Psych Pointe of Florida

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| FIRST NAME |  |  | M.I. | LAST NAME | |  |  |
| SEX: |  | DOB: | SOCIAL SECURITY NO. | |  | | |
| DRIVER'S LICENSE NO. |  |  | HOW DID YOU HEAR ABOUT US? | | |  |  |
| STREET ADDRESS: |  |  |  | | |  | ÄPT NO. |
| CITY: |  |  |  | ZIP CODE: | |  |  |
| HOME PHONE |  |  | May we leave a message? | | |  |  |
| CELL PHONE |  |  | May we leave a message? | | |  |  |
| WORK/OTHER PHONE |  |  | May we leave a message? | | |  |  |
| EMAIL ADDRESS | |  | May we email you? | | |  |  |
| EMPLOYER NAME(S) & ADDRESS(ES): | | | | | |  |  |

PATIENT INFORMATION

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| FIRST NAME | |  | |  | M.I. | LAST NAME | |
| RELATIONSHIP |  | | PHONE NUMBER | | | | |
| FIRST NAME | |  | |  | M.I | LAST NAME |  |
| RELATIONSHIP | |  | |  |  | PHONE NUMBER |  |

IF UNDER 18, NAME OF PARENT(S)GUARDIAN(S)

EMERGENCY CONTACT

|  |  |  |
| --- | --- | --- |
| NAME | RELATIONSHIP | PHONE NUMBER |

AUTHORIZATION & CONSENT FOR TREATMENT

By signing below, I hereby authorize the providers of this facility to provide treatment according to my medical diagnosis and/or mental health.



PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF UNDER 18) DATE: \_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| DATE OF INTAKE | PATEINT PROVIDER(s) | CHART ID NO. |

BILLING GUIDELINES: Please read the following information carefully and initial in the spaces provided to acknowledge you understand your responsibility.

* We will collect your deductible, copay, or percentage (if PPO) at the time of service. Please be prepared to pay with cash, debit card/credit card (Visa, MasterCard or Discover).
* Please bring all insurance information with you to your visit. Please be aware of your insurance benefits before you come into our office as it is ultimately your responsibility for anything not covered by insurance.
* You will need to contact your insurance company to find out if you need to obtain authorization for Mental Health services. If you obtain an authorization number, please bring it with you to your first visit.
* If your insurance changes, you will need to advise us immediately as your new insurance might not pay if the company requires an authorization for services.
* If your insurance company gives you a limited number of visits, you will need to keep track of how many of those visits you have used.

 Your insurance will send you an explanation of benefits defining what they have paid to our office. If you do not agree with the explanation of benefits, you will need to contact your insurance company.

* Please be aware that as a courtesy we try to call the 1-4 days before your appointment to remind you of your appointment; however, it is ultimately your responsibility to remember your own appointments. ALL APPOINTMENTS MUST BE CANCELED 24-HOURS IN ADVANCE OR GUARANTOR WILL BE CHARGED THE STANDARD OFFICE FEE. This includes any "no-show" appointments. This fee must be paid before seeing the doctor for your next visit.

ASSIGNMENT OF INSURANCE: Are you using your insurance for this visit and follow-ups? Yes \_ No\_

|  |  |  |
| --- | --- | --- |
| INSURANCE COMPANY: | PROVIDER TELEPHONE #: | |
| MEMBER ID #: |  | GROUP #: |
| PRIMARY INSURANCE HOLDER'S NAME |  | PRIMARY INSURANCE HOLDER'S DATE OF BIRTH |
| PRIMARY INSURANCE HOLDER'S SOC SEC # |  | PATIENT'S RELATIONSHIP TO PRIMARY INSURANCE HOLDER |
| AUTHORIZATION # (IF APPLICABLE) |  | AUTHORIZED # OF VISITS |

In making this assignment, I understand and agree that if payment is not received from my insurance company within 45 days of the date of service, I am aware that I am fully responsible for the entire balance.



# PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18) DATE: \_\_\_\_\_\_\_\_

SELF-PAYMENT AGREEMENT (IF NOT USING INSURANCE): I have agreed to accept full responsibility for payment of any charges incurred at this facility and I have agreed to pay for these services in full at time of service.



PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18) DATE: \_\_\_\_\_\_\_

# MEDICAL HISTORY

Please check all of these that you have now (present) and/or have had in the past. If it occurred in the past, please indicate the age when it was happening.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PRESENT | PAST | AGE |  | | PRESENT | PAST | AGE |  |
|  |  |  | head injury |  |  |  |  | bed-wetting/soiling |
|  |  |  | unconsciousness |  |  |  | arthritis |
|  |  |  | high fevers |  |  |  | back problems |
|  |  |  | loss of appetite |  |  |  | cancer |
|  |  |  | weight gain/loss |  |  |  | tuberculosis |
|  |  |  | frequent headaches |  |  | | stomach problems |
|  |  |  | seizures |  |  |  | liver trouble |
|  |  |  | fainting/dizziness |  |  |  | hepatitis/jaundice |
|  |  |  | stroke |  |  |  | kidney trouble |
|  |  |  | crying spells |  |  |  | bowel problems |
|  |  |  | heart trouble |  |  |  | bladder problems |
|  |  |  | rheumatic fever |  |  |  | diabetes |
|  |  |  | high blood pressure |  |  |  | thyroid problems |
|  |  |  | chest pain |  |  |  | unusual bleeding |
|  |  |  | asthma |  |  |  | gynecological problem |
|  |  |  | shortness of breath |  |  |  | premenstrual syndrome |
|  |  |  | hives/rashes |  |  |  | pos for AIDS antibody |
|  |  |  | sleep disorders |  |  |  | sexual dysfunction |
|  |  |  | nightmares |  |  |  | other: |
|  |  |  | night sweats |  |  |  | other: |

REASON FOR SCHEDULING YOUR APPOINTMENT TODAY:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MENTAL HEALTH TREATMENT HISTORY

DOCTOR or THERAPIST NAME/LOCATION DATES SEEN PROBLEM

## FROM TO

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

PAST HOSPITALIZATIONS

HOSPITAL NAME/LOCATION DATES SEEN REASON FOR HOSPITALIZATION

## FROM TO

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**1.Current Psychiatric Medications**: Are you currently prescribed psychiatric medication?

**If “Yes,” please list**. Yes\_\_\_\_No\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| MEDICATION | DOSAGE | HOW OFTEN | PRESCRIBING DOCTOR or OTC |
|  |  |  |
|  |  |  |  |
|  |  |  |  |

**2.Other Medications:** Are you currently taking any other prescription or over the counter (OTC) medications not listed above?   
**If “Yes,” please list**. Yes\_\_\_\_No\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| MEDICATION | DOSAGE | HOW OFTEN | PRESCRIBING DOCTOR or OTC |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**3. Prior Psychiatric Medication Trials:** Have you been tried on any previous psychiatric medications?   
**If “Yes,” please list**. Yes\_\_\_\_No\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MENTAL HEALTH HISTORY

In the section below, please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

## YES NO LIST FAMILY MEMBER (e.g. father, mother, sibling, etc.)

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol/Substance Abuse |  |  |  |
| Anxiety |  |  |  |
| Depression |  |  |  |
| Bipolar/Mania |  |  |  |
| Domestic Violence |  |  |  |
| Eating Disorders |  |  |  |
| Obesity |  |  |  |
| Obsessive Compulsive Disorder |  |  |  |
| Schizophrenia |  |  |  |
| Suicide Attempts |  |  |  |
| Other |  |  |  |

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

**LIMITS OF CONFIDENTIALITY:** Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follow:

* + - Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In case in which the client discloses or implies a plan for suicide, the healthcare professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

* + - Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child or vulnerable adult or has recently abused a child or vulnerable adult or a child or vulnerable adult is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

* + - Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

* + - Minors/ Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

* + - Insurance Providers (When Applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. The information that maybe requested include but is not limited to types of service, dates and times of service, diagnoses, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

By Signing Below, I agree to the above-mentioned limits of confidentiality, and I understand their meanings and ramifications:

**X**

**Patient Signature/Parent or Guardian if under 18 Date**

5979 Vineland Road, Suite 109, Orlando, FL 32819

Phone: 1-407-270-7702; Fax: 1-407-270-7705

Email: [PsychPointeFl@Gmail.com](mailto:PsychPointeFl@Gmail.com)

Syed Quadri, MD Randie Morillow, LCSW Michael Kellogg, LMHC

January 2016

Dear Patients:

This is a formal memo to all patients regarding new office policies and confirmation of previous policies that will be enforced as of January 2016.

