Psychiatric Consultants of Central Florida LLC.

3391 W. Vine St. Suite 303 Kissimmee, FL 34741

PATIENT INFORMATION

Email:_____ **Today's Date:**_____

Patient Name: _____

Date of Birth:_____ **Age:**_____ **Sex:** __ **M** __ **F** **S.S. #** _____

Address: _____ **City:**_____ **Zip:**_____

Telephone (H)_____ **(Cell)**_____ **(W)**_____

What is the best way to contact you? ☐ **Phone Call** ☐ **E-mail** ☐ **Text Message (to Cell)**

Emergency Contact Name:_____

Relationship to Patient:_____ **Phone:**_____

Referred By: _____

PARENT/GUARDIAN INFORMATION:

Parent (Guardian) Name: _____

D.O.B.: _____ **S.S.#** _____

Does the minor reside in the physical address stated above? ____ Yes ____ No

If you answered "no" to the above question, what is the minor's physical address of residence?

Address:_____ **City:**_____ **Zip:** _____

Name of the parent/guardian who the minor resides with_____

PARENT/GUARDIAN RESPONSIBILITY

I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY SERVICES RENDERED BY PSYCHIATRIC CONSULTANTS OF CENTRAL FLORIDA LLC IF INSURANCE IS TO BE FILED; I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR SERVICES PROVIDED. I FURTHER AUTHORIZE THE RELEASE OF MEDICAL BENEFITS TO PSYCHIATRIC CONSULTANTS OF CENTRAL FLORIDA LLC A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

Parent Signature:_____ Date:_____

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CHILD HISTORY

Pregnancy Term: ☐ Full-term ☐ Pre-term ☐ Induced

Delivery Type: ☐ Vaginal Birth ☐ C-Section ☐ Vaginal after C-Section
☐ Vacuum Extraction ☐ Forceps Delivery

Delivery Location: ☐ Hospital birth ☐ Home birth

Were there any complications during the pregnancy? _____

_____

Were there any complications after the pregnancy? _____

_____

BIRTH:

At the time of birth: ☐ **Was there delay in Crying?** ___Yes ___No ☐ **Breathing Problems** ___Yes ___No
☐ **Jaundice** ___Yes ___No
☐ **Birth Weight** _____ ☐ **Birth Length** _____

MILESTONES:

Did the child reach all developmental milestones within the normal age range? ___ Yes ___ No

If you answered "No" to the previous question, **check off** which developmental milestones were **NOT** met within the adequate age range and **provide the age** in which it was met.

- ☐ Rolling Over _____
- ☐ Crawling _____
- ☐ Sitting _____
- ☐ Walking _____
- ☐ Talking _____

Parent Signature: _____ Date: _____

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PATIENT MEDICAL HISTORY

Primary Care Physician:_____ **Phone:**_____

What is the main reason for today's visit? (*include symptoms*) _____

_____

_____

CURRENT **or** PAST MEDICAL CONDITION (*Please check all that apply*)

( ) Asthma	( ) Cardiovascular (Heart Attack, Angina)	( ) High Cholesterol
( ) Hypertension	( ) Epilepsy/Seizure Disorder	( ) Diabetes
( ) Head Trauma	( ) HIV/AIDS	( ) Thyroid Disease
( ) Liver Problems	( ) Pancreatic Problems	( ) STDs
( ) Abnormal Papsmear		

CURRENT PRESCRIPTION MEDICATIONS: (*Including psychotropic medications*)

_____

_____

_____

PAST PSYCHIATRIC HISTORY

Have you ever been in an **INPATIENT** psychiatric hospital/facility? ____Yes ____No

If so, please fill in:

Hospital/Facility	Reason	How many times?

Have you ever been in psychiatric **OUTPATIENT** treatment? ____Yes ____No

If so, please fill in:

Hospital/Facility	Reason	How many times?

