FLORIDA PSYCHIATRIC SERVICES

Welcome! Your responses to the questions in this packet will help your mental health care provider identify how to best meet your needs, so please complete all of the items as best you can. If you have questions, please speak with a member of our front desk team—they will be happy to help.

CONTACT INFORMATION

_____ _____ ___/___/____
Legal Name **Nickname/Preferred Name** **Date of Birth**

_____
Street Address

_____ _____ _____ _____
City **State** **ZIP Code** **County**

Social Security # _____

_____ **OK to leave message?** **No** **Yes**
Home Phone Number **Special Calling Instructions?** _____

_____ **OK to leave message?** **No** **Yes**
Cell Phone Number **Special Calling Instructions?** _____

Appointment reminder calls are sent to your cell phone number first, and only to your home number in absence of a cell number.

Who Can We Thank for Referring You? _____
(Facebook, TV Commercial, Radio, Friend, Doctor's Office, Hospital)

EMERGENCY CONTACTS

_____ _____
Name of Contact #1 **Relationship to you**

_____ **OK to leave message? No Yes**
Primary Phone Number **Alternate Number** _____

_____ _____
Name of Contact #1 **Relationship to you**

_____ **OK to leave message? No Yes**
Primary Phone Number **Alternate Number** _____

_____ _____ ___/___/___ Date
Patient Name Nickname/Preferred Name

Insurance Information

Primary Insurance (for billing purposes):

_____ _____
Insured's name Relationship to Patient

_____/_____/_____ _____–____-_____ _____
Insured's Birthdate Insured's SS# Phone Number

_____
Street Address

_____ _____
City, State, ZIP Code Country

_____ _____
Employer Employer Phone Number

_____ _____ _____
Employer Address City, State, ZIP Code Country

_____ _____
Insurance Company Name Policy/Group #

Secondary Insurance (complete only if you have a second insurance plan; otherwise, leave blank):

_____ _____
Insured's name Relationship to Patient

_____/_____/_____ _____–____-_____ _____
Insured's Birthdate Insured's SS# Phone Number

_____
Street Address

_____ _____
City, State, ZIP Code Country

_____ _____
Employer Employer Phone Number

_____ _____ _____
Employer Address City, State, ZIP Code Country

_____ _____
Insurance Company Name Policy/Group #

I hereby authorize SCOY to release to my insurance company all medical information necessary to process my medical claims. I request that payment of authorized benefits be made on my behalf and assign the benefits payable for services rendered to me and/or my dependents to Florida Psychiatric Services or authorize such organization to submit a claim on my behalf.

