Today's Date: Do you see more than one provider at this location? Yes No

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:

Is this your legal name? Yes No	If not, what is your legal name?	Social Security #:	Birth date:	Age:	Sex: F M

Mailing Address:

Cell phone #.:	Check if it is NOT ok to leave a message	Email:
Home phone #.:	Check if it is NOT ok to leave a message	
Parent/ Legal Guardian name:	Birth date:	Soc. Sec. #:

Allergies:

Pharmacy:	Address:	Telephone #:

RESPONSIBLE PARTY INFORMATION

Name of person responsible for payments:	Birth date:	Address (if different than patient's):	Primary phone #:

Relationship to patient: ☐ Parent ☐ Guardian ☐ Other _____

IN CASE OF EMERGENCY ONLY

Name of local friend or relative:	Relationship to patient:	Home phone #.:	Cell phone #.:

INSURANCE INFORMATION

Name of **PRIMARY** insurance company:

Subscriber's name:	Subscriber's Soc. Sec. #:	Birth date:	Policy #:	Group #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of **SECONDARY** insurance company (if applicable):

Subscriber's name:	Subscriber's Soc. Sec. #:	Birth date:	Policy #:	Group #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

PATIENT / RESPONSIBLE PARTY SIGNATURE DATE

Patient is: ☐ Minor ☐ Incompetent/incapacitated

Legal authority: ☐ Parent ☐ Legal Guardian ☐ Other relationship: _____

AUTHORIZATION FOR VERBAL COMMUNICATION

Information to be Disclosed. Verbal communication only – no medical information or copies of records provided. The individual(s) listed in the box below have my permission to verbally answer questions about and to discuss aspects of my care regarding scheduling and billing information with the other individual named below. If you would like to give authorization for medical information to be shared between your provider and another individual or facility a Medical Release of Information must be requested to be filled out.

Communication Between:		**And: (Provider's Name)**	
Name:	Phone #:	Provider Name:	Phone #: 386-423-9161
Address:	Fax #:	Address: 136 Julia St #100	Fax #: 386-423-3094
City: State: Zip Code:		City: New Smyrna Beach State: FL Zip Code: 32168	

Relationship to patient: ☐ Step Parent ☐ Spouse ☐ Child ☐ Friend ☐ Other _____

5. This Authorization will remain in effect for one year from signature unless otherwise indicated. ☐ Indefinite

☐ Ends date _____/_____/_____

I authorize both parties above to exchange information between themselves.

This information is valid from the date of signature or completion of treatment, which includes but is not limited to, final insurance billing or any pending legal cases. This authorization is subject to revocation (in writing) at any time, except to the extent, that the provider has already acted in reliance on it and/or any stipulations as provided in our New Patient Paperwork at time of signature.

Liability Agreement: I hereby release the provider named above from any liability which may arise through the use of the information contained in the copies of records revealed through my Medical OR Verbal Release of Information. It will be presumed, that if this information is later used and has a damaging effect upon myself, that it was obtained as a result of my authorization. I have been provided with a copy of the Privacy Policies.

PATIENT / RESPONSIBLE PARTY SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

I, _____, have been advised of and have read the **NOTICE OF PRIVACY PRACTICES (NPP).** I understand that a copy of this notice can be provided to me upon request. I hereby authorize my provider, _____, to release information for the purposes outlined in the NPP statement only and release the Center from any liability which may arise as a result of the use of the information contained in the copy of records released. Further disclosure is prohibited unless expressly permitted by written consent of the person to whom it pertains or as otherwise permitted.

I have read and understand the Notice of Privacy Practices:

PATIENT / RESPONSIBLE PARTY SIGNATURE DATE

A NOTE FROM YOUR PROVIDER

It is important to me that you, as a consumer, are clear about the manner in which I am able to provide service to you. Our office is structured in a fashion that permits all of us to be completely independent providers who have separate licenses with no affiliation. We have joined our resources to employ the Counseling Center of New Smyrna Beach to handle scheduling and billing in our names. Therefore, all payments should be made directly in my name, not to the Center. As an independent practitioner, all clinical responsibility for your care is mine. If, at any time you feel that there are deficiencies in the process of your care, scheduling, or billing, please bring your concerns to my attention. Thank you for your understanding in this matter.

