Florida Psychiatry Associates

1555 NW St. Lucie West Blvd., Suite 201, Port St. Lucie, FL. 34986; Phone 772-878-7216, FAX 772-878-7218; www.flpsychiatry.com

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of Florida Psychiatry Associates (FPA) Notice of Privacy of Practices which describes how my health information is used and shared. FPA reserves the right to change this Notice at any time. I may obtain a current copy by contacting the facility or by visiting the FPA website at www.flpsychiatry.com

Patient Name:____ Date:_________________________
(print)

Signature of patient or authorized representative*____

Name of authorized representative (if applicable)____
(print)

*Authorized representatives include:
1) Legal Guardian
2) Health Care Power of Attorney
3) Executor of Estate

For Facility Use Only: Complete the section below if unable to obtain a signature.
1. If the patient or authorized representative is unable or unwilling to sign this *Acknowledgment*, or the *Acknowledgment* is not signed for any other reason, state the reason:

____

____

2. Describe the steps taken to obtain the signatures on the *Acknowledgment:*

____

____

________________________________ ____ ____________
Printed name of Patient | Signature of Patient, Guardian or POA Representative | Date

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CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:____

(Please print clearly)

I authorize any FPA staff member who may be directly or indirectly involved in my care to disclose confidential information about me to the persons/agencies listed below. This confidential information includes, but is not limited to: my psychological/psychiatric history, my drug and alcohol use history, medical history, family history, legal and financial status, treatment history, results of diagnostic tests, urine tests, and clinical progress reports, current or planned treatment I may receive, all aspects of my treatment and clinical progress, and, all other information deemed important by the staff of FPA to assist with my treatment and/or other personal or business matters including but not limited to comprehensive medical care, insurance reimbursement, legal action, regulatory action, marital conflict, child custody, etc.

I hereby authorize exchange of this information with the following persons, organizations/agencies:

____ Your Initials:_________

Your psychiatrist, psychologist, or other therapist (specify name of person)

____ Your Initials:_________

Family members (specify name of person)

____ Your Initials:_________

Your attorney (specify name of person)

____ Your Initials:_________

Others (specify name of person)

I understand and acknowledge this consent expires when I am no longer an active patient with the facility listed above or if revoked by me in writing and that I may do so at any time for any reason except to the extent that: 1) this information is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; 2) disclosure has already occurred; or, 3) any action that relies on this disclosure has already been taken and/or is in progress.

______________________________ ____________________________________ ___________

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NEW PATIENT HEALTH INFORMATION

All information is subject to the Consent to Release PHI and the FPA Notice of Privacy Practices

PATIENT INFORMATION Today's Date:________________________

Name:____ Date of Birth:____________
Last First Middle Initial

Address:____
Street Address City State Zip

Sex: ____ Height:________ Weight________ Social Security #: __________________________
M /F

Circle one: Single / Married / Separated / Divorced / Widowed

CONTACT INFORMATION: (Please circle preferred method of contact for appointment confirmation.)
Do you authorize us to leave a message on your voice mail / answering machine? Check one; ___Yes, ____No

Home phone:_______________________________ Work phone:_________________________________

Cell phone:_________________________________ E-mail:____________________________________

INSURANCE INFORMATION: If same as patient check this box ☐ then skip to Emergency Contact

Name:____
Last First Middle I.
Address:____ Social #: ____________
Street City State Zip
Date of Birth:______________ Patient Relationship to Insured____________________
mm/dd/yyyy Self, Spouse, Child, Other

Primary Insurance:_______________________________ Policy #_________________________________

Group #_____________________________ Effective Date: ___________________________________

Secondary Insurance: _____________________________ Policy #_________________________________

Group #_____________________________ Effective Date: ___________________________________

EMERGENCY CONTACT INFORMATION:

Contact Name:______________________________________ Number:___________________________

Relationship to Patient:____

PREFERRED PHARMACY:

Pharmacy:____ Phone:__________________________

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PRIMARY CARE PHYSICIAN:

Name:____ Phone:_________________________

Address:____
Street City State Zip

REASON FOR EVALUATION TODAY:____

WHO REFERRED YOU HERE?____

WE APPRECIATE THE OPPORTUNITY TO SERVE YOU.

I AUTHORIZE THE RELEASE AND DISCLOSURE OF ANY OR ALL OF MY MEDICAL AND TREATMENT RECORDS OR REPORTS TO ANY OTHER HEALTH CARE PROVIDER WHO MAY BE OF ASSISTANCE IN THE OPINION OF FPA PROVIDERS I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY FPA. I UNDERSTAND PAYMENT IS DUE AT THE TIME OF SERVICE. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES.