Parent Signature: _____ Date: _____

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ALLERGIES TO MEDICATIONS *(Please list **ALL** allergies to medications)*

Medication	Allergic Reaction
1.	
2.	
3.	
4.	

PAST PSYCHIATRIC MEDICATIONS *(Please list **ALL** previous psychiatric medications that you have taken)*

Medication	Medication
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

CURRENT MEDICATIONS *(Please list **ALL** medications you are currently taking from any of your doctors)*

Medication	Medication
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Signature: _____ Date:_____

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CONSENT FOR BEHAVIORAL HEALTH TREATMENT

Psychiatric Consultants of Central Florida, LLC. provides psychiatric services designed to alleviate emotional and behavioral symptoms which are interfering with your life. We provide general psychiatric evaluations for children ages 10 and up. We provide medications management services and follow-up care. As well as brief counseling services regarding medication risks, benefits, side effects, and long-term effects of psychiatric medications. We also provide written instructions and literature as and when necessary. We also provide referrals as and when needed to see psychologist/behavior health counselors outside our facility for more in-depth therapy and counseling services.

Behavior Health is a cooperative relationship between you and your provider, and that cooperative effort is needed to resolve difficulties, including working on the mutually agreed upon treatment plan and keeping your appointments. We also try to coordinate care with your primary care physician/family doctor and obtain records to provide continuity of care and to reconcile medications you are taking from your family doctor. We request you to provide consent for obtaining records from your family physician's office. Your behavioral health information is kept confidential and will not be disclosed to third parties without your consent. We also obtain records/admissions records from your previous behavioral health outpatient and inpatient providers as and when needed.

Are you the legal guardian/custodian of the minor? **YES / NO**

Can we mail correspondence to you at your home regarding your behavior health care? **YES / NO**

Can we leave phone messages at your contact number regarding your behavior health care? **YES / NO**

Consent: I have read, understood, and agreed to the information above and consent to the treatment at Psychiatric Consultants of Central Florida, LLC.

Parent Signature: _____ Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). By law I am required to ensure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

II. HOW I WILL USE AND DISCLOSE YOUR PHI. I will use and disclose your PHI for many several reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the distinct categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. Nevertheless, I will provide you with it in specific instances, as described below: 1. For treatment. I may disclose your PHI to psychiatrists, psychologists. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him to coordinate your care. I will inform you of such disclosures and obtain your written consent. 2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Example: My secretarial staff preparing client charts. No written consent is necessary. 3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as my secretarial staff, which process health care claims for my office. No written consent is necessary. 4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment if I attempt to get your consent after treatment is rendered. In the event that I try to get your consent, but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons: 1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding. 2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority. 3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency. 4. If disclosure is compelled by the patient or the patient's representative pursuant to Florida Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice. 5. To avoid harm. I may provide PHI to law enforcement personnel

or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public. 6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger. 7. If disclosure is mandated by the Florida Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect. 8. If disclosure is mandated by the Florida Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse. 9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims. 10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI These are your rights with respect to your PHI: A. The Right to See and review. I will also explain your right to have my denial reviewed. A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

IV. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

3391 W Vine St Suite 303, Kissimmee, FL 34741

407-962-7449/ 407-483-6516

VII. EFFECTIVE DATE OF THIS NOIICE This notice went into effect on April 14, 2003.

*I have read the **HIPPA NOTICE OF PRIVACY PRACTICES** carefully; I understand them and agree to comply with them.*

_____

(Print Name)

_____ _____

(Signature Name) *Date*

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OFFICE POLICIES

FEE FOR SERVICE:
Our policy requires the payment of your deductible and/or co-insurance at the time of service. You are responsible to see that we have a current referral on file. If we do not have this referral at the time of your visit, your insurance company may hold you responsible for all charges. If you are not sure if our caregivers are providers for your insurance plan, please look in your insurance directory or call your insurance carrier.

