Florida Psychiatry Associates, LLC (FPA)
1555 NW St. Lucie West Blvd., Suite 201, Port St. Lucie, FL 34986
Phone: (772)878-7216/Fax: (772)878-7218
www.flpsychiatry.com

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:_____________
First Last 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:_______________________________________

If patient is a minor, who is legally authorized to provide medical consent on their behalf?
Name:____ **Date of Birth:**_____________
First **Last** **Middle Initial**
Address:____
Street Address **City** **State** **Zip**
Preferred Phone: _______________________________ **Email:** __________________________________
Relation to patient: ____

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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:____

PHARMACY:

Pharmacy:____ Phone:________________________

Address: ____

PRIMARY CARE PHYSICIAN:

Name:____ Phone:________________________

Address:____
Street City State Zip

REASON FOR EVALUATION TODAY:____

WHO REFERRED YOU HERE?____

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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.

Name of Patient ____

Name of legal guardian/POA (*If Patient is a minor*) _______________________________

____ Date ___________
Signature of Patient, Legal Guardian/POA

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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

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 Staff Member Date

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AUTHORIZATION TO DISCLOSE OR OBTAIN HEALTH INFORMATION

I, the undersigned patient or legal representative, hereby authorize the use and disclosure of my health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Patient Name:____ **Date of Birth:**_______________

FILL OUT FOR FPA TO **DISCLOSE** INFO:	FILL OUT FOR FPA TO **OBTAIN** INFO:
I authorize Florida Psychiatry Associates to disclose my health information to: Name:____________________________________ Address:__________________________________ ____ Phone:____________________________________ Fax:______________________________________	I authorize __________________________________ to disclose my health information to: Florida Psychiatry Associates, LLC 1555 NW St. Lucie West Blvd., Ste. 201 Port St. Lucie, FL 34986 Phone: 772-878-7216 Fax: 772-878-7218

Method of Disclosure: ☐ Mail ☐ Fax ☐ Verbal ☐ Pick up ☐ Email

Dates of service (if applicable):____

Type(s) of information to be used or disclosed include:

☐ Psychiatric evaluation and follow up notes ☐ Psychiatric Intake and Evaluation ☐ Lab Reports/EKG
☐ Neuropsych Testing ☐ Urgent Care / ER Dept. Records ☐ Discharge Summary ☐ Complete Record

* **The parent or legal guardian must sign the authorization if the patient is a minor (under age 18) or has a legal guardian.**
* This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Florida Psychiatry Associates LLC in writing.
* I understand the revocation will not apply to information that has already been released in response to this authorization.
* I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
* I understand that my treatment or continued therapy by Florida Psychiatry Associates is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
* Minors receiving drug abuse treatment may sign their own authorization.

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed from records whose confidentiality is protected. Federal and state rules prohibit anyone from making any further disclosure of this information unless the patient provides specific written authorization for the subsequent disclosure of this information or as to otherwise permitted by 42.C.F.R. Part 2 or F.S.A. §394.4615. Florida law requires that any person, agency or entity receiving this information shall maintain such information as confidential and exempt from the provisions of the public law (F.S.A. §394.4615(6). Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to F.S.A. §394.4615 or other Florida statute is not subject to civil or criminal liability for such release.

Name of Patient ____________________ **Name of legal guardian (*If Patient is a minor*)** __________________

____ **Date** ___________
Signature of Patient, Legal Guardian