Insured's Signature_____ Date_____/_____/_____

Florida Psychiatric Services
Consent for Treatment

A. During your first session, we will want to know your concerns, the history of these concerns, and how you have been dealing with them so far. We will ask about past events in your/your family's life. Additional information may be gained through more interviewing or testing, which will be discussed with you. After we understand your concerns, we will develop a treatment plan to work with you and schedule appointments accordingly.
B. The content discussed during medication management with a prescriber is confidential; that is, the information you reveal cannot be shared with others unless you sign a release granting your prescriber permission to do so. Nonetheless, there are unusual circumstances in which prescribers are required by law to break confidentiality. These include: situations of potential harm to oneself (suicide) or others (homicide); suspected child or elder abuse or neglect; or if the court issues a subpoena for the release of your records (most commonly contested divorce actions). In addition, depending on licensure requirements, some providers are under the supervision of another mental health care provider; if this is the case for your provider, they will discuss this with you. Finally, in some situations, the release of confidential materials is, or may be, required by your prescriber. You or your prescriber may request that some information be discussed with another person by signing a release form.
C. As a patient of Florida Psychiatric Services (FPS), I have the right to make informed decisions regarding my care. My rights include being informed of my health status, being involved in care planning and treatment, and being able to request or refuse treatment. FPS healthcare professionals will discuss with me the nature of my symptom(s) and condition(s), the proposed treatment(s), medications, the benefits and risks associated with treatment and/or medications, the probability of successful outcomes, and alternatives to the proposed treatment(s) and/or medications, if any or as applicable. I acknowledge and understand that I may revoke consent to further care at any time by informing my FPS healthcare professional of my desire to do so.
D. By accepting screening, evaluation, and treatment from any FPS healthcare professional, I authorize providers using the IcaNotes platform to perform all clinical and professional treatment and services deemed necessary in their determination in order to ensure program outcomes/appropriateness, and acknowledge that I have been informed of the benefits and risks of such treatment and services by the FPS healthcare professional(s) providing my care.
E. I understand that any outside testing or laboratory work that is ordered by FPS' healthcare professionals will be billed to my insurance company by the laboratory/facility conducting the testing and any balance will be my responsibility.
F. I agree to submit urine and/or take alcohol and other drug and toxicology testing, if requested by my FPS provider. I understand that failure to do so could result in discharge from care. Urine/alcohol results may be utilized as treatment interventions or may be completed as determined by external requirements. I understand that if it is determined my urine needs sent for outside testing, my insurance will be billed by that outside laboratory, and I am responsible for any balance that may be incurred.
G. I agree to submit to therapy/counseling, if it is deemed clinically necessary to do so by my FPS Prescriber or by company policy. I understand that failure to do so could result in discharge from care.

I understand and agree to the following:

1. I will be actively involved in the medication management process, including the development of treatment plans, and I will practice at home what is discussed in sessions.
2. I understand that if I have insurance, my insurance company will be billed and that I am responsible for any co-pays my insurance company requires me to pay. I also understand it is my responsibility to make sure that my insurance benefits cover the services rendered by Florida Psychiatric Services and that if my insurance company denies coverage of any of these services, it is my responsibility to pay those charges.
3. I will pay for appointments that I do not cancel within 24-hours, as per the 24-hour cancellation policy notice. (Insurance companies are not responsible for this charge). This applies to all

situations unless a documented emergency occurs. If I have a concern about this, I will discuss it further with my prescriber.

4. If more than ninety (90) days lapse without payment to Florida Psychiatric Services, then Florida Psychiatric Services reserves the right to turn my account over to a collection agency and/or credit reporting service.
5. If I am unsatisfied with the services provided, or I have any complaints, I will then be encouraged to discuss this with my provider. If my concern is not addressed to my satisfaction, then I may contact the Chief Operating Officer:

   Wendy Metheny, Chief Operating Officer
   1 SE Ocean Blvd., Stuart, FL 34994
   Phone*: 772-400-2875*
6. If I have any questions about the nature of my counseling (i.e. goals, procedures, etc.), fees, or any other issue, I need to ask. I am encouraged to bring up such matters for discussion as they are an important part of my treatment.
7. According to Florida Statutes Title XXIX, Chapter 381, Section 026, I have the right to refuse treatment or withdraw from any or all of the specific modalities of treatment provided.

Billing Authorization

Florida Psychiatric Services benefit verification staff makes every effort to obtain accurate information about my insurance benefits and the extent of my mental health / behavioral health coverage. While they attempt to follow my carrier's guidelines in obtaining my information, they cannot guarantee the accuracy of the coverage as stated to them by my insurance carrier. It is ultimately my responsibility to check on my benefits and to determine the extent of my coverage.

