Psychiatry & Research, Inc.

 5956 Turkey Lake Rd, Ste #1, Orlando, FL 32819 • 407-830-0773 PHONE 407-377-6923 FAX

# PATIENT INFO

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| FIRST NAME |  |  M.I. LAST NAME |  |  |  |
| SEXMale Female | DOB: |  | SOCIAL SEC NO. |  |  |
| DRIVER'S LICENSE NO. |  |  | HOW DID YOU HEAR ABOUT US? |  |  |
| STREET ADDRESS |  |  |  |  |
| CITY / STATE |  |  |  |  |  |  |
| HOME PHONE |  | May we leave a message? |  |  |
| CELL PHONE |  | May we leave a message? |  |  |
| WORK/OTHER PHONE |  | May we leave a message? |  |  |
| EMAIL ADDRESS |  | May we email you? |  |  |
| EMPLOYER NAME(S) & ADDRESS(ES): |  |  |



EMERGENCY CONTACT

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | RELATIONSHIP |  | PHONE NUMBER |

#  AUTHORIZATION & CONSENT FOR TREATMENT

By signing below, I hereby authorize the providers of this facility to provide treatment according to my medical diagnosis and/or mental health.



##  PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18) DATE



|  |  |  |
| --- | --- | --- |
| DATE OF INTAKE | PATIENT PROVIDER(s) | CARD ID NO. |

BILLING GUIDELINES: Please read the following information carefully and initial in the spaces provided to acknowledge you understand your responsibility.

 We will collect your deductible, copay, or percentage (if PPO) at the time of service. Please be prepared to pay with cash, debit card/credit card (Visa or MasterCard). 

 Please bring all insurance information with you to your visit. Please be aware of your insurance benefits before you come into our office as it is ultimately your responsibility for anything not covered by insurance. 

 You will need to contact your insurance company to find out if you need to obtain authorization for Mental Health services, If you obtain an authorization number, please bring it with you to your first visit. 

If your insurance changes, you will need to advise us immediately as your new insurance might not pay if the company requires an authorization for services. 

* If your insurance company gives you a limited number of visits, you will need to keep track of how many of those visits you have used. 
* Your insurance will send you an explanation of benefits defining what they have paid to our office. If you do not agree with the explanation of benefits, you will need to contact your insurance company. 
* **Please be aware that as a courtesy we try to call the 1-4 days before your appointment to remind you of your appointment; however, it is ultimately your responsibility to remember your own appointments. ALL APPOINTMENTS MUST BE CANCELED 24-HOURS IN ADVANCE OR GUARANTOR WILL BE CHARGED THE STANDARD OFFICE FEE. This includes any '[no-show" appointments. This fee must be paid before seeing the doctor for your next visit.** 

ASSIGNMENT OF INSURANCE: Are you using your insurance for this visit and follow-ups? C] Yes Cl No

|  |  |  |
| --- | --- | --- |
| INSURANCE COMPANY |  | PROVIDER TELEPHONE NO. |
| MEMBER ID # |  GROUP |
| PRIMARY INSURANCE HOLDER'S NAME |  | PRIMARY INSURANCE HOLDER'S DATE OF BIRTH |
| PRIMARY INSURANCE HOLDER'S SOC SEC # |  PATIENT'S RELATIONSHIP TO PRIMARY INSURANCE HOLDER |
| AUTHORIZATION # (IF APPLICABLE) |  AUTHORIZED # OF VISITS |

In making this assignment, I understand and agree that if payment is not received from my insurance company within 45 days of the date of service, I am aware that i am fully responsible for the entire balance.

x

##  PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18 DATE

SELF-PAYMENT AGREEMENT (IF NOT USING INSURANCE): I have agreed to accept full responsibility for payment of any charges incurred at this facility and I have agreed to pay for these services in full at time of service.

