which there cannot be any guarantee.

Contacting your doctor outside of appointments

Drs. Lovingood, Rigell and Wood endeavor to be as available to their patients as much as possible. There are multiple ways to reach your doctor between appointments if needed. You may message your doctor through a secure patient portal within the electronic medical record; this operates like email and is accessed by your doctor only. Doctors check these messages during business hours. You may also text our main telephone number with questions or refill requests. Text messages are first read by our office staff and then forwarded to your doctor. Messages are also addressed regularly during business hours. Alternatively, you can call the office to speak with the doctor. Please note, the doctors are in session with patients all day. If you call, we will take a message. Unless you have an emergency, the call will be returned as soon as possible.

Please request prescription refills 3-4 days prior to the day you will be out of medication.

Name:_____Date of Birth:_____

If you have a true emergency after office hours call 911 or go to your local emergency room. Drs. Lovingood, Rigell and Wood can be reached for emergencies after hours by calling the main line and following the prompts to page the doctor on call. They cannot address routine refill requests after hours. All other calls will be handled the next business day.

Agreement

By signing below, I acknowledge that I have read, understood and agreed to all of the policies on this page. I agree to an evaluation and/or treatment at Knoxville Psychiatry, PLLC. I authorize Knoxville Psychiatry, PLLC to furnish information to my insurance carriers concerning my treatment at Knoxville Psychiatry, PLLC**.** I assign to Knoxville Psychiatry, PLLC all payments for services provided to me. I understand that it is my responsibility to obtain in advance a referral to Knoxville Psychiatry, PLLC from my primary care doctor, employee assistance program or other gatekeeper, if required by my insurance company. I agree to be responsible for all charges incurred because of my evaluation and/or treatment at Knoxville Psychiatry, PLLC regardless of insurance coverage or pending litigation. I further understand that charges are subject to being turned over to a credit bureau and/or collection agency if not paid within 120 days. I also understand that I will be charged for cancellations made with less than 24-hour notice or in the event I fail to keep my scheduled appointment. I give my permission to Knoxville Psychiatry, PLLC to contact me, when necessary, at any of the telephone numbers I have provided on the New Patient Registration form.

Your agreement to these terms and conditions is required for you to receive professional services from Knoxville Psychiatry. If you do not agree, we will be glad to provide you with names of other providers. Your signature below confirms that you have read and understood all of the policies above and you agree to these terms and conditions.

Signature of Patient: _____Date_____

Printed Name: _____

Signature of Parent or Guardian: _____ Date:_____

Name:_____Date of Birth:_____

Knoxville Psychiatry, PLLC
New Patient Registration

Last Name:		Cell Phone:	
Middle Initial:		Home Phone:	
First Name:		Work Phone:	
Date of Birth: Age:		Name of Pharmacy:	
SSN:		Pharmacy Address:	
Address:		Emergency Contact:	
City, State, Zip		Contact #:	
Email Address:		Relationship:	

	Primary Insurance	Secondary Insurance
Insurance Company Name		
Claims Mailing Address		
City, State, Zip		
Telephone Number		
ID and Group Number		
Name of insured/guarntor		
Insured 's address and phone		
Insured's SSN and Date of Birth		
Relationship to you		
Insured's Employees		

Do you have a Living will? YES/NO Do you have a Durable Power of Attorney? YES/NO

I hereby certify that the above information is complete and correct to the best of my knowledge.

Signature of Patient/Parent/Guardian: _____Date: _____

Name:_____Date of Birth:_____

Knoxville Psychiatry, PLLC
310 N. Forest Park Blvd. Suite 202
Knoxville, TN 37919
Phone: (865) 539-2221

Please list individuals involved in your healthcare that we may contact and/or discuss your care?

