FLORIDA Behavioral Medicine

Child, Adolescent, Adult and Geriatric Psychiatry

# CHILD/ADOLESCENT NEW PATIENT FORM

**Child Name** *

Title | First Name | Middle Name | Last Name

**Adopted?** *

**Age**

**Education**

**Age** *

**Father's Name** *

Title | First Name | Middle Name | Last Name

**Employer**

**Work Phone**

Area Code | Phone Number

**Age** *

**Mother's Name** *

Title | First Name | Middle Name | Last Name

**Education**

**Cell**

Area Code | Phone Number

**Name & Age**

**Name & Age**

**Other relatives or persons living in Home**

**Employer**

**Work Phone**

Area Code | Phone Number

**Cell**

Area Code | Phone Number

## FAMILY

Other Children Living in Home

**Name and Age**

**Other Illness : Yes? No? If Yes, When Describe** *

**Vomiting : Yes? No? If Yes, When Describe** *

**Injury : Yes? No? If Yes, When Describe** *

**Medication During Pregnancy : Yes? No? If Yes, When Describe** *

**Emotional Problems : Yes? No? If Yes, When Describe** *

**Threatened Miscarriage or Early Contractions : Yes? No? If Yes, When Describe** *

**Peri-natal History: (Any other comments about Pregnancy/Labour/Delivery)**

## DEVELOPMENT HISTORY

(As best you remember)

**Peri-natal History: (Any other comments about problems during Pregnancy, Mother's use of Medications)**

## MEDICAL HISTORY OF CHILD

**Measles : Yes? No? If Yes, Age and Describe** *

German Measles : Yes? No? If Yes, Age and Describe *

Mumps : Yes? No? If Yes, Age and Describe *

Chicken Pox : Yes? No? If Yes, Age and Describe *

Whooping Cough : Yes? No? If Yes, Age and Describe *

Toxemia : Yes? No? If Yes, When Describe *

**Anemia : Yes? No? If Yes, When Describe** *

**Diphtheria : Yes? No? If Yes, Age and Describe** *

**Kidney Disease : Yes? No? If Yes, When Describe** *

**Flu : Yes? No? If Yes, Age and Describe** *

**German Measles : Yes? No? If Yes, When Describe** *

**Bleeding : Yes? No? If Yes, When Describe** *

## PREGNANCY HISTORY

(Mother to fill out this section)

**Meningitis : Yes? No? If Yes, Age and Describe** *

**Other Virus : Yes? No? If Yes, When Describe** *

**Encephalitis : Yes? No? If Yes, Age and Describe** *

**High Fever : Yes? No? If Yes, Age and Describe** *

**Elevated Blood Pressure : Yes? No? If Yes, When Describe** *

**Abscessed Ears : Yes? No? If Yes, Age and Describe** *

**Swollen Ankles : Yes? No? If Yes, When Describe** *

**Convulsions : Yes? No? If Yes, Age and Describe** *

**Injuries to head : Yes? No? If Yes, Age and Describe** *

**Other Injuries or Illnesses : Yes? No? If Yes, Age and Describe** *

**Hospitalizations or Surgeries : Yes? No? If Yes, Age and Describe** *

**Flu : Yes? No? If Yes, When Describe** *

**Developmental History: (Any other comments about milestones met early, late, normal)**

**MEDICATION ALLERGIES:** *

**Name** *

First Name Last Name

**Address**

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code Country

## Your Medication History

**Anti-Depressants:** *

- ☐ Celexa
- ☐ Cymbalta
- ☐ Effexor_XR
- ☐ Lexapro
- ☐ Luvox
- ☐ Paxil CR
- ☐ Prozac
- ☐ Remeron
- ☐ WellIbutrln_XL
- ☐ Zoloft
- ☐ None

**ADHD Medications:** *

- ☐ Adderall
- ☐ Adderall XR
- ☐ Concerta
- ☐ Dexedrine
- ☐ Focalin
- ☐ Focalin XR
- ☐ Metadate
- ☐ Ritalin
- ☐ Ritalin LA
- ☐ Strattera
- ☐ None