X

 PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18) DATE

# MEDICAL HISTORY

Please check all of these that you have now (present) and/or have had in the past. If it occurred in the past, please indicate the age when it was happening.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| PRESENT  | PAST | AGE |  | PRESENT  | PAST | AGE |  |
|  |  |  | head injury |  |  |  |  | bed-wetting/soiling |
|  |  |  | unconsciousness |  |  |  | arthritis |
|  |  |  | high fevers |  |  |  | back problems |
|  |  |  | loss of appetite |  |  |  | cancer |
|  |  |  | weight gain/loss |  |  |  | tuberculosis |
|  |  |  | frequent headaches |  |  |  | stomach problems |
|  |  |  | seizures |  |  |  | liver trouble |
|  |  |  | fainting/dizziness |  |  |  | hepatitis/jaundice |
|  |  |  | stroke |  |  |  | kidney trouble |
|  |  |  | crying spells |  |  |  | bowel problems |
|  |  |  | heart trouble |  |  |  | bladder problems |
|  |  |  | rheumatic fever |  |  |  | diabetes |
|  |  |  | high blood pressure |  |  |  | thyroid problems |
|  |  |  | chest pain |  |  |  | unusual bleeding |
|  |  |  | asthma |  |  |  | gynecological problem |
|  |  |  | shortness of breath |  |  |  | premenstrual syndrome |
|  |  |  | hives/rashes |  |  |  | pos for AIDS antibody |
|  |  |  | sleep disorders |  |  |  | sexual dysfunction |
|  |  |  | nightmares |  |  |  | other: |
|  |  |  | night sweats |  |  |  | other: |

REASON FOR SCHEDULING YOUR APPOINTMENT TODAY



# MENTAL HEALTH TREATMENT HISTORY

 DOCTOR or THERAPIST NAME/LOCATION DATES SEEN PROBLEM

##  FROM TO



# PAST HOSPITALIZATIONS

 HOSPITAL NAME/LOCATION DATES SEEN REASON FOR HOSPITALIZATION

##  FROM TO



1. Are you currently taking any prescription or over-the-counter (OTC) medication? No Yes, please list:

|  |  |  |  |
| --- | --- | --- | --- |
| MEDICATION | DOSAGE  | FREQUENCY (TIMES | PRESCRIBED (LIST DOCTOR) OR OTC? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Have you ever been prescribed psychiatric medication? [ ] No [ ] Yes, please list:

|  |  |  |  |
| --- | --- | --- | --- |
| MEDICATION | DOSAGE  | FREQUENCY (TIMES | PRESCRIBED (LIST DOCTOR) OR OTC? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. How would you rate your current physical health? (Please check one)

 **[ ]** Poor **[ ]** Unsatisfactory **[ ]** Satisfactory **[ ]** Good **[ ]** Very good

Please list any health problems you are currently experiencing:

1. How would you rate your current sleeping habits? (Please check one)

 **[ ]**Poor **[ ]** Unsatisfactory **[ ]** Satisfactory **[ ]** Good **[ ]** Very good

Please list any specific sleep problems you are currently experiencing:

1. How many times per week do you generally exercise?

 What types of exercise do you participate in?

1. Please list any difficulties you experience with your appetite or eating patterns:
2. Are you currently experiencing overwhelming sadness, grief, or depression?

**[ ]** No  **[ ]** Yes If yes, for approximately how long?

1. Are you currently experiencing anxiety, panic attacks, or have any phobias? **[ ]** No **[ ]** Yes

 If yes, when did you begin experiencing this?

1. Are you currently experiencing any chronic pain? **[ ]** No **[ ]** Yes

If yes, please describe:

1. Do you drink alcohol more than once a week? **[ ]** No **[ ]** Yes
2. How often do you engage in recreational drug use? (Please check one)

 **[ ]** Daily **[ ]**Weekly **[ ]** Monthly **[ ]**Infrequently **[ ]** Never

1. Are you currently in a romantic relationship? **[ ]** No **[ ]** Yes

 If yes, for how long? 

