NORTH FLORIDA
LEARNING & BEHAVIORAL HEALTH

ADULT INTAKE

Patient Name: _____ Birthdate: ____/____/____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____)_____ Cell Phone: : (____)_____ Gender: ☐ Female ☐ Male

Email Address: _____

How did you hear about us? ☐ Online search ☐ Family/Friend ☐ Physician Referral ☐ College Student Services

Reason you are seeking services:

_____

_____

_____

_____

PATIENT HISTORY:

Present psychological difficulties – please check any that apply to you at this time.

_____ Generalized anxiety (across many situations)
_____ Specific fears/phobias (list): _____
_____ Panic attacks
_____ Social anxiety
_____ Obsessive thinking or compulsive behaviors
_____ Sadness or depression
_____ Emotionally overwhelmed
_____ Frequent crying
_____ Loss of energy
_____ Loss of pleasure in life
_____ Self-injurious / Self-harm behavior (e.g. hair pulling, cutting self, etc.)
_____ Thoughts of suicide
_____ Problems with eating
_____ Problems falling asleep
_____ Problems sleeping through the night (middle of night waking or early morning waking)
_____ Trouble waking up
_____ Nightmares
_____ Fatigue/tiredness during the day
_____ Problems with attention or concentration
_____ Racing thoughts
_____ Problems making or keeping friends
_____ Problems controlling temper
_____ Relationship/Marriage problems
_____ Problems with intimacy
_____ Problems with job
_____ History of abuse (emotional, physical, sexual)
_____ Alcohol/drug use/abuse
_____ Financial problems
_____ Legal situation

Other (please list below):

_____

_____

Describe any previous mental health services you have received (evaluations and therapy). Include the provider, diagnosis, and length of treatment.

_____
_____
_____
_____

What do you wish to accomplish (what are your goals) in seeking services at this time?

_____
_____
_____
_____

Please rate the overall level of stress in your life:

☐ Very low ☐ Low ☐ Average ☐ High ☐ Very High

What is your greatest source of stress at this time?

_____
_____

Rate your overall level of happiness on a scale of 1-5 (1=Unhappy, 5=Happy) _____

FAMILY INFORMATION:

Marital Status (check one):

☐ Single ☐ Living with partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If separated, how long? _____ If Married, how long? _____

Rate quality of present relationship/marriage (if applicable):

☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very poor

Your occupation: _____

Occupation of spouse/partner: _____

Other persons (in the home):

Name	Relationship	Age	Occupation	Education

Other significant people to you (outside the home):

Name	Relationship	Age	Occupation	Education

If divorced, what are the custody and/or visitation arrangements?

_____
_____
_____

GENERAL HEALTH:

Your current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Primary Physician's name/address/phone number:

_____
_____
_____

Date of last physical exam? Any relevant findings?

_____
_____

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (allergies, surgeries/hospitalizations, asthmas, ulcers, hypertension, diabetes, heart disease, cancer, etc.):

_____
_____
_____
_____

Medications, Supplements

List prescriptions or non-prescription medications you are currently taking. If you are taking health supplements, please include those as well:

Medication	Reason placed on med	Dosage	Length of time on med	Prescribing physician

Substance Use History

List any recreational drugs (including alcohol) you are currently using or have used in the past:

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Amphetamines					
Hallucinogens					
Other					

Are you able to stop drinking or using drugs after having a moderate amount? ☐ Yes ☐ No

After drinking/using drugs for a period of time, have you ever had any of the following experiences?

☐ A hangover
☐ Nausea or vomiting
☐ The shakes
☐ Blackouts (can't remember)
☐ Feelings of fear and anxiety
☐ Convulsions or seizures
☐ DTs
☐ Getting arrested
☐ Losing friends
☐ Losing job or jobs
☐ Divorce or separation
☐ Financial problems
☐ Serious medical problems
☐ Depression

FAMILY HISTORY:

Has anyone in your birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child):

Yes	Condition	Family Member
	Intellectual Disabilities	
	Speech or communication disorder	
	Attention-deficit / Hyperactivity / Impulsivity	
	Learning problems / disabilities	
	Autism spectrum / Asperger's Disorder	
	Sleep disorders	
	Generalized Anxiety (across many situations)	
	Social Anxiety	
	Obsessive-compulsive disorder	
	Phobias	
	Depression	
	Manic-depression / Bipolar disorder	
	Suicide attempts / suicide	
	Schizophrenia or other psychosis	
	Alcohol / Substance abuse	
	Seizures and other neurological disorder	
	Genetic disorder (e.g. Down Syndrome, Fragile X)	
	Other: (please list on back if necessary)	

EDUCATIONAL HISTORY:

Your highest level of education completed: _____

Have you had any problems with attention, learning or behavior in school?

