

Florida Psychological Associates, LLC

Client Registration

***Instructions****: Please fill in this form as completely as possible. Fill in all blanks and check the appropriate boxes. If you need help with the form, don’t hesitate to ask a FPA staff member for assistance***.**

**Client Information CID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle Suffix (Jr. Sr.)

 Are you known by any other name? No Yes

 If Yes, please write other name below:

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

Last First Middle Suffix (Jr,,Sr.)

**Address/Phone Numbers:**

Residence (1): Mailing (2):

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

Street Address Apt, Lot, Suite # Street Address / PO Box Apt, Lot, Suite #

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

City State Zip City State Zip

Social Security#: \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ -\_\_\_ \_\_\_ \_\_\_ \_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Phone: Cell: ( ) \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ Alternate: ( ) \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_

**Related Persons/Guardian/Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a citizen of the United States? [ ]  No [ ]  Yes

**Marital Status:** [ ]  Single [ ]  Married [ ]  Remarried [ ]  Separated [ ]  Divorced/Annulled [ ]  Widowed [ ]  Other

**Race:** [ ]  Caucasian/White [ ]  Black/African American [ ]  Hispanic [ ]  American Indian/Alaskan Native [ ]  Asian [ ]  Native Hawaiian or other Pacific Islander [ ]  Multi-Racial

**Ethnicity:** [ ]  None [ ]  Puerto Rican [ ]  Mexican [ ]  Cuban [ ]  Other Hispanic [ ]  Haitian [ ]  Other

**Special Accommodations Needed:** [ ]  None [ ]  Visually Impaired [ ]  Hearing Impaired

[ ]  Mobility Impaired [ ]  Other

**Veteran Status:** [ ]  Not a Veteran (NOT) [ ]  Active Duty (ACT) [ ]  Reserve (RES) [ ]  Honorable Discharge (HON) [ ]  Dishonorable Discharge (DIS) [ ]  Veteran (VET) [ ]  Disabled Veteran (DSB) [ ]  Vietnam Era Veteran (VIE) [ ]  Vietnam Disabled Veteran [ ]  Medical Discharge (MED) [ ]  Retired (RET)

[ ]  Other Discharge Status (OTH)

**Client Employment Status:** [ ]  Full Time [ ]  Part Time [ ]  Unemployed [ ]  Searching for employment [ ]  Receiving unemployment [ ]  Disabled [ ]  Retired [ ]  Student [ ]  Unknown [ ]  Other

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who Referred You to Florida Psychological Associates, LLC?**

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

Name Organization/Relationship Date of Referral

**Please read and sign the following:** Waiver: I confirm that the information on this form is accurate and complete to the best of my knowledge. I am aware that failure to provide complete, accurate, and current information may affect the fees I am personally responsible to pay associated with services rendered. I consent to the release of my behavioral health protected health information, which may include psychiatric, psychological, substance abuse and/or HIV/AIDS information for service authorization, treatment, payment and administrative healthcare tasks, required to obtain insurance or other payer benefits on my behalf and the assignment of these benefits to Florida Psychological Associates, LLC., for the services provided to me. I understand that if my insurance is accepted I will be billed for co-insurance and deductible. I also understand that if my insurance does not pay 100% of the cost of the service(s) billed, I am required to pay the balance for billed fees. I give Florida Psychological Associates, LLC., my permission to bill my insurance and receive payment on assignment.

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

Signature of Client or Legal Representative Date

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

Signature of Witness Date

**Informed Consent for Behavioral Health Services**

**Consent & Authorization for Services & Condition of Admission**

Thank you for seeking our services. This document covers important information about our professional practices and business policies. Please review it carefully and ask me any questions that you may have. Consent for services applies to this organization only and does not extend to any collaborating community partner, contract, or provider organization. Please review each category below and initial on each line acknowledging that you have read and understand the information provided:

**Please check which services you consent to receive:**

\_\_\_\_\_\_ Initial Consultation

\_\_\_\_\_\_ Psychological Evaluation and Testing

\_\_\_\_\_\_ Psychological Evaluation

\_\_\_\_\_\_ Parental Fitness Evaluation

\_\_\_\_\_\_ Psychological Feedback

\_\_\_\_\_\_ Psychotherapy Individual/Group/Couples/Family

\_\_\_\_\_\_ Psychoeducational Group

\_\_\_\_\_\_ Peer Support

\_\_\_\_\_\_ Psychiatric Services/Tele-Health

\_\_\_\_\_\_ Medication Management Services

\_\_\_\_\_\_ Urinalysis

\_\_\_\_\_\_ Other – Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o **Informed Consent**: I give my informed consent to voluntarily participate in Florida Psychological Associates, LLC., behavioral health services. I understand that behavioral health services are not an exact science, and no guarantees are being made relative to the outcome of the services and or recommendations for services. I have the right to refuse services, and to have the consequences of such refusal fully explained to me. I agree to follow all program rules and guidelines, and I understand that failure to do so may result in termination from services. I agree to comply with service/treatment requirements for a medical history, physical examination, laboratory tests, and other behavioral health services. I voluntarily consent to intake and admission to behavioral healthcare services with Florida Psychological Associates, LLC (FPA). \_\_\_\_\_\_\_

o **Confidentiality:**

The law and professional ethics require us to keep client information confidential. This means that, generally, we cannot share your health information without your written authorization and we will strive to protect your privacy. \_\_\_\_\_\_\_

o **Limits of Confidentiality:**

\_\_\_\_\_If we believe you are threatening serious bodily harm to another, we are required to take protective action. This may include notifying the potential victim, contacting the police, or seeking hospitalization.

\_\_\_\_\_If we believe you are at risk of causing severe harm to yourself, we may be obliged to seek hospitalization for you, or to contact members or others who can help provide protection.

\_\_\_\_\_If we have reasonable suspicion that any child, elderly person, or incompetent person is being abused or neglected, the law requires that we report this to the appropriate county agency.

\_\_\_\_\_ If a court of law orders us to release information, we are required to provide that to the court.

\_\_\_\_\_If you are or become involved in any kind of lawsuit or administrative procedure where the issue of your mental health is involved, you may not be able to keep the records private in court.

\_\_\_\_\_\_In order to provide you with the best treatment, we may seek consultation from another licensed behavioral health professional on our team. In these consultations, we make every effort to avoid revealing your identity. The consultant is also legally bound to keep the information confidential, although the exceptions to confidentiality apply to them as well.

\_\_\_\_All team members who are registered interns with the State Department of Health, have earned a field-specific graduate degree, and are working on licensure requirements for the state of Florida licensure. Additionally, all registered interns as previously described, are under the supervision of a licenses professional credentialed as a qualified supervisor by the State of Florida, and are required to discuss all of assigned cases on a weekly basis.

o **Release of Information:** FPA may disclose all or any part of the client record to any person or corporation which is or may be liable under a contract to FPA, or the Client, or to a family member of Client, all or part of the facility charges. FPA may further disclose all or said part of the Client’s record to the referring doctor, hospital, clinic, and in case of minors, may disclose aftercare forms to the Client’s school system, Probation and Parole, and others as specified by the case. \_\_\_\_\_\_\_

o **Abuse Reporting Procedure and Contact Information:** You have the right to contact the Department of Children and Families if you believe your rights have been violated. No patient will be discouraged or prevented from doing so. There are also outside agencies that may be able to help with your complaint. The Florida Abuse Hotline handles abuse and neglect complaints. The Florida Local Advocacy Council is made up of volunteers appointed by the Governor of Florida to investigate complaints against Department of Children and Families provider services. The Agency for Health Care Administration investigates complaints against facilities. The Department of Health takes complaints against licensed professionals such as doctors, nurses, clinical social workers or anyone who is licensed by the State of Florida but you must contact the Agency for Health Care Administration to file the complaint. I confirm receipt of this information and respective contact numbers I can use to file a complaint. \_\_\_\_\_\_\_

o **Emergencies:** If you are experiencing an emergency, please call 911, go to the nearest hospital emergency room, or call 1-800-273-TALK. Please also call us and let us know the nature of your situation as soon as you are able. \_\_\_\_\_\_\_