 On a scale of 1-10, how would you rate your relationship?

 13. Are you currently employed? **[ ]** No **[ ]** Yes

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

1. Do you consider yourself to be spiritual or religious? **[ ]** No **[ ]** Yes

If yes, please describe your faith or belief:

1. What do you consider to be some of your strengths?
2. What do you consider to be some of your weaknesses?

# FAMILY MENTAL HEALTH HISTORY

In the section below, please identify if there is a family history of any of the following, If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc).

 YES NO LIST FAMILY MEMBER (e.g. father, mother, sibling,etc.)

|  |  |  |
| --- | --- | --- |
| Alcohol/Substance Abuse |  |  |
| Anxiety |  |  |
| Depression |  |  |
| Bipolar/Mania |  |  |
| Domestic Violence |  |  |
| Eating Disorders |  |  |
| Obesity |  |  |
| Obsessive Compulsive Disorder |  |  |
| Schizophrenia |  |  |
| Suicide Attempts |  |  |

URINE DRUG SCREEN POLICY:

* Routine and Random urine drug screening (UDS) has become a standard of care in managing patients.
* All new patients should have a UDS with confirmation routinely.
* UDS will be a requirement for treatment to every "established" adult patient (18 years old and older) if:
	1. the patient tested positive for an illicit or undisclosed controlled substance on the day of the first visit;
	2. the patient was started/continued on controlled substances on the first visit;
	3. active chemical dependency/dual diagnosis or illicit substance abuse/recreational use is endorsed or documented by the time of the psychiatric evaluation;
	4. at any time according to the clinical judgment of the psychiatrist/provider
* A negative UDS plus confirmation will be a requirement for a psychiatric evaluation and psychotropic mediation management in every minor (less than 18 years old) with no exceptions.
* A negative UDS and confirmation may be a requirement for prescription of controlled substances for all new and existing patients 18 years and older with no exceptions.

 PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18) DATE

LIMITS OF CONFIDENTIALITY:

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

# Duty to Warn & Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In case in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

# Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

# Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

# Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records,

# Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. The information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

BY SIGNING BELOW, / AGREE TO THE ABOVE LIMITS OF CONFIDENTIALITY AND UNDERSTAND THEIR MEANINGS AND RAMIFICATIONS.

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I understand that under the Health Insurance Portability & Accountability Act of 1996

(HIPAA), I have certain rights to privacy regarding my protected health information

(PHI). I understand that this information can and will be used to

* Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

BYS/GNING BELOW, / ACKNOWLEDGE THAT the Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time or visit our web site

(wwwamilleniapsych.com) to obtain a current copy of the Notice of Privacy Practices.

**[ ]** I have requested and received a copy of the organization's Notice of Privacy Practices.

# OR

# **[ ]** I have declined a copy of the organization's Notice of Privacy Practices.

 PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18) DATE

**APPLICABLE FEES SECTION:**

**ALL APPOINTMENTS MUST BE CANCELED 24-HOURS IN ADVANCE OR GUARANTOR WILL BE CHARGED THE STANDARD OFFICE FEE. This includes any '[no-show" appointments. This fee must be paid before seeing the doctor/therapist for your next visit.** 

* **Missed Visit Fees**
	+ Doctor/ARNP $50
	+ Therapist/PhD $60
* **Call-in Medication**
	+ Fee of $25 will apply to any medication needing to be called in due to patient not being seen in the office / compliance with treatment plan.
* **Paperwork Fees**
	+ Varies based on paperwork being requested. Paperwork will only be filled out for existing patients who have been under treatment for 3-6 months. Paperwork will not be filled out at the first visit.

If you reach the office after hours, you may leave a voice message at phone # **407-830-0773** or email us at **Milleniapsych@gmail.**com with basic medication questions. Any urgent or medical emergencies please call 911. Our turnaround for medication request is 48-72 hours, please be proactive in tracking your medication in order to not go without meds.

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