Psychiatric & Psychological Services

1211 N. Westshore Blvd. Suite 411
Tampa, FL. 33607

Telephone (813)281-8955
Fax (813) 281-2474

Patient Information: Today's Date: ____-____-_____

Last Name: _____ First Name: _____ Mi: ____ Date of Birth: ____-____-_____

Street Address: _____ Gender: ☐ Male ☐ Female

City: _____ State: _____ Zip: _____ Social Security #: _____-___-_____

Home Phone Number: (_____) _____-_____ May we leave a message? ☐ Yes ☐ No

Cell Phone Number: (_____) _____-_____ May we leave a message? ☐ Yes ☐ No

Work Phone Number: (_____) _____-_____ Ext:_____ May we leave a message? ☐ Yes ☐ No

Name of Parent/Guardian (if minor): _____

Relationship with Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: _____

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age: _____

Employer: _____ Occupation:_____

Student? ☐ Yes ☐ No If so, ☐ Part-Time ☐ Full-Time School: _____

Referred by (if any): _____

Insurance Information: (Primary Insured)

Primary Insurance Company: _____ Insurance Policy #: _____

Group #: _____ Primary's Employer: _____

(Person Responsible for Insurance) Last Name: _____ First Name: _____ Mi: _____

Relationship with Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: _____

Street Address: _____ Date of Birth: ____-____-_____

City: _____ State: _____ Zip: _____ Gender: ☐ Male ☐ Female

Social Security #: _____-___-_____

IN CASE OF EMERGENCY: Who should be notified? _____

Phone: (_____) _____-_____ **Relationship to patient: _____**

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

Name: _____ **Date:** _____

Below is a list of problems and complaints that some people have. Read each one and select the number that best describes **how much discomfort that problem has caused you during the past 7 days, including today.** Place the number in the open block to the right of the condition.

Example: **How much were you distressed by:**

Body Aches **[2]**

0 = Not at All
1 = A Little Bit
2 = Moderately
3 = Quite a Bit
4 = Extremely

How much were you distressed by:

Nervousness or shakiness inside [ ]

Faintness or dizziness [ ]

The idea that someone else can control your mind [ ]

Feeling others are to blame for most of your troubles [ ]

Trouble remembering things [ ]

Feeling easily annoyed or irritated [ ]

Pains in heart or chest [ ]

Feeling afraid in open spaces [ ]

Thoughts of ending your life [ ]

Feeling that most people cannot be trusted [ ]

Poor appetite [ ]

Suddenly scared for no reason [ ]

Temper outbursts out of control [ ]

Feeling lonely even when you are with people [ ]

Feeling blocked in getting things done [ ]

Feeling lonely [ ]

Feeling blue [ ]

No interest in things [ ]

Your mind going blank [ ]

Feeling afraid to travel on buses or trains [ ]

Trouble getting your breath [ ]

Hot or cold spells [ ]

Having to avoid certain things or places because they frighten you [ ]

The idea that you should be punished for your sins/mistakes [ ]

Numbness or tingling in parts of your body [ ]

Getting into frequent arguments [ ]

Feeling hopeless about the future [ ]

Trouble concentrating [ ]

Feeling restlessness [ ]

Feeling tense or keyed up [ ]

Thoughts of death or dying [ ]

The urge to beat, injure or harm someone [ ]

The urge to break or smash things [ ]

Feeling worthless [ ]

Feeling weak in parts of your body [ ]

Trouble falling asleep [ ]

Feeling uneasy in crowds [ ]

Spells of terror or panic [ ]

Feeling very self- conscious with others [ ]

Medical History

Client Name: _____ Date of Birth: _____ Age: _____

Circle any adjective that describes your present state of physical health:

Excellent Good Fair Poor

List any prescribed medications you are now taking, including dosages: _____

_____

_____

List any history of serious illness including mental illness or substance abuse: _____

_____

_____

List any history of serious illness in your family including mental illness or substance abuse: _____

_____

_____

List and describe any previous psychiatric hospitalizations: _____

_____

Do you smoke? □ Yes □ No If "yes" how much? _____

Do you drink alcohol? □ Yes □ No If "yes" how much/what type? _____

Give dates and describe any history of counseling including supervisory referrals: _____

_____

_____

Have you ever had any of the following conditions or symptoms?

