

### New Patient Information

Please fill this form out and submit or email before making an appointment

|  |    |             |            |              |
|--|----|-------------|------------|--------------|
| Name (First, Last)   |    | M.I.        | Birth Date | Today's Date |
| Street Address   |    | City        |            | State/Zip    |
| Insurance provider: _____ #: _____   |    |             |            |              |
| Home Phone: _____  |    | Cell: _____ |            | Email: _____ |
| Which preferred: _____ Text OK? Yes    No  |    |             |            |              |
| If needed, may we leave a message on your answering machine? Yes <input type="checkbox"/> No   |    |             |            |              |
| Primary Care Provider Name, Phone and Address  |    |             |            |              |
| Pharmacy Name, Phone and Street/City   |    |             |            |              |
| Where else have you received mental health treatment   |    |             |            |              |
| Allergies:   |    |             |            |              |
| Medications<br>Current and<br>Past   |    |             |            |              |
| In case of an emergency, is there someone we can contact (list below): Can we share with them information about your mental health condition? Please mark Yes or No next to the _____ name |    |             |            |              |
| Yes  | No | Name        | Phone      | Relationship |
| Yes  | No | Name        | Phone      | Relationship |

## Treatment Consent and Acknowledgement

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Effective care provision requires the following policies to enable:

- 1) **Financial Policy:** Behavioral Health of Central Florida PLLC will bill for all appointments unless initially billing insurance. IN the initial process of credentialing (Behavioral Health of Central Florida PLLC) will charge all appointments unless able to bill insurance retroactively after credentialing. For payment of appointment or copay debit or credit card are preferred. In some instances, cash or check may be accepted. Any returned checks are subject to a \$30 service fee. Any returned check or payment due must be resolved before any future appointments can be arranged.
- 2) **Payment Policy:** All payments are due at time of services. All payments can be done online with a debit or credit card. Each client will be asked to keep a major credit card on file. Payment for appointment will be automatically pulled from the account following the appointment, and invoice will be emailed. If client is unable to provide a credit/debit card, alternative may be approved on a case by case basis. After two notices or two months (whichever is sooner) without payment or arrangement between client and provider, outstanding balances will be sent to collections with additional collections fee added. Appointments cannot be made if prior appointments are not paid, or payment arrangements are late. Automatic withdrawal from a credit card will be the default method of payment unless otherwise discussed between client and provider. Copays are due at time of appointment.
- 3) **Appointment /Cancellation Policy:** All appointments should be kept as scheduled to ensure consistency in the treatment process. A \$50 fee will be charged for cancellations without a 24-hour notice or non-appearance for a scheduled visit. As a general rule, for medication management patient must be seen at minimum every 3 months after medications are stabilized.
- 4) **Medication Policy:** Medication renewal will occur during the medication follow -up visit with the prescribing provider. No medication will be prescribed over the phone routinely. Any written script for a controlled substance which is lost will not be re-written. The patient must wait for the next eligibility date for the provider to prescribe . Any script for a controlled substance prescription which has expired requires a return appointment. Illicit substances interfere with the efficacy of psychotropic medication including cannabis and alcohol. The provider may not initiate medication or ask for sobriety prior to initiating medication if substance abuse is evident. **(Behavioral Health of Central Florida PLLC) reserves the right to drug test patients prior to or during medication management. Adequately screening for substances that may interact dangerously like illicit and prescribed drugs is essential to prevent severe injury to our patients.**
- 5) **Refill requests:** Please do not call our office for medication refills- call your pharmacy first, because most likely the pharmacy already has refills available on file. If refill is needed you must have your pharmacy fax us a request at least 7 days in advance
- 6) **Phone Policy:** Phone calls made for treatment purposes may be charged a fee. Phone calls for matters of short duration will not be charged. If you have any questions or having any side effects let us know and the message will be relayed to your provider. Phone call requests made after 3 p.m. may be returned next business day. In case of an emergency please call 911 or go the nearest emergency room.

In signing below, you agree to begin treatment with the policies above and acknowledge receipt of the Privacy Notice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

*If not signed by patient, please indicate relationship to patient (e.g., spouse)*

**Patient's Rights**

1. The Patient has the right to considerate and respectful care and treatment, regardless of gender, race, sexual orientation, age, culture, disabilities, or religious beliefs
2. The Patient has the right to have their care and treatment information kept private and have the opportunity to have their records released only with their written permission, except required by law.
3. Patients have a right to make informed choices regarding their medications, behavioral health services, and their providers.
4. The Patient has a right to expect reasonable continuity of care.
5. The Patient has the right to examine and receive an explanation of costs for treatment as applicable.
6. The Patient has the right to know what relationship Behavioral Health of Central Florida PLLC has with other health care providers and facilities in regard to their health care.
7. The Patient has the right to inquire as to their provider's degree, licensure, and training.
8. The Patient has the right to inquire as to the role of the providers on the treatment team in the treatment process.
9. The Patient has the right to an explanation of their condition and the treatment options.
10. The Patient has the right to expect that Behavioral Health of Central Florida PLLC will make reasonable effort in providing the identified services of the treatment plan.
11. The Patient has the right to be informed if Behavioral Health of Central Florida PLLC is engaging in research about behavioral health care and have the right to refuse participation in that research.
12. The Patient has the right to register complaints to their behavioral health care professional and/or an administrator.

**Patient's Responsibilities**

1. The Patient has the Responsibility to treat those providing care with dignity and respect.
2. The Patient has the Responsibility to ask questions regarding the diagnosis, treatment, medications, or any instructions.
3. The Patient has the Responsibility to follow instructions concerning medications, follow-up visits, and other essential components of their treatment and to notify their behavioral health care provider if the instructions cannot be followed or problems develop.
4. The Patient has the Responsibility to assist Behavioral Health of Central Florida PLLC in obtaining approvals for payments for treatment, referrals, and authorizations.
5. The Patient has the Responsibility to provide as much information as is possible to their provider to assist in the assessment and rendering of services.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Date

*If not signed by patient, please indicate relationship to patient (e.g., spouse)*

