Date:_____

CONFIDENTIAL

PATIENT NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE #_____ CELL #_____ WORK #_____

EMERGENCY CONTACT:_____

AGE_____ DATE OF BIRTH_____ PLACE OF BIRTH_____ SS_____

WHO WERE YOU REFERRED BY:_____

ARE YOU CURRENTLY INVOLVED IN ANY LAWSUIT OR ANTICIPATE ANY?_____
ARE YOU ON DISABILITY OR WORKMEN'S COMP?_____
IF YES, FOR WHAT_____

INSURANCE INFORMATION:

PRIMARY INS:_____ POLICY #_____
SECONDARY INS:_____ POLICY #_____
OTHER INSURANCE NAME_____ POLICY #_____
PHARMACY USED ROUTINELY_____

LIST CURRENT PHYSICIANS, PSYCHOLOGIST AND PHONE NUMBERS_____

_____

_____

_____

I HEREBY GIVE PERMISSION TO COMMUNICATE ABOUT MY TREATMENT WITH THE PHSYCIANS AND PSYCHOLOGIST ALONG WITH THE FOLLOWING PERSON(S) (If you do not wish for me to communicate with specific persons please indicate who and why)._____

_____

SIGNATURE OF PATIENT: _____
AND/OR SIGNATURE OF PERSON FILLING OUT FORM:_____
DATE:_____

ROBERT M. HOMER, M.D., PA
4800 N. Federal Hwy A205
Boca Raton, FL 33431
(561) 392-3557 (O)
(561) 392-3587(F)

ROBERT M. HOMER, M.D., PA
7100 W. Camino Real Ste 302
Boca Raton, FL 33433
(561) 392-3557 (O)
(561) 392-3587 (F)

MEDICAL HISTORY

LIST ANY CURRENT MEDICAL PROBLEMS_____

_____

_____

_____

LIST CURRENT PHSYCIANS & PHONE NUMBERS_____

_____

LIST CURRENT MEDS YOU ARE NOW TAKING (including over the counter)

NAMES	DOSAGE	FREQUENCY	HOW LONG USING

LIST ANY ALLERGIES TO MEDICATIONS_____

_____

DESCRIBE ANY HISTORY OF THYROID PROBLEMS_____

_____

DO YOU SMOKE?_____ IF YES, HOW MANY PACKS PER DAY?_____
ALCOHOL USE (ESTIMATE YOUR DAILY OR WEEKLY USE)_____
OTHER SUBSTANCE ABUSE _____ ANY RECENT ACCIDENTS?_____
DESCRIBE INJURIES _____ RECENT LOSS OF CONSCIOUSNESS OR HEAD INJURY? YES ____ NO _____
SEIZURES?_____ YES _____ NO _____
RECENT CHANGES IN WEIGHT? YES _____ NO_____
(if yes, how much)_____ HEIGHT_____ WEIGHT _____
MOTHER'S AGE/OR AGE AT DEATH_____ HEALTH CONDITION AND/OR
MEDICAL PROBLEMS, CAUSE OF DEATH_____
FATHER'S AGE/OR AGE AT DEATH _____ HEALTH CONDITION AND/OR MEDICAL
PROBLEMS CAUSE OF DEATH_____
SIBLINGS AGES AND HEALTH CONDITION AND/OR MEDICAL PROBLEMS _____

_____
ANYONE WITH SEIZURES IN THE FAMILY?_____

FAMILY PSYCHIATRIC HISTORY:

DOES ANYONE IN THE FAMILY HAVE DEPRESSION, NERVOUSNESS OR ANY OTHER PSYCHIATRIC PROBLEMS? IF YES, DESCRIBE TREATMENT, MEDS_____

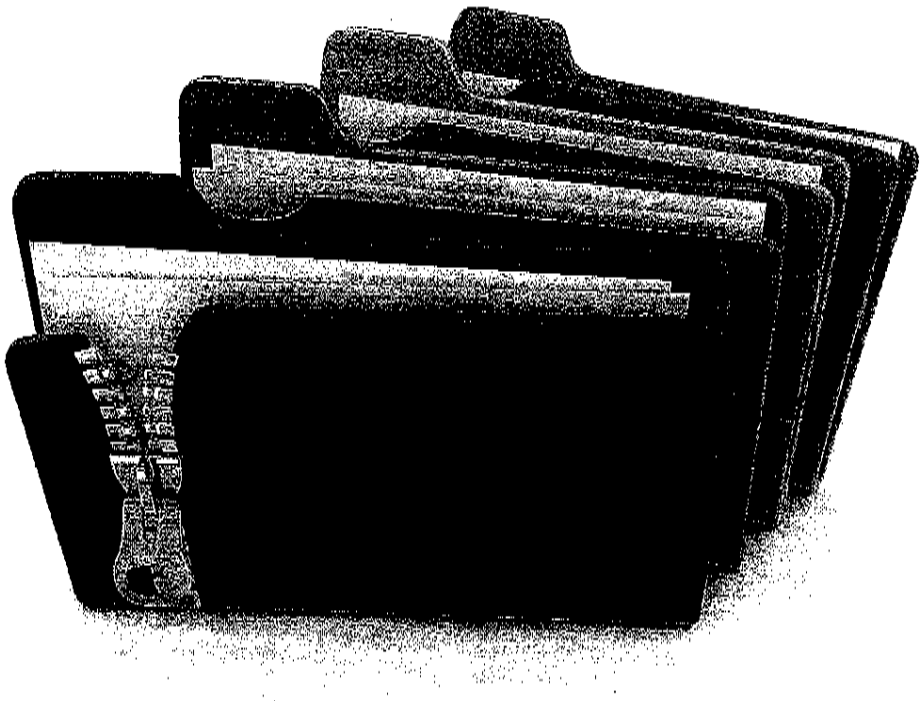
DESCRIBE ANY PRIOR PSYCHIATRIC TREATMENT INCLUDING MEDICATIONS AND HOSPITALIZATIONS