#### o **Patient Safety:** I understand and will follow the instructions for Patients regarding emergency evacuation procedures. I agree to hold Florida Psychological Associates, LLC., its staff and Leadership Team, harmless in the event of any loss and/or injury to my person and/or property while in services/treatment or on the premises of Florida Psychological Associates, LLC. \_\_\_\_\_\_\_

o **Conditions of Treatment:** I acknowledge and understand that that the practice of behavioral healthcare services is not an exact science and that there are no promises or guarantees have been made to me regarding the final outcome of my treatment by FPA and I do hereby absolve FPA from any liability in the event its treatment of my person is unsuccessful either in the short or long term or any events that may due to my Behavioral Health services and/or treatment. \_\_\_\_\_\_\_

o **Authorization for Treatment**: I know that I have voluntarily enrolled in FPA and do herby voluntarily consent to such care-encompassing procedures and treatment by FPA that it’s CEO, employees, medical director and designees deem necessary in their professional judgment. \_\_\_\_\_\_\_

o **Initial Consultation:** During our initial session, we will provide you with an overview of the organization and our system of care. We will conduct an evaluation of your needs and goals and then provide you with our initial impressions and recommendations for treatment. After the initial consultation, you are free to decide if you would like to begin treatment with us, or if we determine that we are not the best fit for you, we will be happy to provide an appropriate referral. \_\_\_\_\_\_

o **Client Rights and Responsibilities:** I confirm receipt and understanding of FPA Client Rights and Responsibilities. \_\_\_\_\_\_\_

o **Rules & Regulations:** I agree to comply with and abide by the policies, rules, and regulations of FPA and related services. \_\_\_\_\_\_\_

o **Personal Property:**  FPA shall not be liable for the loss or damage to any personal property to include but not limited to money, jewelry, eyeglasses, contact lenses, dentures, documents, or other articles of value. \_\_\_\_\_\_\_

o **Code of Ethics:** Employees of Florida Psychological Associates, LLC shall use their expertise in a way that promotes growth and health while protecting the welfare of the individual, the community and the field of behavioral health care. Employees are responsible for delivering the “gold standard” of care in the most humane manner using the least restrictive practices available. \_\_\_\_\_\_\_

o **Communication:** The therapist-client relationship is unique. We have a legal and ethical obligation to keep what you share with us private and confidential, to promote candid and complete communication. We are only able to provide you with truly beneficial services if we are aware of all information that might be relevant to your care. If you have questions or concerns about our services, please let us know. \_\_\_\_\_\_\_

o **Cellular Phone, Texting and/or E-mail Communication Consent**: I hereby authorize the use of cellular phone, texting and/or e-mail communications with me for the purposes of appointment reminders, treatment and/or continuing care sessions and to assist the program staff in locating me for conducting required follow-ups.I understand that this authorization is voluntary. I understand that if the cellular phone gets lost, stolen or misplaced; the released information may no longer be protected by federal privacy regulations. \_\_\_\_\_\_

 \_\_\_\_\_\_ Text for appointments, pro-social activities, and/or required post treatment follow-up reminders

 \_\_\_\_\_\_ Phone calls for treatment and or continuing care sessions, and or reminders

 \_\_\_\_\_\_ E-mails for appointments, pro-social activities, and or required post treatment follow-up reminders

 \_\_\_\_\_ Other forms of communication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o **Complaint Policy and Appeal Procedure:** I confirm receipt and understanding of the FPA Complaint Policy and Appeal Procedure. \_\_\_\_\_\_\_

o **Infection Control Procedure:** I confirm receipt and understanding of the FPA Infection Control Policy and Procedure. \_\_\_\_\_\_\_

o **Alcohol/Drug Screen Consent:** I understand that I may be asked to provide a urine, breath or saliva sample at any time so that it may be tested for the presence of unauthorized drugs and/or alcohol. This testing is done to assist in treatment planning and verify compliance with treatment rules. When asked to provide a urine sample I may be observed by a staff member of the same gender to insure the integrity of the sample. This request may be made at random, or as the result of a reasonable suspicion that I may have used alcohol and/or other drugs. If I have been ordered to treatment by the court, the results of the urinalysis may be provided to authorized representatives of the court. I further understand that part of the treatment offered by FPA may require my submitting to urinalysis for drug/alcohol content, psychological testing and other such similar procedures and that the consent that I have given in this document shall include, but not limited to, the same. The results of urinalysis will be used for treatment planning purpose and will not be released without Client consent. Federal regulations prohibit making any further disclosure of this information unless expressly permitted by written consent of the person whom it pertains or as otherwise permitted by CFR 42, part 2. \_\_\_\_\_\_\_

