Florida Counseling and Evaluation Services

PATIENT INFORMATION AND REGISTRATION FORM

Patient Name (Please Print:)_____ **DOB:** ____/_____/_____

Today's Date: ____/_____/_____

Note: Please print LEGIBLY and in **BLACK INK** only.

PATIENT DEMOGRAPHIC INFORMATION

If you are a parent completing this form for your child, please complete this section for your child and not for yourself. Complete the separate section for minors, below, with parent or guardian relevant information.

Name (last, first, MI):_____ Date of Birth:_____ Gender:_____

Social Security No.:_____ Marital Status:_____ Race:/Ethnicity:_____

Street Address:_____ City/State/Zip:_____

Home/Cell Phone:_____ Daytime (work phone):_____

May we contact you at home? □ YES □ NO May we contact you at work? □ YES □ NO

May we leave a message (home)? □ YES □ NO May we leave a message (work)? □ YES □ NO

Driver's License #:_____ How did you hear about us?_____

Employer:_____

Email address (*if provided, you consent to email communication*):_____

COMPLETE IF PATIENT IS A MINOR

Name of Parent/Guardian:_____ Date of Birth:_____ Gender:_____

Street Address:_____ City/State/Zip:_____

Social Security No.:_____ Race/Ethnicity:_____

Are you the primary custodian of the child? □ YES □ NO *(Please provide supporting documents.)*

Describe parenting/custody arrangement(s) and legal status (if applicable):_____

_____

EMERGENCY CONTACT

If completed, I hereby authorize to contact the below listed person in case of emergency:

Name:_____ Relationship:_____

Street Address:_____ City/State/Zip:_____

Daytime Phone #:_____ Evening Phone #:_____

Patient Name:_____ DOB:_____

INSURANCE/PAYOR INFORMATION

Insured's Name:_____ Insured's Social Security No.:_____

Address:_____

City:_____State:_____Zip Code:_____

Patient's relationship to insured: _____

Name of Insurance Company:_____

Policy or ID #:_____Group #:_____

Is insured employed and covered by employer's health plan? □ YES □ NO

** *If using Employee Assistance Program (EAP) benefits, complete EAP information:*

EAP Company Name:_____ **Visits Authorized:**_____ **Authorization No.:**_____

Worker's Compensation/Auto Accident Only:

Are you here as a result of an accident? □ YES □ NO Work injury? □ YES □ NO

Worker's Compensation? □ YES □ NO Accident Date:_____

Accident Type: (Auto/ Work/ Recreation/ Sports/ Other/ None) – *circle as appropriate*

Worker's Comp Cases Only:

Employer's Name and Address:_____ Supervisor/HR Contact Name:_____

Supervisor/HR Contact Phone #:_____

MEDICAL BACKGROUND AND REASON FOR VISIT

Please describe the reason for your visit:_____

_____

_____

Primary Care Physician:_____ Date of last visit:_____

Phone #:_____ Fax #:_____

List all allergies (including medication):_____

_____

Have you ever had a serious head injury? □ YES □ NO If yes, describe:_____

List any medical problems: _____

Past surgeries:_____

Patient Name:_____ DOB:_____

PAST PSYCHIATRIC HISTORY

Are you currently being treated by a psychiatrist/psychiatric nurse practitioner? □ YES □ NO

If so, please list the name, for how long, and date of most recent appointment:_____

_____

Have you ever been hospitalized for treatment of an emotional/psychiatric problem? □ YES □ NO

If so, what for (e.g., anxiety, depression), when, where, how long?_____

_____

Have you worked with a therapist/psychologist/etc. in the past? □ YES □ NO

If so, please list names, dates, and reason (e.g., anxiety, depression, marital):_____

_____

What psychiatric medications have you tried?_____

PLEASE LIST ALL CURRENT MEDICATIONS:

Note: You can provide a copy of your medication list, if available. ***If you need more space, please ask the front desk associate for an additional medication list form.***

NAME of MEDICATION	DOSAGE/ FREQUENCY	PRESCRIBED BY AND DATE?	REASON

Do you smoke cigarettes or use tobacco products (including vaping): □ YES □ NO If yes, describe:

_____

_____

Former tobacco user? □ YES □ NO If yes, describe and when quit:_____

_____

Patient Name:_____ DOB:_____

CURRENT SYMPTOMS (Indicate any you have experienced in the **past two weeks**)

ANXIETY
☐ Nervousness
☐ Tension
☐ Anxiety
☐ Fears
☐ Panic
☐ Shaking
☐ Tremors
☐ Nausea
☐ Vomiting
☐ Sweating
☐ Palpitations
☐ Choking feeling
☐ Suffocating feeling
☐ Shortness of breath
☐ Headache
☐ Neck Pain
☐ Feelings of dread
☐ Decreased concentration
☐ Faintness
☐ Dizziness
☐ Avoiding people, events
☐ Vague physical complaints
☐ Flashbacks
☐ Numbness
☐ Nightmares
☐ Startle reactions
☐ Obsessive ruminations and worry
☐ Compulsive habits
☐ Other _____

NEUROLOGICAL
☐ Judgment impaired
☐ Memory impaired
☐ Reasoning impaired
☐ Rapid mood swings
☐ Laughs easily
☐ Cries easily
☐ Irritable
☐ Impulsive
☐ Aggressive
☐ Explosive
☐ Thoughts of violence
☐ Violent behavior
☐ Seizures
☐ Head injury (history)
☐ Brain injury (history)
☐ Headaches
☐ Numbness, loss of sensation
☐ Disorientation in time/place
☐ Confusion

DEPRESSION
☐ Sadness
☐ Crying
☐ Irritability
☐ Appetite changes
☐ Weight loss
☐ Weight gain
☐ Insomnia
☐ Early waking
☐ Low energy
☐ Fatigue
☐ Lethargy
☐ Low motivation
☐ Loss of usual interest
☐ Social withdrawal
☐ Work/school inhibition
☐ Agitation
☐ Pacing
☐ Worrying
☐ Preoccupied with body
☐ Ruminations
☐ Guilt
☐ Shame
☐ Helplessness
☐ Feeling worthless
☐ Low self-esteem
☐ Pessimism
☐ Morbid thoughts
☐ Wishes to be dead
☐ Thoughts of Suicide
☐ Plans for suicide
☐ Gestures of self-harm

PERSONALITY
☐ Negative attitudes
☐ Self-centered
☐ Immaturity
☐ Selfishness
☐ Blames others
☐ Self-destructive behavior
☐ Unstable relationships
☐ Promiscuity
☐ Feeling empty
☐ Frequent job changes
☐ Impaired family relationships
☐ At odds with others
☐ Feeling rejected
☐ Fears of rejection
☐ Disregards usual rules
☐ Antisocial
☐ Lack of empathy
☐ Remorseless
☐ Lack of friends
☐ Uses, exploits others
☐ Cutting

THOUGHT DISORDER
☐ Hallucinations
☐ Delusions (persecuting, grandiose, bizarre)
☐ Inappropriate moods/feelings
☐ Feelings of strangeness, alienation
☐ Can't be reasoned with
☐ Talking to self
☐ Thoughts disorganized
☐ Incoherent thoughts/speed
☐ Rambling, directionless thoughts, speech
☐ Bizarre thoughts (body, politics, other)
☐ Feel controlled by TV, others
☐ Lack of thoughts
☐ Thoughts blocked
☐ Bizarre appearance, posture, gestures, mannerisms
☐ Lack of self-care skills
☐ Lack of activities of daily living
☐ Lack of curiosity and interest
☐ Unusual, bizarre preoccupation

BEHAVIORAL DYSCONTROL
☐ Short attention span
☐ Impulsivity
☐ Uncontrolled behavior
☐ Uncontrolled anger
☐ Temper tantrum
☐ Rages
☐ Aggressive behavior
☐ Violent behavior
☐ Verbally abusive
☐ Opposition to authority
☐ Defiance of authority
☐ Threats to harm self or others
☐ Actions harmful to self or others