CURRENT SYMPTOMS AND WHEN BEGAN

SPECIFIC SYMPTOMS (ANSWER YES OR NO AND ANY COMMENTS)

EXCESS SLEEP_____ DIFFICULTY FALLING ASLEEP_____ INTERRUPTED SLEEP_____
EARLY MORNING AWAKENING (3-4 AM AND CANNOT RETURN TO SLEEP)_____
DECREASED CONCENTRATION _____ DECREASE IN INTERESTS_____
DECREASE IN ACTIVITIES_____ DEPRESSED_____ DECREASE IN SEXUAL INTERESTS_____
WORSE TIME OF DAY _____ PHYSICAL SYMTOMS (headaches, stomach problems breathing)

INCREASED NERVOUSNESS_____ PANIC OR ANXIETY ATTACKS_____
WITHDRAWN FROM FRIENDS/FAMILY _____ SUICIDAL THOUGHTS_____
INCREASE IN ANGER, TEMPER OR MOODINESS_____ PERIODS OF FEELING HIGH (now or in the past)_____ GREAT DEAL OF ENERGY (now or in the past)_____
NEED FOR LESS SLEEP (now or in the past)_____ UNUSUAL THINKING _____
HEARING VOICES_____ SENSE THAT PEOPLE ARE WATCHING YOU OR OUT TO GET YOU _____
FEELINGS OF NOT BEING REAL_____ CONFUSION/MEMORY LOSS _____
AGITATION/COMBATIVE BEHAVIOR_____



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: ◦ Preventing disease ◦ Helping with product recalls ◦ Reporting adverse reactions to medications ◦ Reporting suspected abuse, neglect, or domestic violence ◦ Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

Robert M. Homer M.D., P.A.

4800 N. Federal Hwy.
Boca Raton, FL 33431
&
7100 W. Camino Real, suite 302
Boca Raton, FL 33433

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES- EFFECTIVE 9/23/13

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the ROBERT M. HOMER MD PA Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____

Patient Name (Type or Print) Date

Signature _____

Office Policies:
For Robert M. Homer, M.D., P.A.

This is a small private psychiatry practice. It is our goal to provide high-quality care and treat all of our patients in a respectful courteous, and safe manner. We try our best to make sufficient time to see all of our patients and to get them in as soon as possible when needed. In order to run a practice such as this where all of our patients are treated as "VIPs" we have to implement strict office policies. These are some of them:

- All patients are expected to fill out intake forms to make sure they are a good match for this practice and to help guide in the initial treatment.
- When seen for an initial appointment, patients must have at least a one month supply or refills available for whatever medications they are currently taking.
- All patients are to give at least 24 hours notice before an appointment to cancel. A credit card is to be held on file and charged $100.00 for cancellations less than 24 hours in advance. Obviously we do not want you to drive to the office if it is unsafe, and depending on circumstances, this money may be refunded. Dr. Homer will briefly speak to you on the phone and call in prescriptions if indicated. In some cases, only enough medicine will be called in until the next appointment.
- In the case of canceled appointments patients are to take the responsibility to reschedule.
- There is a 150.00 charge for all letters. Written reports may cost more depending on the time involved.
- Payment of co-pays and deductibles are expected to be collected on the day of each appointment.
- Patients are expected to give consent to contact their other health care providers and people in their support system if need arises.
- Patients are expected to agree to be compliant with treatment. If a higher level of care or another type of treatment becomes indicated, patients are to accept that this is being recommended in their best interest.
- Patients who need a psychiatrist for legal issues are recommended to see another psychiatrist, perhaps a forensic psychiatrist.
- Patients being treated with controlled substances e.g. xanax, valium, will agree to be seen at least once per month, with the goal of minimizing if not eliminating the need to be on such medications.
- Pain medications will not be prescribed.
- Lost prescriptions of controlled substances will result in a taper off of the medicine.
- Stolen prescriptions of controlled substances will require a copy of a police report before being prescribed again.
- In the event of being in risk of withdrawal, all patients agree to go to the emergency room or an urgent care center if unable to be seen in the office when they are out of a controlled substance because of any reason.
- If medications need preauthorization, patients are expected to obtain the paperwork and fill it out to the best of their ability. There is no guarantee that medications will be approved by insurance.
- As parking can be scarce at times on our end of the building (at the east Boca Raton office), we recommend that you try to arrive to your appointments a bit early, and persons with difficulty ambulating should have someone drop them off at the A section of the building and then park.
- Email and text messages are not used in this practice.

By signing here, I agree to these office policies in principle

Name: _____ Date: _____

Signature: _____

Robert M. Homer, M.D., PA
Psychiatry

7100 West Camino Real. Suite 302
Boca Raton, FL 33433
PHONE: 561-300-4023
FAX: 561-952-6922

PATIENT SIGNATURE ON FILE FORM

I authorize Robert M. Homer, M.D., P.A. to keep my signature on file and to charge the credit card for **missed appointments**.

Check one:

- o VISA
- o MasterCard
- o American Express
- o Discover

I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

Patient Name: _____
Cardholder Name: _____
Cardholder Address: _____
Cardholder City/State/Zip: _____

Credit Card #: _____ Exp Date: _____ CVCode: _____

Cardholder Signature: _____ Date: _____