Florida Behavioral Medicine

Adult New Patient Form

Patient Name:_____ **Date:**_____

Age: ____ **DOB:**_____ **Sex:**_____ **Email:**_____

Address:_____ **City:**_____ **State:**____ **Zip-Code:**_____

Home Phone:_____ **Cell Phone:**_____**Work Phone:**_____

Person to notify in case of emergency:_____

Relationship to patient:_____ **Phone:**_____

Reason for Evaluation: _____

If referred, then by who?_____

Previous Diagnoses

- ☐ None
- ☐ Depression
- ☐ Anxiety
- ☐ Mania
- ☐ Psychosis
- ☐ Schizophrenia
- ☐ Schizo-affective Disorder
- ☐ ADHD
- ☐ Dementia
- ☐ Other: _____
- ☐ Mental Retardation
- ☐ Developmental Disability
- ☐ Autism Spectrum Disorder
- ☐ Psycho-Educational Testing

Previous Providers: _____

☐ **Prior Psychiatric Hospitalization**
- ☐ None
- ☐ Last Hospitalization: _____
- ☐ Total Days: _____

☐ **History of Electric Shock Therapy**
- ☐ None
- ☐ Last Treatment: _____
- ☐ # of Treatments: _____

☐ **History of Suicide Attempts**
- ☐ None
- ☐ Last Attempt: _____
- ☐ # of Attempts: _____

☐ **History of Self-injurious Behavior**
- ☐ None
- ☐ Head Banging
- ☐ Overdose
- ☐ Other: _____

☐ **History of Suicidal Gesture**
- ☐ Self Injurious Behavior
- ☐ Other: _____

☐ **History of TMS**
- ☐ None
- ☐ Last Attempt: _____
- ☐ # of Attempts: _____

Substance Use: ☐ None (check all that apply, if checked, please mark how often)

- ☐ Tobacco: ____ (packs per day)
- ☐ Alcohol: ____ (amount per day)
- ☐ Other:_____
- ☐ Cannabis Use: _____
- ☐ IV Drug Use: _____
- ☐ Past Drug Use: _____
- ☐

Medical History

- ☐ Anemia
- ☐ Artery Disease
- ☐ Atrial Fibrillation
- ☐ Arthritis
- ☐ Cataracts
- ☐ Chronic Constipation
- ☐ COPD/Asthma
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Failure
- ☐ Liver Dysfunction
- ☐ Lupus
- ☐ Glaucoma
- ☐ Poor vision
- ☐ Reflux
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Dysfunction
- ☐ Parkinson's
- ☐ Hard of Hearing
- ☐ Obesity
- ☐ IBS
- ☐ Benign Prostate Hyperplasia
- ☐ Deep Vein Thrombosis
- ☐ Frequent Urinary Tract Infections
- ☐ Irritable Bowel Syndrome
- ☐ Degenerative Joint Disease
- ☐ Congestive Heart Failure
- ☐ Macular Degeneration
- ☐ Last Menstrual Period: _____
- ☐ Cancer of _____
- ☐ Other: _____

Surgical History

- ☐ Appendectomy
- ☐ CABG/Stent Replacement
- ☐ Cholecystectomy
- ☐ Gastric Bypass/Banding
- ☐ Hysterectomy
- ☐ Joint Replacement Surgery: _____
- ☐ Mastectomy
- ☐ Pacemaker
- ☐ Prostatectomy
- ☐ Other: _____
- ☐ Tonsillectomy
- ☐ Prostate Surgery
- ☐ Gastric Sleeve/Band/Bypass

Current Medications

List all current medication with dosage:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Past Psychiatric Medications

List all past medication with dosage:

_____
_____
_____
_____
_____
_____
_____
_____
_____

(initial here) ___ **I have listed ALL medications currently prescribed by ALL Providers**

Allergic to: _____

If you have no known allergies, check here: ____

Family Psychiatric History

- ☐ None/Unkown
- ☐ Bipolar
- ☐ Dementia
- ☐ Suicide
- ☐ ADHD
- ☐ Depression
- ☐ Schizophrenia
- ☐ Anxiety
- ☐ Substance Abuse
- ☐ Autism

History of Abuse: ☐ None ☐ Physical ☐ Emotional ☐ Sexual

Psycho-Social History

Marital Status: ☐ Single/Never Married ☐ Married ☐ Separated/Divorced ☐ Widowed ☐ Partnered

Living Situation: _____

Where were you born/raised?: _____

_____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Education: _____

Occupation: _____

Previous/Current Legal Issues:_____

Support System: _____

Review of Systems: □ None Apply

General:

□ No Complaints □ Fatigue/Malaise □ Fever/Chills □ Change in Appetite

Other: _____

Head/Ears/Eyes/Nose/Throat:

□ No Complaints □ Vison Changes □ Nose Bleed □ Dental Abscess □ Sore Throat □ Jaw Pain

Other: _____

Cardiovascular:

□ No complaints □ Palpitations □ Chest Pain □ Fainting □ Ankle Edema

Other: _____

Respiratory:

□ No complaints □ Short of Breath □ Cough □ Wheezing □ Phlegm

Other: _____

Gastrointestinal/Genitourinary:

□ No complaints □ Diarrhea □ Constipation □ Abdominal Pain □ Difficulty Urinating

Other: _____

Neuro:

□ No complaints □ Headache □ Tremors □ Involuntary, Abnormal Movements

Other: _____

Musculoskeletal:

□ No complaints □ Muscle Weakness □ Joint Swelling □ Recent Trauma/Fracture

Other: _____

Skin:

□ No complaints

Other: _____

(initial here) ____ I understand this treatment does not involve any legal, disability, and/or worker's compensation claims, custody issues, or court-ordered evaluation.

