**WELCOME TO OUR OFFICE**

|  |
| --- |
|   |

**A NEW PATH IN CHRISTIAN COUNSELING, INC. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1140 S. Semoran Blvd. Suite C. Orlando, FL 32807-1459. Phone: 407-271-8990 Fax: 407-271-8991**

**PATIENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  | Social Security Number: | Birth Date: | Marital Status : Single Married Widowed Divorced  |
| Street Address: | Apt Number: | City: | State: | Zip Code: |
| Home Phone: | Work Phone: | Cellular Phone: |
| Occupation/Student FT/PT | Are you above 18 Years of Age?Yes No  | If you are not 18 years of age, A parent or Guardian must sign these forms for consent to treat and financial responsibility. |

**GUARANTOR INFORMATION** *(Required if patient is under18 years of age)*

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  | Social Security Number: | Birth Date: | Day Time Phone: |
| Street Address: (If different from Child) | Apt Number: | City: | State: | Zip Code: |

**INSURANCE INFORMATION**

|  |  |
| --- | --- |
| Do You Have Medical Insurance?Yes No  | Type Of Insurance:HMO Medicare Medicaid PPO Worker’s Comp. Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Insurance Company: | Policy Number: | Group Number: | Authorization Number: |
| Insurance Company Claims Address: | Insurance Phone Number: | Relationship to Insured:Self Spouse Child Other\_\_\_\_\_\_\_\_ |
| Name of Policy Holder: | Date of Birth: | Social Security # | Address if different from patient: |
| Is the policy through an employer? Yes No  | Name of Employer: | Business Address: |
| Secondary Insurance?Yes No  | Secondary Insurance Company: | Policy Number:  | Group Number: |
| Secondary Claims Address: | Secondary Phone Number: | Relationship to Insured:Self Spouse Child Other\_\_\_\_\_\_\_\_ |

**CLINICAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| Known Allergies: | Primary Care Physician: | Physician Phone Number |
| Emergency Contact | Relationship to Patient: | Phone: |
| What is your chief complaint? |

 I declare all above information is true and authorize this office to release any information necessary to expedite insurance claims.

 I understand that I am responsible for all charges regardless of insurance coverage.

 Patient or Guarantor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**A NEW PATH IN CHRISTIAN COUNSELING, INC.**

Medication Consent Form

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_\_

I have been educated by my health care provider at A New Path in Christian Counseling Inc. regarding the medication that has been prescribed to € me, € my child, or € a person for whom I am the legal guardian, and I consent to the administration of this medication. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication and the possible effects of this medication if the person taking this medication becomes pregnant. I have also been informed of the reason or purpose for which this medication was prescribed.

Patient/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

* It is recommended that women who are or may become pregnant, or are breast-feeding, discuss this with their doctor before taking any medication.
* It is recommended that patients be educated on reporting all side effects they experience, including but not limited to, which side effects to report immediately to a health care provider.
* It is recommended that any provider prescribing medications obtain a thorough patient history that should include (buy may not be limited to)

1. What medications, including prescribed and over-the-counter medications, the patient is or has been taking.

 2. What food and drug allergies the patient has.

 3. What medical condition(s) the patient has.

The prescription which you have been given today is for a very specific purpose. As your physicians and health care providers, we are concerned that all medications be used appropriately. Medication refill requests should be made between the hours of 8 a.m. and 5 p.m., Monday through Friday (excluding holidays). It is advisable to call in two or three days in advance as only your physician or health care provider can authorize the refill. If you call in after hours or on a holiday, the physician who answers your call will not have your chart available and will be unable to refill your prescription.

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

Provider Signature

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

ON HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We use this information to decide on what treatment is best for you and to provide the treatment. There are circumstances when we may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

Our Notice of Privacy Practices explains in detail your rights and how we can use and share your information. They are posted in our waiting room and we will furnish a copy to your upon your request. By signing this form you are acknowledging that we have made this information available to you agree to the terms and conditions therein.

If you do not sign this consent from agreeing to the terms our Notice of Privacy Practices, we cannot treat you. If you are concerned about some of your information, you have the right to ask us not to use it for treatment, payment, or administrative purposes. You will have to tell us specifically what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish to the extent that the law requires.