I have read and understand the above statement from my provider:

PATIENT / RESPONSIBLE PARTY SIGNATURE DATE

FINANCIAL POLICY

We are committed to providing you with the best possible care and service. In order to achieve these goals, we ask that you review the following information to facilitate your understanding of our financial policies. Please do not hesitate to ask questions and/or discuss any concerns.

- Visit Payments: Payments, when due, are made to the provider of service on the day of your visit. We accept cash, Visa, MasterCard or check. For your convenience, we can also accept credit card payments by phone. Any returned checks will be subject to a $30.00 service fee to cover bank charges.
- Private Pay Arrangements: Payment is due in full at the time of service unless you have made payment arrangements in advance with our business office or the provider of service.
- Insurance: Your insurance plan is a contract between you and/or your employer, and the insurance company. We are not a party to that contract. All charges are the responsibility of the patient from the time services are rendered. As a courtesy to you, we will attempt to contact your primary insurance company prior to your first visit to determine mental health eligibility and benefits, including co-pays/co-insurance, any deductible amounts and any pre-authorizations required. If you have not already done so, we strongly urge you to contact your insurance company to verify your mental health benefits and any pre-authorization required. This is due to the fact that we have found on occasion that the insurance information provided to us by your insurance carrier prior to your first visit is in error. Since, you are ultimately responsible for payment, we urge you to notify us if there is a discrepancy. If we do not receive payment from your insurance company within 60 days, we will make every effort to contact them to determine the reason and resolve the issue if possible. We will notify you if your insurance indicates the claim is under review and they require additional information from you. If claims are not paid due to deductibles not met, exhausted benefits, denial of services, insurance termination or your insurance company has not paid the claim after two follow-up calls, we will transfer the charges to you. If requested, we will provide you with any documents your insurance company may require in order for them to reimburse you directly.
- Co-Pays and Deductibles: We require that these be paid at the time of your visit. If an insurance deductible has not been met at the time of your initial and/or subsequent visits, we will expect payment at the time of service until your deductible has been met. We will bill your insurance company to reflect your payment(s).
- Insurance Change: If there is a change in your insurance carrier or benefits, it is your responsibility to determine if a pre-authorization is required and notify us of your new insurance information prior to your next scheduled appointment. Failure to do this may result in non-payment by the insurance making it necessary to transfer the charges to you.

I have read and understand the financial policy.

PATIENT / RESPONSIBLE PARTY SIGNATURE DATE

APPOINTMENT and CANCELLATION POLICY

You agree to the appointment times the office staff and the provider of services schedules especially for you. Failure to keep an appointment not only results in a loss of revenue to the provider, but it also prevents another patient from being scheduled for that same time. Our providers have waiting lists for those who are seeking appointments. As a courtesy to you, we try to make appointment reminder phone calls the day prior to your visit. However, the policies below will apply even if we are unable to contact you due to office time constraints.

We expect you will keep your scheduled appointment and give us at least 24 business hours' notice when it is necessary to change your appointment to enable us to schedule someone else. As the office is closed weekends and holidays, it is necessary to notify us in time for us to schedule another patient in need.

If you are greater than 15 minutes late for a therapy session or 10 minutes late for medication management, your appointment is considered a NO SHOW which will result in a fee. You will need to reschedule your appointment. Your prescriber will not fill your script without seeing you at your scheduled follow up. Availability will be limited, so please do everything you can to keep your appointment and arrive early rather than late.

Our policy regarding late cancelations and missed appointments is as follows:

- A patient with a scheduled appointment must call at least 24 business hours in advance of the appointment to cancel or reschedule to avoid a fee. For Monday appointments, we must receive notice of cancellation by Friday before the scheduled time. If the office cannot answer your call, we do honor the time stamp of your voicemail.

- Cancelations with less than 24 hours' notice will result in a fee of 50% of the provider's current hourly self-pay rate. Missed appointments will result in a charge of the provider's FULL current hourly self-pay rate. I have been informed of my provider's current hourly rates and fees and understand they are subject to change.

- A missed appointment or cancellation charge applies for EACH occurrence. After the third occurrence, with less than the required 24 business hours' notice, the provider of service will determine if this will result in a discharge from service. You will send a letter vi USPS to notify you in this case.

- We are aware that at times, it is just not possible to give 24 hours' notice. The decision to waive the fee for extenuating circumstances resulting in the cancellation or missed appointment will be up to the individual provider only, not the staff.