Patient Name:_____ DOB:_____

MOOD

☐ Feeling high, euphoric
☐ Feels wonderful all the time regardless of circumstances
☐ Feeling very powerful
☐ Believes can do virtually anything
☐ Irresponsible
☐ No attention to consequences
☐ Impulsive, lack of planning
☐ Spending sprees
☐ Taking on more than can finish
☐ Irritable, angry, irrational when crossed
☐ Cannot be reasoned with
☐ Cannot be slowed down
☐ No response to usual limits
☐ Inflated self-esteem
☐ Exaggerated success
☐ Minimizing weaknesses
☐ Pressure, fast speech
☐ Loud, non-stop speech
☐ Can't be interrupted
☐ Follow own thoughts only
☐ One idea after another
☐ Needs little sleep or food and never tired, hungry, or slowed down
☐ Excessive spending, drinking, staying out
☐ Excessive letter writing to authorities
☐ Excessive phoning to authorities
☐ Excessive sexuality
☐ Excessive ideas
☐ Feeling mistreated, suspicious, paranoid
☐ Over-friendly
☐ Unable to keep promises
☐ Reckless behavior
☐ Bizarre behavior
☐ Excessive gambling
☐ Excessive risk taking
☐ Hallucinations
☐ Threatens dangerous behavior
☐ Unstable moods

Additional symptoms not listed:_____

_____

FINANCIAL POLICY AND AGREEMENT

Our professional services are rendered to you, and not to the insurance company or other third-party payor. As such, payments for all services (e.g., examination, treatment, testing, documentation, etc.) is your financial responsibility. By signing below, I affirm that I am directly and fully financially responsible for any and all charges not covered by my insurance company. I further understand that any such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover such fee. I realize that if my insurance company (or other payor) fails to pay my balance in full, or there is not payment received within 60 days, it is my responsibility to pay for any and all services rendered. Additionally, I understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collections, including filing fees and attorney fees.

I specifically understand that should my account be referred to a collections agency, I will be assessed a **$25.00** non-refundable service charge. Furthermore, I am responsible for any and all fees assessed in addition to my outstanding balance(s) for services by a collections agency. I understand that I will be responsible for other fees associated with collections, including attorney and court costs.

Fees for returned checks are **$35.00**. Credit card company dispute fees subsequently determined as valid (i.e., because I filed an incorrect/fraudulent dispute) will be assessed a **$25.00** fee, which is added to your account balance with us.

Patient's Signature (*Responsible Party if Minor or Guardian*) _____

Date:_____

Patient Name:_____ DOB:_____

NON-COVERED SERVICES AGREEMENT

Our staff will make every effort to assist you with your insurance company (or respective payor) to verify that your treatment or other service is authorized and you receive the maximum reimbursement to cover the cost of your treatment or other services we provide to you. In the event that your insurance company or other payor refuses to authorizes services as medically necessary, you will be responsible for all charges associated with your care. I understand that if my insurance company (or other respective payor) refuses to authorize services for any reason, I will be responsible for all charges and payments for services rendered.

Patient's Signature (*Responsible Party if Minor or Guardian*) _____

Date:_____

MEDICAL RECORDS FEES

Medical records may be requested and sent if approved. The fees for medical records are compliant with the State of Florida's statues and are $1.00 per page up to 25 pages and $0.25 per page thereafter. Fees for medical records must be pre-paid unless otherwise arranged. I understand that I will be responsible for any and all fees not paid within 60 days from other respective payors/parties (e.g., insurance, disability carrier, etc.), where applicable. Please allow up to 30 days for medical records requests to be completed, particularly during periods of high demand.

Patient Initials:_____

MEDICAL FORM FEES

Should you ask for letter or other form to be completed by your healthcare provider, there will be a fee for these services. The fees vary, and you will be notified in advance of the cost depending on your specific need. Please allow up to 30 days for medical forms or letter requests to be completed, particularly during periods of high demand.

Patient Initials:_____

CANCELATIONS / NO-SHOW POLICY

Should you have to reschedule or cancel a scheduled appointment, Florida Counseling and Evaluation Services requires a 24-hour advanced notice. Unless opted out, we do attempt to make a confirmation call for the respective appointment, but this is a courtesy and not a guarantee. It is the patient's responsibility to keep track of any scheduled appointments. In the event that we do not receive at least 24 hours' advanced notice, or the patient does not show for a scheduled appointment, there will be a fee of $65.00, which is not covered by your insurance company. We realize that emergencies occur, but we ask that you contact the office and let us know.