**Mood Stabilizers:** *

- ☐
- ☐
- ☐

Depakote | Lithium | Neurontin

☐ ☐ ☐
☐

**Anti-Psychotics:** *

☐ Abilify ☐ Geodon ☐ Risperdal
☐ Seroquel ☐ Zyprexa ☐ None

**Other Medical History**

**Write all Medications & Prescriber**

*

☐ I have listed ALL medications currently prescribed by ALL Doctors

**Allergies** *

## PAST SURGICAL HISTORY

**Tick boxes if you have had any of the following Surgery** *

☐ None ☐ Depression ☐ Anxiety
☐ Mania ☐ Psychosis ☐ Schizophrenia
☐ Schizo-affective ☐ Disorder ☐ ADHD
☐ Dementia ☐ MR/DD ☐ Organic Brain Disorder
☐ Psycho Educational Testing

**Previous Doctors** *

**If yes, Name Of the Doctor**

**Prior Psych. Hospitalization** *

- [ ] N/A
- [ ] Yes

**Total Days**

**Last Hospitalization**

**History of ECT** *

- [ ] N/A
- [ ] Yes

**Last Treatment**

**Number of Treatments**

**History of Suicide Attempt** *

- [ ] N/A
- [ ] Yes

**History of Self-injurious Behavior** *

- [ ] None
- [ ] Head-banging
- [ ] Overdose
- [ ] Cutting
- [ ]

**History of Suicidal Gesture** *

- ☐ N/A
- ☐ Yes

**Other comments**

## Consent & Signature

**I HEREBY AUTHORIZE COMMUNICATION WITH MY PRIMARY CARE PHYSICIAN:** *

- ☐ YES
- ☐ NO

**Name & Address of Your Primary Care Physician** *

**Phone Number of Primary Care Physician**

Area Code Phone Number

**Informed consent for treatment**

I hereby give consent to the staff of FLORIDA BEHAVIORAL MEDICINE for my evaluation and treatment. My choice has been voluntary and I understand that I may terminate treatment at anytime. I further understand that psychiatric treatment is a cooperative effort between myself and the doctor. I will work with the doctor in a cooperative manner to resolve any difficulties.

I understand that psychiatric records are confidential, unless the client expresses harm to self and/or others or in case of court order.

I have read and understood the above.

**Patient Financial Obligation Agreement**

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Florida Behavioral Medicine for services rendered. I authorize representatives of Florida Behavioral Medicine to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

**Mice of Privacy Practices: Acknowledgement of Receipt**

I acknowledge that I was provided with a copy of the Florida Behavioral Medicine Notice of Privacy Practices (NOPP).

**Information Disclosure and Consent**

Florida Behavioral Medicine will provide you with the health insurance that your provider(s) accepts*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

***I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).***

**Patient or Legal Guardian Full Name** *

First Name Last Name

**Date** *

Month Day Year

# General Information

- Patients under the age of 18 must be accompanied by parent or guardian on the first visit.
- Office hours are (Monday to Thursday: 9am to 5pm / Friday: 9am to 4pm / Saturday & Sunday CLOSED)
- Patients are seen by appointment only.

- If the new patient form has been completed and returned to our office at least 24 hours in advance, new patients must arrive NO LATER THAN their appointment time. If the form is NOT completed and returned to our office at least 24 hours in advance, the patient must arrive one hour early. Otherwise, we will reschedule the appointment.
- Established patients arriving ten or more minutes late will be rescheduled.
- Our main line, (Largo Clinic: 727 518 6444 / St. Petersburg Clinic: 727 518 6444 / Tampa clinic: 813 358 5644)

MEDICATIONS

- Patients are asked to bring their current medications or a list thereof to each visit.
- Medication refills are not given to patients who do not keep their follow-up appointments.
- Medications will not be prescribed for illness unless the patient sees the physician first.
- Patients must allow no less than 48 hours for prescription refills.
- The physician "on-call" does not prescribe or refill medications.

FEES

- Patients are assessed a $20 fee for appointments not canceled at least 24 hours in advance.
- We charge a $20 for preparation of forms for FMLA, disability, etc. The fee is payable in advance. We require no less than 10 days for preparation of forms for FMLA, disability, etc.
- Payment is required at the time of service. This includes co-pays, deductibles, and previous balances.
- Payment for services is the responsibility of the patient.
- We will not re-file claims if the patient has not updated their information.

## General Consent for Care & Treatment Consent

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and other health care providers or the designees as deemed necessary to

perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and Cully understand the above statements and consent fully and voluntarily to its contents.

**If Representative signing, please sate your relation to Patient**

**Full Name of Patient or Personal Representative** *

First Name Last Name

**Date** *

Day Month Year

**Full Name of Witness**

First Name Last Name

**Date**

Day Month Year

## Notice of Privacy Practices

If you require authorization from your insurance and you obtained this authorization, please give:

**AGREEMENT FOR SERVICES**

1. I understand that I am responsible for payment of co-pays, co-insurance and/or deductibles and that payment is due when services are rendered.

