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: _____

PATIENT QUESTIONNAIRE

Name: Age: Marital status:

Occupation: Place of employment

If a student, Grade level: School:

Lives with:

Who referred you to us?

Please check all that apply:

☐ depressed mood	☐ suicidal thoughts	☐ obsessions	☐ alcohol abuse	☐ bedwetting
☐ anxiety	☐ homicidal thoughts	☐ rituals	☐ drug abuse	☐ soiling
☐ lack of interest	☐ self destructive acts	☐ hallucinations	☐ seizures	☐ learning problems
☐ decreased sleep	☐ poor concentration	☐ delusions	☐ blackouts	☐ delayed development
☐ increased sleep	☐ mood swings	☐ trauma	☐ DTs	☐ mental retardation
☐ decreased appetite	☐ muscle tension	☐ flashbacks	☐ hyperactivity	☐ other:_____
☐ increased appetite	☐ panic attacks	☐ nightmares	☐ impulsivity	☐ other:_____
☐ guilt	☐ headaches	☐ dissociation	☐ inattention	☐ other:_____
☐ social withdrawal	☐ stomach aches	☐ gambling	☐ distractibility	☐ other:_____
☐ hopelessness	☐ muscle aches	☐ lying	☐ explosive temper	☐ other:_____
☐ helplessness	☐ back pain	☐ phobias	☐ poor frustration	☐ other:_____

Duration of condition:

Triggers/stressors:

List all current medications and dosages with name of prescribing physician:

Allergies:

Medical illnesses:

Are you on medical leave? N/Y by whom/when?

Are you in counseling? N/Y If yes, name of counselor:

List all psychiatric hospitalizations and dates:

History of physical abuse N/Y (by whom/when?)

History of domestic violence N/Y (by whom/when?)

History of drug/alcohol or cigarette use? N/Y describe:

Do you currently use alcohol, drugs, or cigarettes? N/Y describe:

History of legal problems N/Y (details, when?)

Are you on probation N/Y If yes, name of Probation Officer

Where were you born? Raised in?

How many brothers? Sisters? Birth Order?

Parents Divorced? If yes, how old were you then?

Signature (Patient/Parent/Legal Guardian) Printed Name Date

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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 behavioral 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.

After two missed or canceled appointments with a minimum of 24 hrs will result in a discharge.

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.

Telephone number to confirm appointments: (_____) _____ - _____

_____ 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, Custodial Guardian or Power of Attorney Date Signed

_____ _____/____/_____
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:

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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, Custodial Guardian, or Power of Attorney Date Signed

_____ _____/____/_____
Witness Date Signed