NAME	RELATIONSHIP	PHONE NUMBER

I authorize Dr. Ginger Lovingood, Dr. Allen Rigell, Dr. Julia Wood and the staff of Knoxville Psychiatry to contact me or the individuals listed above. If necessary Knoxville Psychiatry may leave medical information pertaining to my care by the following methods. I assume responsibility for notifying them whenever this information changes

Address:_____ YES NO

Home Phone:_____ YES NO

Cell Phone: _____ YES NO

Text Message: _____ YES NO

Email: _____ YES NO

Signature of Patient: _____Date:_____

Signature of Parent or Guardian: _____ Date:_____

Name:_____Date of Birth:_____

Who referred you or how did find our practice?_____

Psychiatric History:

State in your own words the nature of your problem:

_____

_____

_____

How old were you when your symptoms first began?

_____

_____

How have your symptoms changed over time (from onset to present):

_____

_____

_____

_____

List all psychiatric hospitalizations including drug/alcohol treatment facilities with dates of admission:

_____

_____

_____

List all outpatient mental health treatments including psychotherapy, intensive outpatient, partial hospitalizations and previous psychiatrists with the dates of treatment:

_____

Name:_____Date of Birth:_____

Please check any of the following medication you have taken:

Antidepressants:
- ☐ Fluoxetine/ Prozac
- ☐ Sertraline/ Zoloft
- ☐ Paroxetine/ Paxil
- ☐ Citalopram/Celexa
- ☐ Escitalopram/Lexapro
- ☐ Fluvoxamine/ Luvox
- ☐ Trazodone/Desyrel
- ☐ Nefazadone/Serzone
- ☐ Duloxetine/Cymbalta
- ☐ Venlafaxine/Effexor
- ☐ Desvenlafaxine/Pristiq
- ☐ Buproprion/Wellbutrin
- ☐ Buproprion-Dextromethorphan/ Auvelity
- ☐ Vortioxetine/Trintellix
- ☐ Vilazadone/Viibyrd
- ☐ Levomilnacipan/ Fetzima
- ☐ Mirtzapine/Remeron
- ☐ Desipramine/ Norpramin
- ☐ Clomipramine/Anafranil
- ☐ Nortriplyine/Pamelor
- ☐ Amitriptyline/Elavil
- ☐ Doxepin/Sinequan
- ☐ Imipramine/Tofranil
- ☐ MAOIs (Nardil, Parnate
- ☐ Marplan, Ensam

Mood Stabilizers:
- ☐ Lithium
- ☐ Lamotrigine/Lamictal
- ☐ Carbamezapine/ Tregetol
- ☐ Oxycarbazepine/ Trileptal
- ☐ Valopric Acid/Depakote

Anxiolytics:
- ☐ Alprazolam/Xanax
- ☐ Lorazapam/Ativan
- ☐ Clonazapam/Klonopin
- ☐ Diazepam/Valium
- ☐ Temazepam/Restoril
- ☐ Chlordiazepoxide/ Librium
- ☐ Oxazepam/Serax
- ☐ Clorazepate/Tranzene
- ☐ Propranolol/Atenolol
- ☐ Buspirone/Buspar
- ☐ Hydroxyzine/Vistaril

Antipyschotics:
- ☐ Olanzapine/Zyprexa/ Lybalvi
- ☐ Clozapine/Clozaril
- ☐ Quetiapine/Seroquel
- ☐ Risperidone/Risperdol
- ☐ Aripiprazole/Abilify
- ☐ Brexpiprazole/Rexulti
- ☐ Paliperidone/Invega
- ☐ Ziprazidone/Geodon
- ☐ Lurasidone/Latuda
- ☐ Cariprazine/Vraylar
- ☐ Asenapine/Saphris
- ☐ Lumateprone/Caplyta
- ☐ Iloperidone/Fanapt
- ☐ Chlopromazine/ Thorazine
- ☐ Trifluperazine/Stelazine
- ☐ Navane/Thiothixene
- ☐ Loxapine/Loxitane
- ☐ Perphenazine/Trilafon
- ☐ Fluphenzapine/Prolixin
- ☐ Haloperidol/Haldol