I AUTHORIZE COMMUNICATION WITH MY PRIMARY CARE PHYSICIAN: □ YES or □ NO

Name and address of your primary care physician: _____

_____

Telephone 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 any time. I further understand that psychiatric treatment is a cooperative effort between myself and the provider. I will work with the provider 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 orders.
-
- I have read and understood the above

Patient Signature: _____ Date: _____

Signature of Personal Representative: _____

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 before services are rendered.
2. I understand that if I am uninsured, I will be responsible for payment of the current self-pay rate.
3. 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.
4. I authorize and direct payment of my medical benefits to Florida Behavioral Medicine on my behalf for any services furnished to me by the providers.
5. I authorize Florida Behavioral Medicine to release my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification or authorization for referral to other medical providers.
6. (**If you have Medicare**) I request payment of authorized medicare benefits to me or on my behalf for any services rendered to me by or in Florida Behavioral Medicine. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.
7. I understand that I will be charged a minimum of $25 for **completion of any forms** I request. and this charge must be pre-paid.
8. I understand that **if I fail to give Florida Behavioral Medicine twenty-four (24) hours notice of cancellation of my *follow-up* appointment, I will be charged a no-show fee.**
9. I understand that **if I fail to give Florida Behavioral Medicine forty-eight (48) hours notice of cancellation of my *new patient* appointment, I will be charged a no-show fee**
10. I understand that **I will be subject to a $50 no-show fee if I fail to give notice of cancellation for any appointment.**
11. I understand that after ***3* missed appointments** I may potentially be **discharged/terminated** from the practice for non-compliance.
12. I understand that I should arrive 15-30 minutes early if I need to complete paperwork before my appointment, otherwise, I may be rescheduled.
13. I understand that if I am late for my appointment and the Provider does not have time to see me I will have to be rescheduled.
14. I understand that Florida Behavioral Medicine will not release my mental health record directly to me, only to the parties outlined in Florida State Statute 456.057 which consists of another provider, lawyer, or court order request.
15. I consent to allow Florida Behavioral Medicine to perform urinalysis randomly at the provider's discretion to make sure I am in compliance with my treatment.
16. **Assignment of Benefits**:
    I must assign Florida Behavioral Medicine any insurance or third-party benefits available for healthcare services provided. I understand that Florida Behavioral Medicine has the right to refuse or accept the assignment of such benefits. If the benefits are not assigned to Florida Behavioral Medicine by the insurance company, I agree to forward Florida Behavioral Medicine immediately upon receipt of all benefits paid that I receive for services rendered.

(initial here) ___ I understand and agree with the above-mentioned “Assignment of Benefits”

17. **Release of Information**:
    I must 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 a written revocation to Florida Behavioral Medicine.

(initial here) ___ I understand and agree with the above-mentioned “Release of Information”

18. **Privacy Act Statment**:
    We are authorized by CMS, CHAMPUS, and OWCP to ask you for the 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 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et. seq. And 10 USC 1097 and 1086; 5 USC 8101 et. seq; and 30 USC 901 et. seq; 38 UISC 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 receive are covered by these programs and to ensure 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-party payers to pay primary to a 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 Provider. Additional disclosures are made through routine use for information contained in systems of records.

(initial here) ___ I understand and agree with the above-mentioned “Privacy Act Statement”

(initial here) ___I have been given a copy of the “Florida Behavioral Medicine Notice of Privacy Practices” and have read and understood its contents

(initial here) ___ I understand that the providers do not engage in treatment involving any legal disability, worker’s comp, custody issues, or court orders. I also understand that providers will not fill out any disability paperwork.

(initial here) ___ I understand that not listing all medications being taken now may result in a non-compliant status for my treatment.

Patient Signature: _____ Date: _____

Signature of Personal Representative: _____

Florida Behavioral Medicine

Notice of Privacy Practices

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 Administrator or our privacy officer at PO Box 2256, Clearwater, FL, 33757-2256

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 healthcare and any related services. Payment: Your PHI will be used, as needed, to obtain payment for your healthcare 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 healthcare. In emergencies: We may use or disclose your PHI for emergency treatment. If a communication barrier exists, 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 as 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 case of criminal activity only when the appropriate conditions apply. To comply with 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: Psychiatry and 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 the Department 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 became effective on April 14, 2003.