_____
Print Name

_____ _____
Client's Signature **Date**

_____ _____
Parent or Guardian Signature **Date**

Florida Psychiatric Services
Telepsychiatry Informed Consent

Introduction

Telepsychiatry is the form of telemedicine that allows patients to access psychiatric care using interactive video and audio communications (including, but not limited, to video, phone, and email. Telepsychiatry includes the practice of psychiatric health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. Florida Psychiatric Services utilizes secure, encrypted, and HIPAA compliant audio/video transmission software to deliver telepsychiatry.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- By signing this form, I understand the following:
- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of telepsychiatry which identifies me will be disclosed to researchers or other entities without my consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I have the right to inspect all information obtained in the course of a telepsychiatry interaction and may receive copies of this information for a reasonable fee.
- I understand that a variety of alternative methods of psychiatric care may be available to me, and that I may choose one or more of these at any time.
- I understand that it is my duty to inform my psychiatrist of any other healthcare providers involved in my medical/psychiatric care.
- I understand that I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.
- There is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
- In the event audio/video services are unavailable or interrupted for any reason, the session can occur over the telephone. If I, as the client, would prefer not to utilize telephone for the session, I can communicate this to my psychiatrist and have that appointment rescheduled.
- I understand that telephone may not be an encrypted form of electronic communication, and by agreeing/requesting to utilize it for service delivery, I am responsible for confidentiality in my own environment.
- The laws, ethics and professional standards that apply to in-person psychiatric services also apply to services delivered by electronic means. This document does not replace other agreements, contracts, or documentation of informed consent covering other issues. If you want licensing information on your prescriber, you can find it at Florida's licensing board website at https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders. Psychiatric statutes, rules and other helpful information may be found on the Florida State Medical Board's website at www.flboardofmedicine.gov.

Payment for Telepsychiatry Services

Florida Psychiatric Services will bill insurance for telepsychiatry services when these services have been determined to be covered by an individual's insurance plan. Copays will be the individual's responsibility. In the event that insurance does not cover telepsychiatry, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, a prompt pay discount is available. We will provide you with a statement of service to submit to your insurance company if you wish. Prompt pay service can be discussed with our billing department at 772-400-2875.

Patient Consent To The Use of Telepsychiatry

By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.

If a crisis arises during a telepsychiatry session, my medical provider may be required to alert local authorities for intervention. These details will also be verbally reviewed by my medical provider at the start of telepsychiatry services.

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my medical provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care.

I hereby authorize the prescribers of Florida Psychiatric Services to use telepsychiatry in the course of my diagnosis and treatment.

_____

Print Name

_____ _____

Client's Signature **Date**

_____ _____

Parent or Guardian Signature **Date**

Florida Psychiatric Services'
Failed Appointment/Attendance Policy

**** PLEASE BE SURE TO READ THIS DOCUMENT IN ITS ENTIRETY ****

In the event you fail to show up for your scheduled appointment and/or do not call within 24 hours in advance of your scheduled appointment, you will be charged a *$25.00* failed appointment fee.

Florida Psychiatric Services' clinical staff needs to have sufficient time to fill your canceled appointment slot with another patient. If you do not give sufficient time for our clinical staff and fail to cancel within the allotted 24 hours, you are responsible for the above payment. These rates are subject to change.

The only given EXCEPTION is if an illness or injury occurs which prevents you from attending your scheduled appointment. A medical excuse may be requested.

Florida Psychiatric Services is sincere and serious about providing quality treatment. We realize that consistent attendance is key to your progress. We expect patients who are serious about their care to recognize and understand the importance of consistent attendance at all scheduled appointments as well.

ATTENDANCE POLICY

If you miss three (3) appointments that occur within a 60-day period (either not showing for the appointment or canceling without giving a 24-hour notice), you will be excused/discharged from our practice's services. Referrals to other providers will be offered. You will have the opportunity to return to Florida Psychiatric Services after 30 days from your initial discharge; however, if you again miss or 'late cancel' 3 more appointments within a 60-day period, you will once again be discharged and will not be able to return for services for a period of 60 days. After 60 days you may then return for one last chance at treatment with Florida Psychiatric Services; however, if past attendance behaviors are again repeated by missing 3 appointments within a 60-day period (either not showing for the appointment or canceling without giving a 24-hour notice), you will be permanently discharged from the practice's services and will no longer be eligible to return.

Please sign. By signing, you are agreeing to the FAILED APPOINTMENT/ATTENDANCE POLICY.