o **Consent for Therapeutic Photograph**: I consent to allow my child to be photographed by FPA staff upon admission. These photographs are to remain as part of the permanent medical record and not otherwise disseminated without client specific consent. It is the policy of FPA that the photo and camera surveillance is for therapeutic purposes and will be conducted upon consent of the client and only with approved equipment. \_\_\_\_\_\_\_

o **Psychological Feedback and Report:** Following psychological evaluation and testing, I give my permission to Florida Psychological Associates, LLC (FPA) to contact me to schedule an appointment for report review and discussion of findings. I understand that I am required to schedule and confirm the follow up appointment within 30 days of initial follow up contact. Furthermore, I understand that my failure to schedule and confirm within the above noted 30 days will release FPA from any and all obligation to provide me a copy of the written report and/or discussion of findings. \_\_\_\_\_\_\_

o **ePrescribe Authorization:** ePrecribing is defined as a physician/psychiatrist/ARNP's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

* **Formulary and benefit transactions** -Gives the prescriber information about which drugs are covered by the drug benefit plan.
* **Medication history transactions** - Provides the physician/psychiatrist/ARNP with information about medications the patient is already taking to minimize the number of adverse drug events.
* **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

I hereby authorize FPA to access, review, and transmit behavioral health information electronically \_\_\_\_\_\_\_.

**ACKNOWLEDGMENT AND CONSENT**

In consideration of the acceptance of the undersigned for voluntary care by FPA, I do hereby waive, release and indemnify FPA, it’s officers, agents, employees and professional associates of all any kind of liability (legal,

financial, medial, and otherwise) for any claim of loss or damages, because of any injuries, direct or indirect which may occur to me or to my family or friends, or for loss, damage or theft of any of my personal property during my enrollment, whether or not the professional associates, and whether or not such injury, loss of damage occurs on or off the premises or in or out of a vehicle, surveillance or supervision of FPA or its officers, agents, employees or professional associates. I certify that I am capable of mentally and physically sustaining my life.

The undersigned certifies to understand and agree to above, receiving a copy thereof, and is the Client, or is duly authorized by and on behalf of the Client to execute the above and accepts its terms personally and upon the

Client’s behalf. I voluntarily agree to receive psychological services from Florida Psychological Associates, LLC. I understand and agree that I will participate in the planning of my care and that I may discontinue participation in services with FPA at any time.

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

Client Signature Date

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

Parent/Guardian Signature Date

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have met with this client and parent/guardian and have reviewed the above information. I believe this person has full understanding and is fully competent to give informed consent.

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

FPA Representative Signature & Credentials Date

**Medical History & Screening**

This is your medical history form, to be completed prior to your intake session. All information will be kept confidential. This information will be used for the evaluation of your health, wellness and related service needs. The form is extensive, but please try to complete as accurately as possible.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Client Signature & Date Staff Signature, Credentials & Date

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

Qualified Supervisor & Date

## General Information

Family Physician and/or Primary Health Care Provider:

Doctor/Other Phone

Address City

## Present Medical History

Check those questions to which you answer yes (leave the others blank).

* Has a doctor ever said your blood pressure was too high?
* Do you ever have pain in your chest or heart?
* Are you often bothered by a thumping of the heart?
* Does your heart often race?
* Do you ever notice extra heartbeats or skipped beats?
* Are your ankles often badly swollen?
* Do cold hands or feet trouble you even in hot weather?
* Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
* Do you suffer from frequent cramps in your legs?
* Do you often have difficulty breathing?
* Do you get out of breath long before anyone else?
* Do you sometimes get out of breath when sitting still or sleeping?
* Has a doctor ever told you your cholesterol level was high?
* Has a doctor ever told you that you have an abdominal aortic aneurysm?
* Has a doctor ever told you that you have critical aortic stenosis?

Do you now have or have you recently experienced?