_____

_____

_____

Grades repeated and reason:

_____

_____

_____

Served in Special Education?

_____

_____

_____

Additional comments:

_____

_____

_____

LEGAL HISTORY:

Have you ever filed or been involved in any litigation? Please explain.

_____

_____

_____

PROBLEM CHECKLIST

(Make a check mark next to any problems you are having)

- ☐ Convulsions
- ☐ Sleep disturbances
- ☐ Numbness
- ☐ Dizziness
- ☐ Joint pain
- ☐ Unable to relax
- ☐ Hear sounds/see visions
- ☐ Fainting spells
- ☐ Stomach trouble
- ☐ Bowel disturbances
- ☐ Insomnia
- ☐ Take sedatives
- ☐ Feel tense
- ☐ Tremors
- ☐ Drugs
- ☐ Unable to have a good time
- ☐ Over-ambitious
- ☐ Can't make friends
- ☐ Can't make decisions
- ☐ Inferiority feelings
- ☐ Financial problems
- ☐ Tingling
- ☐ Suicidal attempts
- ☐ Sexual problems
- ☐ Don't like weekends/vacations
- ☐ Shy with people
- ☐ Feel lonely
- ☐ Can't keep a job
- ☐ Home conditions bad
- ☐ Weight loss
- ☐ Weight gain
- ☐ Difficulty walking
- ☐ Crying spells
- ☐ Paralysis
- ☐ Loss of interest in work/hobby
- ☐ Sadness
- ☐ Headaches
- ☐ Palpitations
- ☐ No appetite
- ☐ Fatigue
- ☐ Nightmares
- ☐ Alcoholism
- ☐ Feel panicky
- ☐ Depressed

Patient Signature: _____

Date:_____

NORTH FLORIDA
LEARNING & BEHAVIORAL HEALTH

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE PERTAINS TO THE PRACTICES OF NORTH FLORIDA LEARNING & BEHAVIORAL HEALTH, LLC. THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE AND ALL OF THESE RIGHTS MAY NOT APPLY TO YOU IN SOME CIRCUMSTANCES WHICH ARE NOT COVERED BY FEDERAL HIPAA REGULATIONS. YOU MAY BE PROTECTED UNDER OTHER FEDERAL AND STATE LAWS.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

_ "PHI" refers to information in your health record that could identify you.

_ "Treatment, Payment and Health Care Operations"

- Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
- Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

_ "Use" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

_ "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

We would also need to obtain an authorization before releasing your "psychotherapy notes". "Psychotherapy notes" have a very limited definition under HIPAA rules, and would be notes made about analyses of conversations during a private, group, joint, or family counseling session, which would be kept separate from the rest of your medical record. It is our office practice not to keep "psychotherapy notes" under this definition. Your diagnosis and relevant treatment information, symptoms complaints and information about progress are maintained in "Progress Notes" which document your care.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If we know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that we report such knowledge or suspicion to the Florida Department of Child and Family Services.
- Adult and Domestic Abuse: If we know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, we are required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- Health Oversight: If a complaint is filed against us with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from us relevant to that complaint.

Government: We may disclose the PHI information of military personnel and veterans to government benefit programs relating to eligibility and enrollment.

Impaired Professionals: We may disclose information pertaining to the safety to practice to the Florida Department of Health for health care professionals if we have reasonable reason to believe public safety is endangered or where there would be a statutory duty to report.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform us that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, we may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.
- Worker's Compensation: If you file a worker's compensation claim, we must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons

Litigation: If you have a pending personal injury claims such as auto accident, malpractice claim or other situations in which you are eligible to collect damages, your entire records may be subject to disclosure by subpoena or court order and are subject to full disclosure to the payer of any claims we file for services on your behalf. You may object, in writing, to a subpoena for such records. In the case of an Independent Medical Examination which is being conducted on behalf of a third party, any information is subject to disclosure to that third party. However, you may have additional rights under State law.