_____ _____

Client or Parent/Guardian's Signature **Date**

FLORIDA PSYCHIATRIC SERVICES
Notice of Privacy Practices

I, _____, the undersigned client (or parent/guardian of minor client, do hereby attest that FLORIDA PSYCHIATRIC SERVICES, Inc. provided me with a copy of its HIPAA NOTICE TO PRIVACY PRACTICES.

HIPAA (the Health Insurance Portability and Accountability Act of 1996), requires that effective April 14, 2003, all healthcare providers present their patients with a copy of the health provider's Privacy Practices.

By signing below, I attest only that I was indeed provided with a copy of the Privacy Practices. The HIPAA Notice of Privacy Practices handout is mine to review and keep for my own records. This form will be kept as a permanent part of my medical record at FLORIDA PSYCHIATRIC SERVICES.

_____ _____

Client or Parent/Guardian's Signature **Date**

Notice of Patient Rights

I, the undersigned patient (parent/guardian of minor patient) do hereby attest that FLORIDA PSYCHIATRIC SERVICES provided me with a copy of its Patient Rights Policy. By signing below, I attest that I was indeed provided with a copy of the Patient Rights Policy. I understand that it is mine to review and keep for my own records. This form will be kept as a permanent part of me medical record at FLORIDA PSYCHIATRIC SERVICES.

Please direct any further questions to:

Wendy Metheny, Chief Operating Officer
Florida Psychiatric Services
1 SE Ocean Blvd., Stuart, FL 34994
Phone*: 772-400-2875*

_____ _____

Client or Parent/Guardian's Signature **Date**

FLORIDA PSYCHIATRIC SERVICES

FEE SCHEDULE

SERVICES	FEE FOR SERVICES
PSYCHIATRIC EVALUATION	$225
MEDICAL OFFICE VISIT (DEPENDING ON COMPLEXITY OF VISIT)	$80-$150
URINE DRUG SCREEN	$15
MISSED APPOINTMENT FEE- NO-SHOW/CANCEL< 24 HR (NON-MEDICAID)	$25

SLIDING-SCALE AMOUNTS AVAILABLE UPON REQUEST FOR FINANCIAL HARDSHIP, SELF-PAY SITUATIONS

_____ _____

Client or Parent/Guardian's Signature **Date**

Medical History & Physical Health Screening

_____ ___/___/_____ __/___/____
Your Name Date of Birth Today's Date

Height: _____ Weight: _____ Sex: ☐ Male ☐Female

Do you have a primary care physician? ☐ No ☐Yes Date of last physical? ___/___/_____

If yes, what is his/her name: _____ office number: _____-_____-_____

Allergies: Have you ever had an **allergic reaction**? ☐ No ☐Yes *(please describe below)*

_____

_____

Have you ever had other **aversive reactions** to a medication? ☐ No ☐Yes *(please describe):*

_____

_____

Known Vaccinations: check all that apply: ☐ Smallpox ☐DPT ☐ MMR ☐MMR Booster

☐Hepatitis B ☐ Tetanus (Date): _____ ☐Other vaccines: _____

Nutrition:

Meal Consumption:

Breakfast: ☐ Good ☐Fair ☐ Poor ☐ Skip
Lunch: ☐ Good ☐Fair ☐ Poor ☐ Skip
Dinner: ☐ Good ☐Fair ☐ Poor ☐ Skip

Snacks: what do you eat, and when:

_____
_____
_____
_____
_____

Are you currently on a special diet? ☐ No ☐Low Salt ☐ Diabetic ☐ Other: _____
Have you experienced any recent weight changes within the last *three (3) months*?
☐ No ☐Loss of ____ lbs ☐ Gain of ____ lbs
How is your appetite? ☐ Always hungry ☐ Good ☐Fair ☐ Poor ☐ Varies more than it should.
Is this different from usual? ☐ No ☐Yes, decreased ☐Yes, increased

Were you ever diagnosed with growth problems? □ No □Yes
Were you ever diagnosed with an eating disorder? □ No □Yes
Do you have any current dental problems? □ No □Yes
If so, what: _____
Are they being treated? □ No □Yes
Do you have any food allergies? □ No □Yes
If yes, which: _____