I FURTHER UNDERSTAND IF I DO NOT SHOW UP, OR CALL LESS THAN 24 HOURS BEFORE AN APPOINTMENT TO CANCEL OR RESCHEDULE, I WILL BE CHARGED A $100 FEE FOR INITIAL APPOINTMENTS OR A $50 FEE FOR FOLLOW-UP VISITS. **NOTE: THIS FEE IS NOT COVERED BY ANY INSURANCE AND IS BILLED DIRECTLY TO PATIENTS.**

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, NO CALL–NO SHOW FEE AND RELEASE OF MEDICAL INFORMATION. THIS AUTHORIZATION IS VALID UNTIL RESCINDED IN WRITING.
I UNDERSTAND THAT PROVIDING FALSE INFORMATION IS CAUSE FOR TERMINATION.

I AUTHORIZE MEDICAL TREATMENT BY FPA.

________________________________ ____ ____________
Printed name of Patient Signature of Patient, Guardian or POA Representative Date

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OFFICE POLICIES

MEDICATION POLICY:

Medication refills: Notify your provider during your visit if you need a prescription renewal so it may be completed at that time. Refills WILL NOT be issued over the phone. Prescriptions for controlled substances (stimulants or benzodiazepines) WILL NOT BE REISSUED until the date the prescription is due to run out. You are responsible for safeguarding your prescriptions and medications. Florida Psychiatry Associates (FPA) cares about your overall safety, health and longevity. We expect all patients to gradually wean themselves off Xanax, Ativan, Valium or Klonopin, and to acquire other healthier coping skills for chronic anxiety.

We participate in E-FORCSE® The Florida Prescription Drug Monitoring Program, known as E-FORCSE® (Electronic-Florida Online Reporting of Controlled Substance Evaluation Program) is a database tool we use to improve patient care by identifying potentially hazardous or fatal drug interactions. As a responsible health care provider, our goals include safe prescribing, in addition to reducing drug abuse and diversion.

If you experience a psychiatric emergency, call 911 or go to the nearest emergency room for urgent treatment.
If you are having medication problems, make an appointment to permit your provider to give you the care and attention you deserve.

PHONE POLICY

We take pride in answering your call in person whenever possible. However, there are times when heavy call volume may prevent us from speaking with you directly. If you get a recording, PLEASE FOLLOW THESE INSTRUCTIONS:

- To uphold the quality of care and in fairness to all, Providers cannot accept or return phone calls during office hours. If you feel you must speak with your Provider, please request an appointment. Thank you for understanding.
- Do not call more than once per day for the same issue. Doing so only adds more delay in returning your call.
- Keep your message as brief as possible (name, number and reason for call)
- Allow up to 24 hours for a return call, especially if you call late in the day.
- Abusive or incessant calling is cause for termination. All threats are reported to the authorities.

NO CALL / NO SHOW CHARGE POLICY:

FPA hours are by appointment only. In order to provide the best possible service and timely availability of appointments to all our patients, we require 24-hour notice if you need to cancel or reschedule your visit. A $50 no-show fee will be applied to broken appointments and we may ask you to prepay for future services. ***Note: Insurance companies do not reimburse for this fee.***

PAYMENT, INSURANCE, OTHER POLICIES AND FEES:

Payment policy: Payment of all applicable charges is due when service is rendered. If not, your appointment will be rescheduled. For your convenience, we accept major credit cards, cash and personal checks. We do not accept post dated checks. There is a $50 fee for checks returned for insufficient funds. We reserve the right to charge a service fee of $50 on unpaid balances after 60 days.

Insurance: FPA is a network provider for Aetna, Blue Cross Blue Shield, Cigna, Medicare, Tricare Standard, and accepts most out-of-network insurances. At your request, you will be furnished proof of treatment and payment which you may then submit to your insurance company for reimbursement if needed.

Inactive Patient: Any patient not seen by an FPA Provider within the previous 12 months is inactive and subject to termination.

Termination Policy: It is the policy of this practice to establish and maintain a cooperative trust based provider/patient relationship. Should the relationship, trust or mutual goals of the provider and patient not be realized, either party may terminate the relationship within the bounds of applicable state and federal laws, rules and regulations.

FMLA/legal paperwork charges: Cost is $50 per page in advance. <u>We do not process long-term disability applications.</u>

____ ____________________

Printed name of Patient Signature of Patient, Guardian or POA Representative Date