Patient Initials:_____

LITIGATION, COURT PROCEEDINGS, SUBPOENA, OTHER FORENSIC WORK

I understand that if I require my healthcare provider or a representative to engage in any forensic activities on my behalf, I will be responsible for any and all costs. Such services may include appearances in court, conversations with probation officers, expert testimony, and more. If my healthcare provider or respective representative agrees to engage in any such activities, I will be provided in advance with information about the fees associates with such activities.

Patient Initials:_____

CONSENT TO USE AND DISCLOSE LIMITED HEALTH INFORMATION FOR TREATMENT AND INSURANCE AGREEMENT

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide any treatment to you. We may also share limited information to arrange payment for your treatment. By signing this form, you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights, and how we can use and share your information. Please read this carefully before you sign this consent form.

Patient Name:_____ DOB:_____

If you do not sign this consent form agreeing to what is in 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 to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us 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.

After you have signed this consent, you have the right to revoke it (by writing a letter advising us you no longer consent), and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

I hereby assign to Florida Counseling and Evaluation Services or its representatives, the insurance benefits on all insurance policies otherwise payable to me for medical treatment. I authorize Florida Counseling and Evaluation Services to submit insurance claims to insurance companies and to apply insurance proceeds to my bill and to make refunds to insurance companies, if refunds are due, under the provision of such insurance policies.

I authorize this office to prepare and submit to my insurance carrier or plan administrator all insurance claims, forms, questionnaires, and all other statements or documents required by my insurance carrier or plan administrator.

Patient's Signature (*Responsible Party if Minor or Guardian*) _____

Date:_____

NOTICE OF PRIVACY PRACTICES (NPP)

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. The information in this document is a shorter version of the full, legally required NPP, which is on display in the waiting room for your review. However, we can't cover all possible situations, so please talk to our Privacy Officer or your healthcare provider.

We will use the information about your health, which we get from you or from others, mainly to provide you with treatment, to arrange payment for our services. or for some other business activities, which are called, in the law, health care operations.

If you or we want to use or disclose (share, release) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization to allow this.

LIMITS OF CONFIDENTIALITY AND PRIVILEGED COMMUNICATION

Any communication between a patient and healthcare provider shall be confidential. This privilege may be waived under the following conditions:

1. When the patient or client agrees to the waiver in writing, for purposes such as insurance assignment.
2. When there is clear and immediate risk of physical harm to the patient, other individuals, or society.
3. When there is evidence of abuse or neglect of children, aged persons, or adults with disabilities.
4. Under worker's compensation statues, health-care providers are required to submit records upon request.
5. For specific litigation or court proceedings or upon receipt of a court order.

There are a few other situations like these, which don't happen very often. They are described in the longer version of the NPP, available in the waiting room and/or from front desk personnel.

CHILDREN'S CONFIDENTIALITY

When a child or adolescent is seen by a healthcare provider, it is just as essential that his/her confidentiality and right to privacy is preserved and respected. Parents will be provided information concerning the healthcare professional's impressions, conclusions, and recommendations only.

I have read and understand the above exceptions to confidentiality. I authorize Florida Counseling and Evaluations Services and/or its representatives to release records as required by law and to honor subpoena for records should one be received.

Patient's Signature (*Responsible Party if Minor or Guardian*) _____

Date:_____

Patient Name:_____ DOB:_____

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule, or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement, except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at limited health information we have about you, such as your medical and billing records. You can obtain a copy of these records, but we may charge you.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP, we will post it in our waiting room and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the care you receive.

I have read and understand the privacy policy and exceptions to confidentiality. I authorize Florida Counseling and Evaluation Services and/or its representatives to release records as required and to honor subpoena for records should one be received.

Patient's Signature (*Responsible Party if Minor or Guardian*) _____

Date:_____

PATIENT RESPONSIBILITIES AND CODE OF CONDUCT

Successful medical care requires an ongoing collaborative effort between patients and clinicians. Clinician and patient are bound in a partnership that requires both to take an active role in the healing process. Such a partnership does not imply that both partners have identical responsibilities or equal power. While clinicians have the responsibility to provide health care services to patients to the best of their ability, patients have the responsibility to communicate openly, to participate in decisions about the diagnostic and treatment recommendations, and to comply with the agreed-upon treatment program.