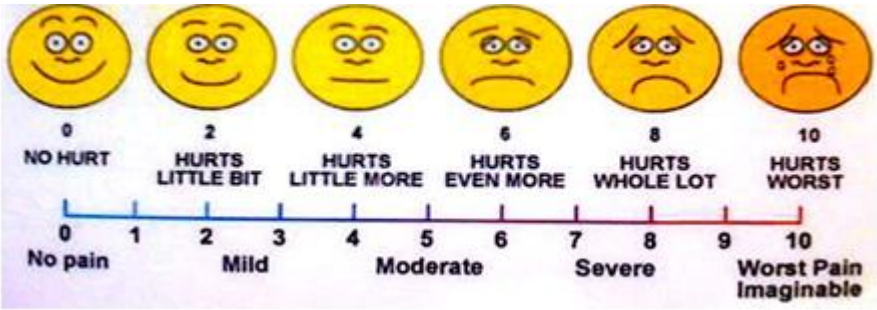
Surgical Procedures:

Reason for Surgery	Year/Age	Where Preformed

Pain: Are you currently experiencing any ***physical*** pain? ☐ No ☐ yes *(please explain):*

_____
_____

If yes, place an "X" where your level of pain would fall on the following scale:



Do you go to a pain clinic? ☐ no ☐ yes, please specify: _____

Have you experienced physical pain in the recent past? ☐ no ☐ yes *(please explain):*

_____
_____
_____

Family Medical History:

Problem	Y	N	Whom?	Problem	Y	N	Whom?
Alcohol/Drugs				Seizures			
Cancer				Hypertension			
Diabetes				Heart Problems			
Depression				Stroke			
Suicide				Thyroid Problems			
Anxiety				Obesity			
Psychiatric Hospitalization				Arthritis			
Allergies				Other:			

Personal History:

For each of the following, indicate if this area is a concern for you now, in the past, or both:

Problem/Difficulty	NOW	PAST	Problem/Difficulty	NOW	PAST	Problem/Difficulty	NOW	PAST
Food craving			Heart attack			Itching/Rash		
Sleep difficulty			Chest pain			Jaundice		
Headaches			Stroke			Excessive sweating		
Migraine/Tension Headaches			Nausea/Vomiting			Hair pulling/twisting		
Seizures			Abdominal pain			Diabetes/Insulin		
Dizziness			Heartburn			Asthma		
Blackouts			Diarrhea			Alcoholism		
Anxiety			Constipation			Drug Abuse/Addiction		
Depression			Irregular bleeding			Neurological Disease		

Eye problems			Painful menstruation			Irritable bowel/Colitis		
Hearing problems			Vaginal discharge			Fatigue/Exhaustion		
Ear infections			Breast lumps			Grinding teeth		
Sinus infections			Burning urination			Stiff/painful neck		
Frequent nose bleeds			Bladder infections			Thyroid problems		
Speech difficulties			Arthritis			Kidney disease		
Short of breath			Joint pain/Swelling			Cancer		
Persistent cough			Tumors			Bed-wetting		
Smoker (# packs/day: ___)			Paralysis			Soiling		
High blood pressure			Loss of Sensation			Ticks/twitches		
Chronic pain								

Other Information: Is there anything that was not covered above that you feel would be helpful for your /nurse/psychiatrist to know about your physical health or medical history? If so, please add it below. **Be sure to include past medical diagnoses and treatment:**

_____

_____

_____

Please list **all** CURRENT prescription medication

Name	Dosage	Reason Prescribed	Response	Prescriber	Start Date	Complaints

Please list **all** CURRENT over-the-counter medication, vitamins, supplements, nutraceuticals, herbals, etc.

Name	Dosage	Reason Prescribed	Response	Prescriber	Start Date	Complaints

Please list **any** PAST **psychiatric** medications (prescriptions you took to treat a **mental health** condition)

Name	Dosage	Reason Prescribed	Response	Prescriber	Start Date	Complaints