Stimulants:
- ☐ Amphetamines
- ☐ Methylphenidate
- ☐ Modafinil/Armodafinil
- ☐ Atomoxetine/Straterra
- ☐ Viloxazine/Qelbree
- ☐ Solriamfetol/Sunosi

Sedative Hypnotics:
- ☐ Zolpidem/ Ambien
- ☐ Eszopiclone / Lunesta
- ☐ Zaleplon / Sonata
- ☐ Ramelton / Rozerem
- ☐ Doxepin / Silenor
- ☐ Suvorexant /Belsomra
- ☐ Lemborexant / Dayvigo
- ☐ Daridorexant/Quviviq

Other:
- ☐ Topiramate/Topamax
- ☐ Naltexone/Vivitrol
- ☐ Disulfram/Antabuse
- ☐ Acamprosate/Camprol
- ☐ Baclofen/Lioresal
- ☐ Gabapentin/Neurotonin
- ☐ Pregabalin/Lyrica
- ☐ Clonidine/ Catapres
- ☐ Guanfacine /Tenex/ Intuniv
- ☐ Pimavanserin/Nuplazid
- ☐ Dextromethorphan-quinidine/Nuedexta
- ☐ Benztropine/Cogentin
- ☐ Trihexiphenidyl/Artane
- ☐ Amantadine
- ☐ Deutetrabenazine / Austedo
- ☐ Valbenazine / Ingrezza
- ☐ Galantamine / Razadyne
- ☐ Donepezil / Aricept
- ☐ Rivastigmine Patch/ Excelon Patch
- ☐ Rivastigmine /Execlon
- ☐ Memantine / Namenda
- ☐ Thyroid
- ☐ Light therapy
- ☐ Electroconvulsive Treatment/ECT
- ☐ Transcranial Magnetic Stimulation/TMS
- ☐ Ketamine infusion/ Spravato

Name:_____Date of Birth:_____

Please circle each item below that relates to you:

Very Withdrawn
Loss of interest
Crying a lot
Often Irritable
Decreased Motivation
Decreased Energy
Poor Concentration
Feel Worthless
Feel Guilty
Feel Hopeless
Feel Helpless
Feel Ugly
Can't make decisions
Can barely work
Suicidal thoughts
Attempted Suicide
Extremely Tense
Difficulty controlling worry
Anxiety attacks
Lying
Belittled/Shamed

Shy/Inhibited
Restlessness
Hyperactive
Obsessive thoughts
Intrusive thoughts
Repetitive behaviors
Checking Compulsions
Rituals
Defect in appearance
Flashbacks
Impulsive or reckless
Violent to property
Violent to other people
Want to harm others
Hearing things
Seeing things
Cannot Trust Others
Mistrustful/ Paranoid
Extreme Jealousy
Anger outbursts/Temper
Learning difficulties

Loses things
Forgetful
Lightheaded
Severe Headaches
Fainting Spells
Sexual Problems
Nightmares
Sleepwalkng
Acting out dreams
Snoring
Numbness and Tingling
Poor appetite
Weight loss
Weight gain
GI upset
Vision Changes
Problems sleeping
Breathing too fast
Unsteady on Feet
Palpitations
Sick often

Have you been diagnosed with bulimia, anorexia or binge eating?	Yes	No
Have you used laxatives induced vomiting to control your weight?	Yes	No
Have you ever been the victim of abuse?	Yes	No
Have you ever been kicked, punched or hurt by someone?	Yes	No
Have you ever been diagnosed with ADHD?	Yes	No
Have you ever been concerned you might have ADHD?	Yes	No
Have you ever been diagnosed or concerned about OCD?	Yes	No

Medical History

Who is your family or primary care doctor? _____

When was you last physical? _____
Height: _____ Weight: _____ Usual Weight:_____

Please list all medical illnesses that you have now or have had in the past. For examples high blood pressure, diabetes, stroke, cancer:

_____

Name:_____Date of Birth:_____

_____

_____

Please list all of you active medications (medical and psychiatric) including over the counter, supplements with the dosages and frequency. You may attached a list.