Like patients' rights, patients' responsibilities are derived from the principle of autonomy. The principle of patient autonomy holds that an individual's physical, emotional, and psychological integrity should be respected and upheld. This principle also recognizes the human capacity to self-govern and choose a course of action from among different alternative options. Autonomous, competent patients assert some control over the decisions which direct their health care. With that exercise of self-governance and free choice comes a number of responsibilities:

(1) Good communication is essential to a successful patient-clinician relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their clinicians.

(2) Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.

(3) Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.

(4) Once patients and clinicians agree upon the goals of therapy and a treatment plan, patients have a responsibility to cooperate with that treatment plan and to keep their agreed-upon appointments. Compliance with clinician instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.

(5) Patients generally have a responsibility to meet their financial obligations with regard to medical care or to discuss financial hardships with their clinicians. Patients should be cognizant of the costs associated with using a limited resource like health care and try to use medical resources judiciously.

(6) Patients should be committed to health maintenance through health-enhancing behavior. Illness can often be prevented by a healthy lifestyle, and patients should take personal responsibility when they are able to avert the development of disease.

(7) Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk. Patients should inquire as to the means and likelihood of infectious disease transmission and act upon that information which can best prevent further transmission.

(8) Participation in medical education is to the mutual benefit of patients and the health care system. Patients are

encouraged to participate in medical education by accepting care, under appropriate supervision, from medical students, residents, and other trainees. Consistent with the process of informed consent, the patient or the patient's surrogate decision maker is always free to refuse care from any member of the health care team.

(9) Patients should not initiate or participate in fraudulent health care and should report illegal or unethical behavior by clinicians and other providers to the appropriate medical societies, licensing boards, or law enforcement authorities.

My signature on the treatment agreement, below, acknowledges that I have read and have a good understanding of this patient responsibilities and conduct policy. If so requested, I was provided with a copy of this document for my records.

PATIENT/CLIENT GRIEVANCE POLICY

Purpose: To establish a method for patient, client, and participant grievances.

Scope: This procedure applies to all patients, clients, and participants of Florida Counseling and Evaluation Services.

Policy: (A) New patients, clients, and participants are alerted of the presence of this FLCES grievance procedures in the intake paperwork, which is completed before meeting with a clinician. Patients are also alerted of their right to grievance in the patient bill of rights, which is displayed in the waiting room of each FLCES location. (B) The CEO will appoint a Client Rights Officer (CRO) and the CRO or other staff may assist individuals completing the Grievance Form. It is the responsibility of all staff members to know the grievance process, inform the individual of the correct procedures to file a grievance and the time periods involved. (C) The grievance form should be submitted to an administrative staff member. Upon receipt, the staff member

will request the client, patient, or participant to wait in the lobby while the CRO is contacted. The CRO will either meet with the client immediately or schedule a meeting at a later time with the client. In the event the CRO is absent from the office, an alternate will be appointed by the CEO. (D) Consumers and family members may have advocates present during all steps of a grievance who may or may not be staff members of FLCES. (E) If the grievance is predominantly of an administrative nature, the grievant should report/file the grievance through the relevant administrative channels. Grievance procedures should be followed in a hierarchical manner; that is, should a grievance resolution remain unfruitful at one level, the grievance should be escalated to the next level in the resolution chain. The following is the hierarchy of grievance:

Clinical Grievance Procedures:

1. Client/Patient/Participant who has a grievance should attempt to resolve the problem with his or her clinician.
2. If the clinician and the client/participant/patient cannot come to a mutually acceptable resolution, the grievance will be elevated to the CRO. The CRO will attempt to resolve the grievance.
3. Should the CRO and the grievant be unsuccessful in negotiating a resolution, the grievance will be escalated to the CEO or his/her appointed management representative.
4. If no mutually acceptable resolution can be reached, the CEO will consult additional (and if relevant, outside) consultation in an effort to finalize the grievance.
5. Unresolved grievances can be brought to the attention of the Florida Department of Health for additional guidance.

Administrative Grievance Procedures:

1. Client/Patient/Participant who has a grievance should attempt to resolve the problem with administrative staff member involved.