- Medical Evaluations are billed at $150-200 and follow ups are $75-150 per hour. Therapy sessions range from $50-125 per hour. Forensic services are billed at $250 per hour and in 15 minute increments with a minimum of 2 hours and must be prepaid. Writing of professional letters are billed at $250 per hour and billed in 15 minute increments.

I have read and understand the Appointment and Cancelation Policy:

PATIENT / RESPONSIBLE PARTY SIGNATURE

DATE

PAYMENT AUTHORIZATION

By signing this authorization, I acknowledge that **I have read and agree to all policies** and warrant all information given is true in the new patient packet. This form is to protect the provider from NO SHOWS and LATE CANCELATION, it is not used as a form of payment when checking in unless specified by the card holder (i.e.: to pay for a minor's appointment that attends an appointment without his/her parent or guardian, telehealth appts., etc). I understand to revoke this authorization, the card holder must submit request by certified letter. Please note that if you use a credit card there is a 3% surcharge that is automatically added to the fee.

Patient Name:				
Provider Name:				
Type of Payment:	Visa	Mastercard	Discover	American Express
Debit or Credit Card #:				
Exp. Date on Card (mm/yr):				
Verification Code: (3 digit code on the back of card):				
Name as it Appears on Card:				
Card Billing Address:				
City:		State:	Zip:	
Phone Number:				
This authorization is given to the provider mentioned above and subject to the terms of the above policies which are incorporated by reference herein.				
Printed Name of Person Authorizing the Use of this Card:				

I have read and understand the Appointment and Cancelation Policy:

SIGNATURE OF AUTHORIZED CARD USER	DATE

NOTICE OF PRIVACY PRACTICES

This notice is covered under HIPAA (Health Insurance Portability & Accountability Act). Any state law that is more stringent than the HIPAA rules and regulations has priority.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information, referred to as PHI. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 1, 2003.

We reserve the right to change our privacy practices and the terms of the notice at any time. If we do so, we will post a new notice in our office waiting area and advise you of the new notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

Payment – We may use your PHI to obtain payment for services rendered. This can include insurance billing departments, collections agencies, and hospital departments.

Treatment – We may use or disclose your PHI to a physician or other healthcare facilities providing treatment to you.

Your Authorization – You may give us authorization to use your PHI or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Without your authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

To your family and friends – We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if your authorize us to do so.

Persons involved in care – We may use or disclose PHI to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to disclosing your PHI we will provide you with the opportunity to object to such disclosures. In the event of your incapacity or emergency circumstances, we will disclose PHI based on a determination using our professional judgment and disclosing only what is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services – We will not use your health information for marketing communications.

Required by Law – We may disclose your health information when we are required to do so by law.

Abuse or Neglect – We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety and the health or safety of others.

Appointment Reminders – We may disclose your health information to provide you with reminders of your appointments. These may come in the form of voicemail messages on phone numbers provided by you, postcards or letters to the address you have provided us.

PATIENT RIGHTS

Access – Unless your access is restricted for clear and documented treatment reasons you have the right to see your protected health information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. You may obtain a form to request access to your health information directly from our office. We will charge a reasonable cost-based fee for expenses such as copies and staff time.

Restrictions on Disclosures – You have the right to ask that we limit the disclosure of you PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on the disclosure of your Phi we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit disclosure of information that is required by law.

Contact – You have the right to ask that we send your information to an alternative address or by alternative means. However, you must make this request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you have requested.

Disclosure accounting – you have the right to receive an accounting of disclosure that we have made. If you would like to receive an accounting, you may send us a letter to request this. The accounting will not include several types of disclosures, including disclosures for treatment and disclosures for which you have given your consent. It also will not include disclosures made prior to April 14, 2003. However, from that day forward, disclosures must be documented and retained for a period of 6 years. We will respond to your written request for such a list within 60 days of receiving it.

Amendments – You have the right to request that we amend your health information. We must receive this request in writing and the reasons must be clearly stated. We have the right to dent these changes if we determine the PHI is (1) amended and complete, (2) not created by us and/or not part of our records, or (3) not permitted to be disclosed. Any denial will state the reasons for denial. If we approve the request to amend, we will amend the PHI and so inform you, and tell others that need to know about the amendment in the PHI.

Notice – You have the right to request a paper copy of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services, Offices for Civil Rights, Atlanta Federal Center, Suite 3870 61 Forsyth Street SW, Atlanta GA 30303-8909

CONTACT INFORMATION

If you have any questions regarding this notice please contact