Florida Psychiatry Associates, LLC (FPA)

260 NW Peacock Blvd Suite 102, Port St. Lucie, FL 34986
Phone 772-878-7216 – Fax 772-878-7218 – www.flpsychiatry.com

NEW PATIENT HEALTH INFORMATION

Information is protected by 45 CFR § 164 (HIPAA - Health Insurance Portability and Accountability Act) and applies to information on all FPA forms

PATIENT INFORMATION Today's Date:_____

Name:_____ Date of Birth:_____
Last First Middle Initial (MM/DD/YYYY)

Address:_____
Street Address City State Zip

Sex: ____ Height:_____ Weight_____ Social Security #: _____
M /F

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

CONTACT INFORMATION:

Home phone:_____ Work phone:_____

Cell phone:_____ E-mail:_____

Indicate your prefered method(s) of contact for appointment related messages using checkboxes below.
Do you authorize FPA to leave audio messages on your voice mail / answering machine? Check one; ☐ Yes, No ☐
Do you authorize FPA to send you e-mail messages? Check one; ☐ Yes, No ☐
☐ By checking this box you agree to receive TEXT messages from FPA at the cell phone number provided above.
STANDARD MESSAGING DISCLOSURES; *Reply STOP to opt out; Reply HELP for support; Message and Data rates apply; Message frequency will vary. Visit http://www.flpsychiatry.com/?page_id=3 for Privacy Policy and http://www.flpsychiatry.com/?page_id=97 for SMS Terms of Service.*

If patient is a minor, who is legally authorized to consent on their behalf? (Must be Parent or Legal Guardian)
Name:_____ Date of Birth:_____
Last First Middle Initial
Address:_____
Street Address City State Zip
Preferred Phone: _____ Email: _____
Relationship 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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Acknowledgement 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

Below is 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 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:_____ Facility:_____ Address:_____ _____ Phone:_____ Fax:_____	I authorize: Name:_____ Phone:_____ Fax:_____ to disclose my health information to: Florida Psychiatry Associates, LLC 260 NW Peacock Blvd, Ste. 102 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

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OFFICE POLICIES

MEDICATION POLICY:
If you experience a psychiatric emergency, call 911 or go to the nearest emergency room for urgent treatment.
If you have medication issues, please make an appointment to allow your provider to give you the care and attention you deserve. **Medication refills will not be issued by phone.** During visits, tell your provider about any refills needed before your next visit. By law, controlled substance prescriptions require follow up appointments every 3 months and must be submitted electronically.

Replacement medications will not be issued before the date they were due to run out. You must safeguard your medications. **We expect you to gradually wean yourself off addictive benzodiazapine medications such as Xanax, Ativan, Valium, etc.** We care about your overall health and longevity. We encourage you to acquire other healthier coping skills for chronic anxiety. **E-FORCSE®** The law requires us to use the Florida Prescription Drug Monitoring Program to reduce drug abuse and diversion.

PHONE POLICY
To uphold the quality of care and in fairness to all, Providers cannot interrupt appointments to take phone calls. If you feel you must speak with your Provider, please make an appointment. Thank you for understanding. We take pride in answering your call in person whenever possible. However, when all three lines are busy, calls are routed to our staff member's voicemail, if this happens to you…

1. Do not call more than once per day for the same issue. Doing so only adds more delay in returning your call.
2. Keep your message as brief as possible (name, number and reason for call)
3. Allow up to 24 hours for a return call, especially if you call late in the day.

Please ensure that we can reach you by checking that your personal voicemail box is not full.
Help us reduce our call volume and improve your ability to reach us by requesting appointment reminders via text message.
NOTE: Abusive, threatening or incessant calling is cause for termination. Threats are reported to appropriate authorities.

NO CALL / NO SHOW CHARGE POLICY:
FPA providers are seen by appointment only. To provide the best possible service, we require 24-hour notice to cancel or reschedule appointments. Broken appointments may require you to prepay to reschedule. If you no-show or cancel less than 24 hours before your initial appointment, you may not be able to reschedule. For return visit appointments, a $50 no-show fee will apply. ***Note: Insurance companies do not reimburse for these fees.***

SCHEDULING, PAYMENT, INSURANCE, OTHER POLICIES AND FEES:
Scheduling appointments: Our office is open Monday through Friday from 8 am to 12pm and 1pm to 4:30 pm.
Initial appointments are for evaluation purposes. We will make every attempt to schedule your appointment as soon as possible.
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 and Tricare Standard. We accept out-of-network benefits from most other plans and we furnish proof of treatment for your reimbursement upon request.
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 bounds of applicable state and federal laws, rules and regulations.
Inactive Patient: Any patient not seen by an FPA Provider within the previous 18 months is inactive and will be terminated.
FMLA, Legal paperwork charges and limitations: Cost is $50 per page in advance.
We do not process long-term disability applications nor provide letters of endorsement for emotional support animals.
Use of recording devices in the office is prohibited unless approved in advance in writing.

By my signature below, I acknowledge that I have read and agree to abide by the FPA Office Policies stated above.

_____ / _____ _____
Printed name of Patient, Guardian or POA Representative **Signature** Date