* + - All letters needed from the doctor will have a fee of **$25.** All forms/paperwork needed **MUST** be approved by the doctor and will have a fee of **$200.** No Exceptions.
    - The doctor does **not** fill out anything for Disability/ Social Security benefits or anything court ordered.
    - If a patient runs out of medication and does not come in for their routine appointment with the doctor-upon approval from Dr. Quadri-there will be a

**$25** fee to call in medications to the pharmacy.

* + - If an appointment is cancelled the same day/less than 24 hours' notice, there will be a **$50** No-Show/Missed Visit fee. Please be advised, appointment reminder calls, when they occur, are a courtesy.
    - Be aware that the doctor may order a urine drug screen at any time based on treatment and medications.

By signing this memo, you agree to the above terms/policies of this practice.

**X**

**Patient Signature/Parent or Guardian if under 18 Date**

**HIPAA PRIVACY AND SECURITY POLICIES**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used for the following:

* + - Conduct, Plan, and Direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment - directly and indirectly.
    - Obtain payment from third-party payers.
    - Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations, and I understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

By signing below, I acknowledge that the Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time or visit our website, [www.milleniapysch.com,](http://www.milleniapysch.com/) to obtain a current copy of the Notice of Privacy Practices.

I have requested and received a copy of the organization's Notice of Privacy Practices.

OR

I have declined a copy of the organization's Notice of Privacy Practices.

**X**

**Patient Signature/Parent or Guardian if under 18 Date**

**MEDICATION CONSENT**

**NAME: DOB: \_\_\_\_\_\_**

**SSRIs/SNRIs**

Risks, benefits, and side effects-including risk of falls, nausea, weight gain, abdominal pain, cardiac arrhythmias, liver toxicity and liver failure, serotonin syndrome, teratogenicity, vomiting, and headaches-were discussed, and the patient gives full informed consent.

**ANTIPSYCHOTICS**

Risks, benefits, and side effects-including abdominal pain, nausea, QT prolongation, extrapyramidal symptoms (EPS), tardive dyskinesia (TD), abnormal involuntary movements (AIMs), metabolic syndrome, hyperprolactinemia, galactorrhea, gynecomastia, weight gain, vomiting, liver toxicity and liver failure, and headaches-were discussed, and the patient gives full informed consent.

**MOOD STABILIZERS**

Risks, benefits, and side effects-including falls, rash, Stevens-Johnson syndrome, metabolic syndrome, hyperprolactinemia, galactorrhea, weight gain, vomiting, renal/liver toxicity and renal/liver failure, and headaches-were discussed, and the patient gives full informed consent.

**STIMULANTS/WELLBUTRIN**

Risks, benefits, and side effects-including risks of falls, nausea, weight gain, abdominal pain, loss of sleep, loss of appetite, psychosis, palpitations, increased risk of sudden death, liver toxicity, and liver failure-were discussed, and the patient gives full informed consent.

**BENZODIAZEPINES/VISTARIL**

Risks, benefits, and side effects-including falls, nausea, vomiting, abdominal pain, drowsiness, tolerance, addiction, loss of appetite, psychosis, palpitations, increased risk of sudden death, liver toxicity, and liver failure-were discussed, and the patient gives full informed consent.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT’S NAME SIGNATURE DATE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT/GUARDIAN’S NAME SIGNATURE DATE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT/GUARDIAN’S NAME SIGNATURE DATE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESCIBER’S NAME SIGNATURE DATE**

**AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION**

**PATIENT NAME: DOB: \_\_\_\_\_\_**

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (IF MINOR PARENT”S NAME) authorize the PSYCH POINTE OF FLORIDA to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_release to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_obtain from:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_exchange with:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The following information pertaining to myself:**

**\_\_\_\_\_history/initial consultation**

**\_\_\_\_\_psychiatric evaluation/medication history**

**\_\_\_\_\_treatment summary and progress notes**

**\_\_\_\_\_diagnosis and lab reports**

**\_\_\_\_\_psychiatric and psychological test results**

**\_\_\_\_\_dates of treatment attendance**

**\_\_\_\_\_other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For:**

**\_\_\_\_\_evaluation/assessment and/or coordinating treatment efforts**

**\_\_\_\_\_ other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This consent will automatically expire Three (3) years after the date of my signature as it appears below, or on the following earlier date, condition, or event \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**Print name (if minor parent name) Signature of Client (if minor parent sign) Date**

A close-up of a questionnaire

Description automatically generated

A questionnaire with blue and white lines

Description automatically generated

A close-up of a document

Description automatically generated