John Lambert M.D.
1529 Hunt Club Blvd
Gallatin TN, 37066
615-206-8650

Patient Information:

Last Name:_____ First Name:_____ MI:_____

Prefers To Be Called (If Different From Legal Name):_____

Address:_____

City:_____ State:_____ Zip code:_____

Home Phone:_____ Cell Phone:_____

Date Of Birth:__________ Age:_____ Sex: MALE/FEMALE

Social Security # _____

How Were You Referred 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 methods of traditional communication (i.e. telephone, written, 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 as part of the medical record. Therefore, please consider electronic communications may not be confidential and can be included in your medical record. 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:_____

Email Address:_____

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Payment Information:

Payment Information and/or Payment is required in full at the time of service before Dr. Lambert will begin initial consultation. Dr. Lambert accepts cash, check, debit or credit card. Change is not available in the office, but will gladly place credit on your account if you do not have exact amount available.

- For your convenience, we can keep a credit card on file to charge at the time of your appointments

Credit/Debit Card Payments For Appointments:

I/We authorize John Lambert M.D. to bill the below 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/debit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature:_____ Date:_____

Credit/Debit Card Payments For Missed Appointments:

I/We authorize John Lambert M.D. to charge the below credit/debit card when the patient does not give advance notice (at least 24 hour) notice for late cancellation or no-show, as per office policy. Less than 24 hour notice for no-show/late cancellations will be considered on a case by case basis. I understand that if I do not want my credit/debit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature:_____ Date:_____

_____Visa _____Mastercard _____Discover_____American Express (AMEX)

Name On Card:_____ Security Code:_____
Billing Zip Code:_____
Card#_____
Expiration Date:_____

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Insurance Policy:

As an out of network provider, Dr. Lambert is not contracted with any insurance companies and Dr. Lambert does not accept payments from insurance companies. As a courtesy, Dr. Lambert can file insurance for you, however any reimbursement will be paid directly from your insurance company. Please note, Dr. Lambert can't file your insurance until payment is received in full. This policy applies to commercial insurance policies. Dr. Lambert doesn't bill Medicare Advantage plans but can provide a receipt if you wish to file it yourself. Dr. Lambert has opted out of Medicare. Please notify Dr. Lambert if you have Medicare as there is an additional form needed to be signed.

Appointment Charges/Cancellation Policy:

Dr. Lambert does not overbook and appointments made are reserved for the patient. Dr. Lambert requires a 24 hour cancellation notice. Patient will be charged scheduled session rate (I.e. rate charged if patient attended appointment time/length normally) if they fail to keep appointment on the day it is scheduled. Exceptions will be considered on a case-by-case basis (mainly due to medical emergency, or sudden/urgent events requiring patient to not be present at time of appointment). If you need to change your appointment, please call the office in advance so Dr. Lambert can reschedule your appointment.

Office Hours:

Dr. Lambert's office hours are by appointment Monday through Thursday, 8AM - 4PM (with exceptions on Fridays on a case-by-case basis). If you need to contact the office regarding appointments and/or general questions, please call the office during these hours. Dr. Lambert will return calls in the order he has received them as soon as possible (typically within 24 hours, barring emergencies). If you have a psychiatric emergency after hours, please call the office and leave a message and Dr. Lambert will respond (typically within 30 minutes to 1 hour). If Dr Lambert is unable to respond within the above time frame to your psychiatric emergency, please call 911 and/or present to the ER for further care. Psychiatric emergencies are defined as suicidal thoughts or imminent self-harm, sudden/unexpected medication side effects. Medication refill requests are not psychiatric emergencies. Do not email Dr. Lambert regarding possible psychiatric emergencies or issues that need to be address quickly.

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Medication Use/Refill Policy:

Medication refill requests require a 48-hour notice. Please allow 48 hours for medication refill requests if made after hours/over the weekend. If medication refills are required between appointments, please call your pharmacy to send the office a refill request. Refill requests made after office hours or over the weekend may not be completed until the next business day (please allow 24-48 hours to process the refill request). If you leave a refill request, please leave prescription information along with pharmacy location/contact number. Dr. Lambert requires his patients to be seen on a regular basis to ensure medication refills. Dr. Lambert WILL NOT refill medications without regular follow up.

Prescribed medications must be used in a manner recommended by Dr. Lambert at time of appointment. Please discuss any medication adjustments with Dr. Lambert before making them. Regular appointments must be made/kept for all patients prescribed controlled substances including stimulants (including but not limited to: Vyvanse, Concerta, Ritalin, etc) and benzodiazepines (including but not limited to: Alprazolam, Clonazepam, Valium, etc). Controlled substances must be taken in a manner recommended at time of office encounter. This is due to these medications having a high potential for abuse/misuse. If a patient uses controlled substances in a non-recommended manner, it may be grounds for dismissal from the practice.

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Consent To Treatment and Patient Financial Responsibility:

- I have read the policies listed above and I agree to them. I agree to be treated by Dr. John Lambert M.D.

- I authorize John Lambert M.D. to release any information my insurance company requests or requires regarding patient care regarding billing or prescription needs.

I, the undersigned, regardless of insurance coverage, am financially responsible for all charges for services rendered. As stated above, office policy requires payment at the time of service. I understand that unpaid balances of 30 days or later may be subject to late fees. I understand that unpaid balances of 90 days or later may be referred to collections and may be grounds for termination from the practice.

Termination of Treatment:

Patients are not obligated to continue treatment with Dr. Lambert and may request transfer of care at any time.

Patient Signature:_____

Date:_____

Person Responsible For Payment (Complete only if patient NOT paying for bill)

Name of Person Responsible For Bill:_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

Date Of Birth:_____/_____/_____ Social Security #:_____