NO SHOW/ LATE CANCEL FEE (COMMERCIAL INSURANCE ONLY):
You are responsible for a payment of **$25.00** for all broken appointments **(No Show)** and cancellations made in less than 24 hours prior to the scheduled appointment. Refills will **NOT** be granted to all broken appointments until day of follow up visit with physician. **NO EXCEPTIONS.** _____ **INITIAL**

NO SHOW/ LATE CANCEL FEE (MEDICAID ONLY):
If you have accrued 2 consecutive unexcused/unjustified missed appointments or cancellations made less than 24hrs, it will result in an AUTOMATIC TERMINATION OF TREATMENT. **NO EXCEPTIONS.**
(By initialing I understand and agree to abide by the office policy and the termination of my treatment and will be responsible to seek for a new provider to continue my treatment.) _____ **INITIAL**

PRESCRIPTIONS – misplaced, lost or stolen prescription may be replaced on Dr. Approval **ONLY**, **EXCEPT** all controlled substances prescriptions. **NO EXCEPTIONS.** _____ **INITIAL**

ACCOMMODATIONS FEES:
- **SPECIAL ACCOMMODIATIONS LETTERS** will **ONLY** be granted base on compliance of treatment and a **$20.00** fee will be applied to all forms**.** _____ **INITIAL**
- **IMMIGRATION FORMS $150.00** fee will be applied to all forms. _____ **INITIAL**
- **STD or DISABILITY QUESTIONAIRE FORMS $40.00 - $75.00** fee will be applied to all received forms. Please be advised that Leave of Absence will be granted per Dr. Approval only up to 2 months with all kept appointments unless advised otherwise by Physician. _____ **INITIAL**
- **FMLA FORMS** a fee of **$25.00** will be applied to all received forms. _____ **INITIAL**

TERMINATION OF TREATENT
- **Treatment Non-Compliance**- **The patient does not or will not follow treatment plan, and has misused or abused medications**. **NOSHOWFEE/LATECANCELLATIONFEE-**The patient has 3 or more NSF/LCF visits with outstanding balances **NO EXCEPTIONS. ALL CONTROLLED SUBSTANCE MEDICATIONS** are **CLOSELY MONITORED.** _____ **INITIAL**
- **Verbal Abuse**- Patient or Family member is rude, uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm and uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions. _____ **INITIAL**
- **Non- Payment-** The patient has an outstanding balance and no effort has been made to arrange a payment plan. If services and treatment were terminated due to any **NSF/LCF** outstanding balances your account must become current to reinstate services/ treatment and a penalty fee of **$100** will be applied and collected in full. **NO EXCEPTIONS**. _____ **INITIAL**

I have read and understood the financial responsibility and office policies. Should my account become delinquent and be referred to any third party for collection efforts, I agree to pay all reasonable attorneys' fees and a collection expense.

_____ _____
Patient Signature (Responsible Party) Date

_____
Print Name

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AUTHORIZATION FOR RELEASE OF INFORMATION

I_____ DOB:_____

Authorize Psychiatric Consultants of Central Florida, LLC. To obtain the following confidential information:

- ☐ Comprehensive Psychosocial Assessment
- ☐ Counseling/Psychotherapy Progress Note
- ☐ Psychological Testing
- ☐ Psychiatric Evaluation
- ☐ Psychiatric Progress Summary
- ☐ Treatment Plan an Updates
- ☐ Other: _____

  _____

From previous or current treating physician or agency: _____

_____

Physician or agency phone number: _____

For the purpose of assisting my diagnosis, treatment or rehabilitation, I understand that only the above specified information can be disclosed. This release is protected under the State and Federal Confidentiality Regulations (42 CFR part 20 and shall be in compliance with section 33 of Public Law 91-515 as amended by Public Law 93-282). A general authorization for release of information of medical or other information is not sufficient. This release of information shall become void one year from the date of signature or shall expire upon completion of treatment. I also understand that I may revoke this release of information at any time, providing that I notify in writing to this effect, but that revocation has no effect on action previously taken.

Signature: _____ Date: _____