2. If the administrative staff member and the client/participant/patient cannot come to a mutually acceptable resolution, the grievance will be elevated to the supervisor (i.e., location office manager). The supervisor will attempt to resolve the grievance.
3. Should the supervisor and the grievant be unsuccessful in negotiating a resolution, the grievance will be escalated to the company business manager or his/her appointed management representative.
4. If no mutually acceptable resolution can be reached, the business manager will forward the grievance to the company CEO who will work with the grievant on finding a resolution.
5. Unresolved grievances can be brought to the attention of the Florida Better Business Bureau, though FLCES is not a member of the bureau.

As of October 2018, the Client Rights Officer (CRO) is: Sean Meyer, LMHC, Director of Clinical Services; Phone: (904) 239-3677; Email: smeyer@flces.com; Mailing Address: PO Box 54723; Jacksonville, FL 32245.

Acknowledgement:

I acknowledge that I have read this Grievance Policy and, if asked for, have been given a copy for my records. I understand that I can file a grievance complaint without worry or fear of retribution.

Patient Signature:_____

Patient Name:_____ DOB:_____

CONSENT TO EXAMINE AND TREAT

I hereby consent to examination and treatment by a behavioral health clinician on staff at Florida Counseling and Evaluation Services. I hereby affirm that I am of legal age and otherwise competent to consent to medical treatment. If I am not, the person signing below represents such person as the parent, legal guardian, or person otherwise allowed by law to consent to the examination and treatment of the patient and by their signature hereto so consents. As applicable, the treatment of minors (unaccompanied or accompanied) is hereby given.

I understand that developing a treatment plan with my provider and regularly reviewing our work toward meeting the treatment goal(s) are in my best interest. I agree to be an active participant in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist or the offices and staff of FLCES. I am aware that I may stop my treatment with my provider at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) I know that I must call to change/cancel an appointment at least 24 hours (1 full day) before the time of the appointment. I understand that my provider has reserved this appointment time specifically for me. If I do not cancel and do not show up, I will be charged **$65** for that appointment. I am aware that an agent of my insurance company or other third-party payor may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the provider may stop my treatment. I also understand that I am responsible for any payments not covered by my insurance or other third-party payor, including deductibles, out-of-network deductibles, and denial-of-service fees.

In order to foster a safe environment for everyone at Florida Counseling and Evaluation Services, the agency utilizes 24-hour video and audio surveillance recording services in all common, public areas of the premises. No surveillance or recording of any kind will be conducted in exam rooms, counseling, rooms or similar treatment areas unless a specific authorization has been obtained and has been signed by you (i.e., for student supervision observation services). By signing this consent form, you agree to video and audio surveillance and recording in the aforementioned areas of the agency. Review of surveillance and/or recordings is limited to authorized personnel only as directed by the privacy officer.

Patient's Signature:_____ Date:_____

For child (minor) patient, both parents should to sign this authorization:

***Parent's Signature** (**Parent 1** or Guardian)* _____ *Print Name:*_____

***Parent's Signature** (**Parent 2** or Guardian)* _____ *Print Name:*_____

Additional Information

If you are here to attend one of our Intensive Outpatient Programs (IOP) for Mental Health or Substance Abuse treatment, group counseling, of if you are here for a pre-surgical psychological evaluation (i.e., for bariatric surgery or spinal cord/pain pump surgery), please complete any additional forms provided by the front desk representative.

If you have been court-ordered, have been referred by the Safety Council (DUI-related), or have been referred by the drug and mental health court, please notify the front desk associate; additional forms may need to be completed. Also, provide referral documentation, including court orders for your healthcare provider.

If you want us to communicate or exchange medical information with your doctor (i.e., PCP, surgeon, etc.), please complete a Release-of-Information (ROI) form; ask the front desk associate for assistance.

If you require the completion of any paperwork (i.e., FMLA, short- or long-term disability, accomodation, etc.), please provide the front desk representative with any forms or relevant information.

Patient Name:_____ DOB:_____

HEALTH CARE STATUS AUTHORIZATION

I, _____ (name of patient, parent, or guardian) hereby give authorization to FLCES for the release of limited information concerning the status of my health care, including appointment information (obtaining, making, changing), and to discuss my plan of treatment with the following person(s):

Name of Individual (not patient's name):_____

Relationship to Patient (Ex. Wife, Spouse, Partner, etc.):_____

Telephone number of Authorized Individual:_____

I understand that I may revoke this authorization, in writing, at any time.