_____

_____

_____

_____

_____

Please list all allergies or adverse reactions you've had to medications. Please name the medication and the reaction you had:

_____

_____

Social/Developmental/Sexual History:

Sex assigned at birth:_____
Gender identity: _____
Sexual identity/Sexual Orientation:_____
Did you reach your developmental milestones on time? _____
Any learning disabilities? _____
Did you mother use drug or alcohol while pregnant with you?_____
Where you born vaginally or via c-section?_____
Any complications/problems with your birth?_____
Birthplace and where you were raised:_____
Who raised you? _____
What was your childhood home-life like?_____

_____

_____

Are your parents still married? If no, when did they divorce? _____

Name:_____Date of Birth:_____

Were you able to confide in your parents?_____
How were you disciplined?_____
Childhood Traumas:_____

Father's Age:____ Education:_____ Occupation:_____
Briefly describe your father:

_____

_____

_____

How did you get along with him? _____

Mother's Age:____ Education:_____ Occupation:_____
Briefly describe your mother:

_____

_____

_____

How did you get along with her? _____

Are Married/Divorced/Single/Dating/Engaged/Partnered? _____
How many marriages have you had?_____
Dates of each marriage and why they ended:

_____
Current Partner's Name:_____Age:_____Occupation:_____
How long have you been together?_____
How do you and your partner get along?_____
Anything else you would like share about your marriage/partnership:

_____

Have you been stalked or harassed in the community?	Yes	No
Have you been forced into sexual acts against your will?	Yes	No
Have you been in a relationship that frightened you?	Yes	No
Do you feel safe in your current relationships?	Yes	No

Do you have children?_____
# of Pregnancies/Miscarriages?_____
Who are the most important people in your life? _____
Are you religious or spiritual? Religion of Choice:_____

Name:_____Date of Birth:_____

Three most stressful things in your life:
1._____
2._____
3._____

Education:
Do you have problems reading or writing? Reading/ Writing/ Both
What is you highest level of education? _____
What is/was your field of study?_____
What are the average grades that you received? A / B/ C/ D/ F

Work History:
Are you currently working? No If YES, job title_____
Describe your work?_____
Are you disabled? No If YES, when did you last work? _____

Military History:
Branch, Rank, Discharge Date:_____
Describe your job:_____
Deployments:_____Combat YES / NO
Do you have service connection and for what? _____ %_____

Drug/Alcohol History:
Do you drink alcohol (how often and how much)? _____
Have you ever had a problem with alcohol?_____
Anyone else think you have a problem with alcohol?_____
Do you drink in the morning? _____
Do you use nicotine products? Cigarettes / Chew / Dip / Vape / Patches / Gum
Quit date: _____
Have you ever abused illicit or prescription drugs? _____
Do you use cannabis? Smoke / Vape / Edibles How often?_____
Do you have drug or alcohol cravings?_____
Have you ever been in withdrawal (Tremors, hallucinations, Seizures)?_____
Have you been arrested?_____

Name:_____Date of Birth:_____

Family History:

Have any of the following family members had psychiatric difficulties (including depression, anxiety, bipolar disorder, alcohol or drugs abuse, personality disorders):

Mother-_____

Father-_____

Brothers-_____

Sisters-_____

Aunts-_____

Uncles-_____

Cousins-_____

Maternal Grandmother-_____

Maternal Grandfather-_____

Paternal Grandmother-_____

Paternal Grandfather-_____

Children-_____

Name:_____Date of Birth:_____

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often ...Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever...Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____

4. Did you often feel that ...No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____

5. Did you often feel that ...You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?
Yes No If yes enter 1 _____

7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____

10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score