PATIENT’S ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maiden or other name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that A New Path in Christian Counseling Inc. has made a copy of their Notice of Privacy Practices available to me effective January 1, 2009.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment, and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature (patient or authorized representative): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship/Authority (if signed by authorized representative):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s Assignment and Release**

INFORMED CONSENT FOR TREATMENT: I, the patient/guarantor, agree and consent to participate in mental health care services offered by **A New Path in Christian Counseling Inc.** I understand that I am consenting and agreeing only to those services that the above named group’s providers are qualified to provide within: (1) the scope of the provider’s license, certification, and training; or (2) the scope of the license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and or/legally authorized to initiate and consent to treatment on behalf of this individual.

RELEASE OF INFORMATION: The undersigned hereby authorizes any Physician/Nurse Practioner /Therapist who have attended the patient to furnish any potentially liable insurance companies or their representatives with any and all information concerning hospitalization, treatment, interpretation and/or examination that may be contained in their medical records.

ASSIGNMENT OF INSURANCE BENEFITS: As undersigned, I hereby authorize direct payment to any involved Healthcare Providers of the benefits otherwise payable to the patient or guarantor. I also assign any and all rights to insurance coverage relative to this treatment, but not to exceed the regular charges for consultation, treatment, interpretation and/or examination.

FINANCIAL RESPONSIBILITY: As undersigned, I understand that I am responsible for any service rendered by a Physician/Therapist, regardless of whether this service is covered by an insurance policy. I understand that payment is due at the time of service unless other arrangements have been made in advance. The accepted methods of payment are Cash, Visa, MasterCard, and Discover. If my insurance companies require pre-certification, I understand that I am responsible for obtaining the initial authorization. If the insurance does not pay for the services received, I will be responsible for such charges.

 **Any missed or canceled appointments without a minimum of 24 hrs will result in a $25.00 late/no show fee.**

CONFIRMATION OF APPOINMENTS: At **A New Path in Christian Counseling Inc.,** one of our top priorities is to maintain our patients’ confidentiality. As we call to confirm your future appointments, please indicate below which telephone number you would prefer us to use or provide us with your e-mail.

Telephone number to confirm appointments: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Patient/Guarantor Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor Name and relationship (If applicable) Witness

PRIMARY CARE PHYSICIAN

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This form will allow your Behavioral Health Provider to share protected health information with your Physician. This information will not be released without your signed authorization. This protected health information may include diagnosis, treatment plan, progress, lab reports, and medication if necessary. You are not required to complete this authorization form.

I hereby authorize:

A NEW PATH IN CHRISTIAN COUNSELING, INC.

1140 S. Semoran Blvd. Suite C

Orlando, FL 32822

Tel: 407-271-8990 Fax: 407-271-8991

To release confidential protected health information, including personal, psychological, psychiatric, substance abuse, AIDS-related information, medical records, and opinions resulting from my contact with them for the purpose of providing coordination and continuity of care, to:

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

Physician Name

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

Address

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

City/State/Zip

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

Phone Fax

I understand that this consent is revocable upon written notice to the facility, except to the extent that action has already been taken by the facility pursuant to this authorization. This consent shall remain in force for twelve months.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Patient Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Signature - Patient, Custodial Parent, Date Signed

Custodial Guardian or Power of Attorney

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Witness Date Signed

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize and request:

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

Name

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

Address

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

City/State/Zip

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

Phone Fax

To release confidential professional information, including personal, psychological, psychiatric, substance abuse, AIDS-related information, medical records, and opinions resulting from my contact with them, to:

A NEW PATH IN CHRISTIAN COUNSELING, INC.

1140 S. Semoran Blvd. Suite C

Orlando, FL 32822

Tel: 407-271-8990 Fax: 407-271-8991

The request specifically includes the following:

€ Summary (Specify inclusions and exclusions) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ Psychiatric Evaluation

€ Progress Notes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ Lab Reports

€ Authorization for communication between A NEW PATH IN CHRISTIAN CONSELING INC. and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ regarding all aspects of my treatment, diagnosis, and prognosis.

 € Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this consent is revocable upon written notice to the facility, except to the extent that action has already been taken by the facility pursuant to this authorization. This consent shall remain in force for twelve months.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Patient Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Signature - Patient, Custodial Parent, Date Signed

Custodial Guardian, or Power of Attorney

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Witness Date Signed