* Chronic, recurrent or morning cough?
* Episode of coughing up blood?
* Increased anxiety or depression?
* Problems with recurrent fatigue, trouble sleeping or increased irritability?
* Migraine or recurrent headaches?
* Swollen or painful knees or ankles?
* Swollen, stiff or painful joints?
* Pain in your legs after walking short distances?
* Foot problems?
* Back problems?
* Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea?
* Significant vision or hearing problems?
* Recent change in a wart or a mole?
* Glaucoma or increased pressure in the eyes?
* Exposure to loud noises for long periods?
* An infection such as pneumonia accompanied by a fever?
* Significant unexplained weight loss?
* A fever, which can cause dehydration and rapid heart beat?
* A deep vein thrombosis (blood clot)?
* A hernia that is causing symptoms?
* Foot or ankle sores that won’t heal?
* Persistent pain or problems walking after you have fallen?
* Eye conditions such as bleeding in the retina or detached retina?
* Cataract or lens transplant?
* Laser treatment or other eye surgery?
* Disrupted sleep?
* Insomnia?

List any prescription medications you are now taking to include medication name, dose, and prescribing doctor:

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:

Date of last complete physical examination:

Results:

 Normal Abnormal Never Can’t remember

List any drug allergies:

## Past Medical History

Check those questions to which your answer is yes (leave others blank).

* Heart attack if so, how many years ago? \_\_\_\_\_\_\_\_
* Rheumatic Fever
* Heart murmur
* Diseases of the arteries
* Varicose veins
* Arthritis of legs or arms
* Diabetes or abnormal blood-sugar tests
* Phlebitis (inflammation of a vein)
* Dizziness or fainting spells
* Epilepsy or seizures
* Stroke
* Diphtheria
* Scarlet Fever
* Infectious mononucleosis
* Nervous or emotional problems
* Anemia
* Thyroid problems
* Pneumonia
* Bronchitis
* Asthma
* Abnormal chest X-ray
* Other lung disease
* Injuries to back, arms, legs or joint
* Broken bones
* Jaundice or gall bladder problems

## Familial Diseases

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those to which the answer is yes (leave other blank).

* Heart attacks under age 50
* Strokes under age 50
* High blood pressure
* Elevated cholesterol
* Diabetes
* Asthma or hay fever
* Congenital heart disease (existing at birth but not hereditary)
* Heart operations
* Glaucoma
* Obesity (20 or more lbs. overweight)
* Leukemia or cancer under age 60

Do you ever drink alcoholic beverages?

\_\_\_\_ Yes \_\_\_\_ No

If yes, what is your approximate intake of these beverages?

**Beer**:

\_\_\_\_ None \_\_\_\_Occasional \_\_\_\_ Often If often, \_\_\_\_\_ per week

**Wine:**

\_\_\_\_ None \_\_\_\_ Occasional \_\_\_\_\_ Often If often, \_\_\_\_\_ per week

**Hard Liquor:**

\_\_\_\_ None \_\_\_\_ Occasional \_\_\_\_ Often If often, \_\_\_\_\_ per week

At any time in the past, were you a heavy drinker (consumption of six ounces of hard liquor per day or more)?

\_\_\_Yes \_\_\_ No

**Cancellation/No Show Policy**

1. Patients will be held responsible for any scheduled appointment time they make with the organization.  In the event of cancellation of an appointment; the patient will be assessed a fee (up to full fee for the scheduled respective service) for each cancellation not received by the office no less than 24-hours before the scheduled appointment.  The exception to this policy is Medicaid clients.  Medicaid recipients cannot be charged for missed or cancelled appointments.

1. This policy may be waived due to certain exceptions which are listed:  Illness, with documentation from patient as required; death in family; or other extenuating circumstances. It is the policy of this organization that a patient may request a No-Show Fee Wavier but the no-show fee may only be waived once in a 12-month period.

1. Authority to charge for no-show fees is held by front office staff upon cancellation received within approved policy guidelines or true no-show for scheduled appointment.

1. Patients will be reminded of their no-show fees charged and requested to pay the no-show fee at their next appointment along with their other existing fees.

**Acknowledgement of Cancellation/ No Show Agreement**

**Client Signature Date**

**Parent/Guardian Signature Date**

**FPA Representative Signature & Credentials Date**