2. I understand that I am responsible for charges not covered by my insurance or if payment has not been received from my insurance company within 60 days from the date of service.

3. I understand that I will be charged a minimum of $20 for completion of any forms I request, and this charge must be pre-paid.

4. I understand that if I fail to give Florida Behavioral Medicine twenty-four (24) hours notice of cancellation of my appointment, I will be charged the full rate of my appointment.

**Date** *

Day Month Year

**Assigment of Benefits**

I hereby assign to Florida Behavioral Medicine any insurance or other third-party benefits available for health care services provided. I understand that Florida Behavioral Medicine has the right to refuse or accept assignment of such benefits. If the benefits are not assigned to Florida Behavioral Medicine by ie insurance company, I agree to forward to Florida Behavioral Medicine immediately upon receipt all benefits paid that I receive for services rendered.

**Release of Information**

I authorize Florida Behavioral Medicine to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Florida Behavioral Medicine. I agree that these provisions will remain in effect until I provide written revocation to Florida Behavioral Medicine.

**Privacy Act Statement**

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 41 l.24(a) and 424.S(a)(6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. If you have any questions about this Notice please contact our Office Manager at the office location or our Privacy Officer at: 1100 Clearwater-Largo Road, Largo, FL 33770.

1) Uses and Disclosures of Protected Health information based Upon Your Written Consent Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. Payment: Your PHI will be used, as needed, to obtain payment for your health care services. Office Support Activities: We may use or disclose, as-needed, your PHI in order to support the business activities of our practice.

2) Uses and Disclosures of Protected Health Information Based upon Your Written Authorization Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below.

3) Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. In Emergencies we may use or disclose your PHI for emergency treatment. If a Communication Barrier exists if, using professional judgment, the provider determines your intent use or disclosure under the circumstances.

4) Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object As Required By Law. To a public health authority that is permitted by law to collect or receive the
information. If authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition. To a health oversight agency for activities authorized by law. To a public health authority that is authorized by law to receive reports of child abuse or neglect. To the Food and Drug Administration to report adverse events, product defects or problems. In Legal Proceedings in response to an order of a court. For law enforcement purposes as long applicable legal requirements are met. To Coroners, Funeral Directors, and Organ Donation Organizations. For Research when research has been approved by an institutional review board. In the case of Criminal Activity only when consistent with applicable federal and state laws. For Military Activity and National Security when the appropriate conditions apply. To comply with workers' compensation laws. If an inmate, to a correctional facility. When required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

5. Your Rights
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes.
You have the right to request a restriction of your protected health information.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location
You may have the right to have your physician amend your protected health information.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information
You have the right to obtain a paper copy of this notice from us,

6. Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

7. Effective Date: This notice was published and becomes

ve on April 14. 2003.

# HIPAA Compliant Request for Information

**1) MY INFORMATION:**

## Name *

First Name Last Name

## Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

## Email

example@example.com

## Phone Number *

Area Code Phone Number

## Fax Number

Area Code Phone Number

## Date *

Day Year

**Last 4 SSN# ***

**2) CUSTODIAN INFO:**

I hereby give the following entity permission to release my Protected Health Information (PHI):

**Name**

First Name Last Name

**Address**

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

**Phone Number**

Area Code Phone Number

**Fax Number**

Area Code Phone Number

**3) INFORMATION REQUESTED:** I instruct the above entity to release a copy of the following information:

**(Please Tick One)**

☐ Comprehensive Care Summary Entire record

Please note that Behavioral Health Records release may only be a summary by the doctor

4) WHERE TO SEND: I am requesting the above designated records be released to the following entity or person:

**Name**

First Name Last Name

**Address**

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

**Phone Number**

Area Code Phone Number

**Phone Number**

Area Code Phone Number

**5) FORM & FORMAT OF RECORDS:**

I request the copies of records be delivered as follows (Tick One):

**Form Format Method of Delivery**

**Electronic**

☐ PDF

**Email the records to:**

**Electronic**

☐ Fax

**Fax the records to the number indicated above:**

**Electronic**

☐ PDF

**Download - Email a secure link to:**

**Hard Copy**

☐ Papaer

**Mailed to the address indicated above:**

This authorization is valid for 1 year (365 days). I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

**Date**

Month Day Year

**Date** *

Month Day Year

## Patient Insurance Information