□ Trouble Sleeping	□ Appetite Changes	□ Fainting	□ Emotional/Physical/Sexual Abuse
□ Headaches	□ Crying Spells	□ Irritability	□ Memory Problems
□ Stomach Trouble	□ Trouble Concentrating	□ Anxiety	□ Indecisiveness
□ Depression	□ Unexplained Pain	□ Obsessions	□ Numbness or Tingling
□ Thoughts about Suicide	□ Extreme Nervousness	□ Nightmares	□ Problems with Anger
□ Weight Loss/Gain	□ Repetitive Irrational Behavior	□ Low Energy	□ Seeing or Hearing things not real

List goals you would like to accomplish out of your time in therapy? _____

_____

_____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice is dedicated to maintaining the privacy of your personal health information. State law requires that no information about your treatment can be given without your permission. The only exceptions to this are 1) if it is believed that there is clear and present danger of harm to anyone, 2) if a judge requires specific information in a court case, 3) if it is suspected that a criminal offense of child, disabled adult, or elderly abuse or neglect has occurred.

Treatment covered by insurance requires authorization to release information to your insurance provider, in order to obtain treatment approval and to bill for services. If there is a need to use or disclose your personal information for any other reason, this will be discussed with you and you will be asked to sign an authorization of release.

The recently enacted Health Insurance Portability and Privacy Act of 1996 (HIPPA) requires us to provide this privacy policy. This notice of privacy practices is a summarized version of the full policy that is available in the office. Please ask if you would like to review it.

When we assess, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. This information will be used to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or who need it to arrange payment for your treatment or to perform other healthcare operations, provided that this is not in violation of state law. We will disclose the minimum information necessary. You have a right to ask and be told to whom your PHI has been released. You have the right to request in writing that disclosure of your PHI be restricted. While the therapist is not required to agree to the request, if the therapist agrees to the restriction, that agreement will be honored. There may be changes to this policy, and if there are changes, those changes will be posted in the office for review.

Please feel free to discuss with me any questions or concerns that you may have.

SERVICE AGREEMENT

Treatment Authorization:
The undersigned authorizes _____to administer mental health and/or chemical dependency treatment to the patient named below either in person or tele-health. I understand that I may revoke this consent at any time during the treatment period. No guarantee or assurance of results has been made to me regarding the treatment.

Signature:_____**Date**:_____
Self:_____Spouse:_____Parent:_____Guardian:_____

Information Authorization (Primary Care Physician):
I authorize _____ or decline_____authorization of the release of information to the primary care physician for the purpose of coordinating care.

Name of PCP:_____**Phone**:_____

Signature:_____**Date**:_____

Consent for use and disclosure of Personal Health Information (PHI):
I have reviewed the Privacy Policy and give consent for the use and disclosure of personal health information to provide treatment, to arrange payment for services, and/or for other health care operations as provided by law. I understand that changes in the policy are possible, and that if there are changes, those changes will be posted in the office for review.
I understand that I may request in writing that disclosure of my PHI be restricted, and that the therapist is not required to agree to my request. If the therapist agrees to the restriction, that agreement will be honored. I understand that I may revoke this consent, except to the extent that information has already been disclosed.

Signature:_____**Date**_____

Legal Acknowledgments:
I understand that my therapist may be required by law to release information without my approval to legal authorities if 1.) there is a clear and serious danger of harm to anyone, 2.) a judge requires specific information in a court case, 3.) it is suspected that criminal offense of a child, disabled adult, or elderly abuse or neglect has occurred.

Signature:_____**Date**:_____

Payment Authorization:
1.) I understand that I am responsible for payment for any service rendered regardless of whether this service is covered by an insurance policy.
2.) I authorize insurance benefits payable to those health care providers described above for services rendered by them.
3.) I understand and agree to give 24 hours notice if unable to keep any appointment. I understand that if I fail to show for a scheduled appointment, or if I do not cancel with 24 hours notice, I will be charged a $50 no show fee/Late cancellation fee and will be responsible for payment of that fee.

Signature:_____**Date**:_____

Statement of Responsibility for Payment Regarding No Shows or Late Cancellations

_____

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I understand and agree to give 24-hours notice if I am unable to keep an appointment.

I understand and agree that after three consecutive cancellations, with or without 24-hours notice (or failure to show up for my scheduled appointment), I must speak with my therapist to schedule future appointments.

I understand and agree that if I fail to show up for my scheduled appointment, or if I do not cancel with 24-hours notice, I will be responsible for payment of my co-pay or a minimum of $50.00.

_____
Signature

_____
Date

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with:
_____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:
1)I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2)I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3)I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4)I understand that the privacy laws that protect the confidentiality of my protected health information(PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5)I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6)I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session.

If we are unable to discuss since we may reconnect within ten minutes, please call me at_____ have to re-schedule.

7)I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is:

_____ and my emergency contact person's name, address, phone:

_____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of Client/Parent/Legal Guardian Date

_____ _____

Signature of Therapist Date