Forensic Evaluation at the request of your attorney: In most circumstances, such evaluations if arranged for and paid through your attorney's office retain a special status of attorney-client privilege until such information is disclosed by your attorney or used for legal purposes. Such evaluations are not protected by rights established under HIPAA.

Law Enforcement: We may disclose health information for law enforcement purposes and special governmental functions only as required by Federal, State or Local law.

Business Associates: We have Business Associates with whom we may share your Protected Health Information. For example, we may share necessary information with Business Associates. Examples include Business Associates who provide coverage while we are out of town, answering services as necessary, shared clerical functions with Business Associates with whom we may share offices with, collection agencies or collection attorneys, or technicians who may need to service equipment where necessary information is stored. We enter into agreements with such associates such that they are also obligated to respect the privacy of your Protected Health Information.

Communication with Family: If a family member or close friend calls for scheduling, payment, or changing appointments and in our best judgment we do not believe you would object, we may communicate minimal necessary information to facilitate scheduling, payments and appointments. With your signed consent, if family members, other relative, close personal friend, or any other person you identify as participating in your care, minimal necessary health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency. Unless you notify us otherwise, we may leave messages on your home phone if you utilize an answering machine regarding contacting our office regarding scheduling, or regarding personal or third party payment.

Marketing: We may Contact you to provide you with appointment reminders, with information about treatment alternatives or with information about other health-related benefits or services that may be of interest to you.

Health Research: We may use Personal Health Information to conduct or participate in research studies based upon our clinical and health records. In such cases any personal identifying information shall be removed. For example, we may collect outcome data on group treatment approaches or we may use data from your record to conduct a study of test patterns in head injury. Of course, we will not conduct any experimental research without a separate informed consent.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents there of your PHI necessary for your health and the health and safety of other individuals.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, we will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, we will discuss with you the details of the request process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, we will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

We may bill you for professional time involved in explaining or reviewing these procedures with you.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

If we revise our policies and procedures, we will post these on the NFLBH.COM website and notify active patients by mail along with billing statements. Returning patients will be notified upon their first visit following a change in policy and procedures. Patients may request a written copy at anytime by mailing such a request to North Florida Learning & Behavioral Health, LLC, 8825 Perimeter Park Blvd, Suite 302, Jacksonville, FL 32216.

V. Questions and Complaints

If you are a patient of NFLBH and have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Dr. Renee Winner, Director, at 8825 Perimeter Park Blvd, Suite 302, Jacksonville, FL 32216.

If you are a patient of NFLBH and believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Dr. Renee Winner, Director, at North Florida Learning & Behavioral Health, LLC, 8825 Perimeter Park Blvd, Suite 302, Jacksonville, FL 32216.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The persons listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 8/1/17.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting this to the NFLBH.COM website, notifying active patients by mail in their billing statements, and returning patients upon their first visit after such a change in this notice.

NORTH FLORIDA
LEARNING & BEHAVIORAL HEALTH

Patient Privacy Practice Acknowledgement & Consent

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

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third party payers.
- Conduct normal health care operations such as quality assessments and provider certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change this Notice of Privacy Practice from time to time and that I may contact this organization at any time at this location to obtain a current copy of the Notice of Private Practices.

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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I have reviewed and consent to all the above statements. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name:_____
Signature of Parent/Guardian:_____
Relationship to Patient:_____
Date:_____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Location:_____

Reason:_____

NORTH FLORIDA
LEARNING & BEHAVIORAL HEALTH

Patient Financial Responsibility Policy

Financial Policies:

- As a private practice, it is important for us to manage reimbursements effectively in order to avoid billing issues from interfering with psychological services. Therefore, payment for each session is due at the time of service.
- Payment is due in full at the time that services are rendered. If insurance is used, we will collect your initial estimated portion (deductible, coinsurance and/or copay) and then bill the insurance company for the visit. You will be responsible for any outstanding balance following insurance reimbursement.
- Previously approved financial arrangements can be made for subsequent visits depending on the circumstances. Our office accepts credit cards, Flexible Spending Account debit cards, personal checks, and cash as forms of payment.
- Although estimated information regarding your insurance coverage is provided as a courtesy, we suggest that you confirm your benefits with your insurance company as well. We will work with your insurance company to help you receive the benefits for which you are entitled. However, you, not your insurance company, are ultimately responsible for full payment of fees.
- You will receive a Statement of Services if a balance remains on your account after insurance reimbursement is received by our office. The amount on your statement is due upon receipt of your bill. A finance charge of 1.5% of the balance due will be applied to accounts over 30 days old. If your account has not been paid for more than 60 days after insurance reimbursement has been received, and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment.
- As noted, statement balances are due upon receipt. This means that any outstanding balance at the time of your next appointment must be paid before the session begins.
- In the case of parents who are divorced or separated, copayments and coinsurance payments are the responsibility of the parent accompanying the child to the session.
- Cancellation Policy: Once an appointment is scheduled you will be expected to provide notice of cancellation at least 24 hours in advance. Exceptions will be made for emergencies or inclement weather. If you do not appear for a scheduled appointment, you will be charged up to 50% of the total fee for the day's visit.

Please Sign Page 2

NORTH FLORIDA
LEARNING & BEHAVIORAL HEALTH

Patient Financial Responsibility Agreement

Welcome to North Florida Learning & Behavioral Health, LLC. We are happy to answer any and all questions regarding payment policies.

Our Policy requires payment at the time of service for your visit. If you are a member of an insurance plan, it is your responsibility to:

- Provide us with information relative to your claim, including insurance card, number, birth date, and address.
- Pay your estimated deductible, coinsurance, and copay at the time of service.
- Pay for services not covered by your insurance carrier upon receipt of the Statement of Services. Insurance claims for your carrier are filed as a courtesy.
- To assist you with your payment, our office accepts credit cards, Flexible Spending Account debit cards, personal checks, and cash as forms of payment.
- In the case of divorced or separated families, the parent bringing in the child for the session is responsible for payment at the time of the appointment.
- **Important note: Insurance companies do not pay for learning evaluations such as dyslexia testing or testing for academic accommodations.**

  When your bill is unpaid, a collection agency may be chosen to manage delinquent accounts. Please refer to the Financial Responsibility Policy for more information.

  Cancellation Policy: Once an appointment is scheduled you will be expected to pay a fee unless you provide notice of cancellation at least 24 hours prior to the scheduled time of the appointment. Exceptions will be made for emergencies or inclement weather. If you do not appear for a scheduled appointment, you will be charged up to 50% of the total fee for the day's visit.

  Your signature below indicates that you have read the Patient Financial Responsibility Policy and the Patient Financial Responsibility Agreement and agree to its terms.

  Patient name (print): _____

  _____ Date_____
  (Signature of patient/legal guardian)

  Relationship to patient, if applicable: _____

NORTH FLORIDA
LEARNING & BEHAVIORAL HEALTH

Insurance information

(We are currently in-network with Cigna, Blue Cross Blue Shield, and Tricare)

This form is not needed if services are for a psychoeducational (i.e. dyslexia) evaluation

Primary Insurance Information

Name of Primary Insurance Holder: _____

Relationship to Patient: _____ Birthdate: _____

Social Security Number: _____ Telephone #: _____

Driver's License #/State: _____

Insurance Company: _____

Group Number: _____ Policy/ID Number: _____

Secondary Insurance Information (if applicable)

Name of Primary Insurance Holder: _____

Relationship to Patient: _____ Birthdate: _____

Social Security Number: _____ Telephone #: _____

Driver's License #/State: _____

Insurance Company: _____

Group Number: _____ Policy/ID Number: _____

*We release only the minimum Information needed in order to file your claim. *

I HEREBY AUTHORIZE NORTH FLORIDA LEARNING & BEHAVIORAL HEALTH, LLC TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Signature: _____Date: _____

NORTH FLORIDA
LEARNING & BEHAVIORAL HEALTH

Email Risk Acknowledgement & Consent (Optional)

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been explained the risks involved in transmitting personal and confidential information through email. I give Dr. Winner permission to communication information and transmit evaluation results via email, if requested, and I agree to accept all risks involved in confidential information being sent in this format. I understand that results can alternatively be delivered in other formats such as through the United States Postal Service or via fax.

I have reviewed and consent to all the above statements. I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken relying on this consent.

Patient name (please print):_____
Signature of Patient/Parent/Guardian:_____
Relationship to Patient:_____
Date:_____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Email Risk, but was unable to do so as documented below:

Date:_____ Initials:_____ Location:_____

Reason:_____