_____ _____

Patient/Guardian Signature **Date**

Patient Name:_____ DOB:_____

Credit/Debit Card Payment Consent and Authorization Form and Agreement

In an effort to settle potential outstanding charges on your account, we ask that you complete the following payment authorization form. As with your medical record, this information is kept confidential. Please read this agreement carefully and complete the fields below:

Patient Name _____
Print Last *First* *Middle Initial*

Name on card if different from above _____

I hereby authorize Florida Counseling and Evaluation Services to bill and charge my card for professional services and related fees as follows:

(Please initial)

_____ Charges determined by my insurance company as not covered for services received (including: co-pays, co-insurances, non-covered services, etc.), and missed appointments or appointments canceled with less than 24 hours' notice for the amount of **$ 65** for each missed appointment. I further authorize to be responsible for any charges occurred relative to collecting my outstanding debt including, but not limited to dispute fees, chargeback fees, collections costs, etc.

Type of card: VISA ____ MASTERCARD ____ AMEX ____ DISCOVER ____

Is this a health-savings/flexible spending account? YES ☐ NO ☐

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ **Security Number** (on back of card)**:** _____

Card holder's billing address for monthly card statements:

_____
Street/apt/floor *City* *State* *Zip Code*

I indemnify and hold Florida Counseling and Evaluation Services harmless against any liability pursuant to this authorization. I understand that my signature on this form and on a subsequent facsimile will serve as authorized signature on the credit card charge slip. This authorization will remain in effect until such time when a written request to cease charges is received. I understand that credit disputes subsequently ruled as valid by my credit card company will incur a $25.00 fee per dispute, which is my responsibility.

Card holder's signature: _____ **Date:** _____ / _____ / _____

Florida Counseling and Evaluation Services
PO BOX 54723, Jacksonville, FL 32245
Tel.: 904-239-3677 – Fax: 904-866-4029

Primary Care Provider (PCP) Coordination Authorization and Release of Information (ROI)

Patient Name: _____ **DOB:** _____

Address: _____ **Telephone:** _____

By marking (✓) on the applicable line(s)/field(s), I hereby authorize my provider and Florida Counseling and Evaluation Services (FLCES) to:

☐ I **DECLINE** to have my care coordinated with my primary care provider (PCP) or specialist. **Signature:** _____

*(Sign and date to the right **ONLY** if you **DECLINE** care coordination and ROI)* **Date:** ___/___/_____

☐ I **AUTHORIZE** to Obtain, Release, and Exchange my personal/health information/PHI to/with my primary care doctor or specialist below:

Physician's Name, Group, Clinic, etc.: _____

Address *(Street, City, State, ZIP)*: _____

Phone/Fax: _____

Type of communication/exchange of information/records authorized, check EITHER entire record OR summary, then additional fields:

☐ Entire Record (including psychotherapy notes) **OR** ☐ Summary Only **AND** ☐ Verbal Communication Only

I authorize to discuss my health care/treatment records (or my child's treatment, *where applicable*) with the releasing or obtaining entity.

Information I **DO NOT** want released pursuant to this authorization: _____

I hereby acknowledge awareness that such records may contain information related to mental health (including psychotherapy notes), substance abuse (both alcohol and drug), and sexually communicable diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information by signing this authorization and initialing the line that following this statement. _____ **(Initials of Patient)**

I understand that this authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released/exchanged pursuant to this authorization. I understand that I am not under any obligation to sign this authorization and that my ability to obtain treatment from FLCES or any entity affiliated with Florida Counseling and Evaluation Services will not depend in any manner on whether or not I sign this authorization.

I understand that I may obtain a copy of this authorization. I understand that the disclosing entity or person may charge me reasonable cost-based fees for any record it releases pursuant to this authorization, including records requested for my own personal use. The disclosing entity/person may waive such fees for records provided to another health care provider for continuing care.

I understand that although federal or state law may prohibit the recipient from re-disclosing information provided pursuant to this authorization, the disclosing entity/person may not have any control over the recipient, and, therefore, cannot guarantee that the recipient will not re-disclose such information. I hereby release the disclosing entity or its respective representatives and affiliates from any and all liability related to (a) the reliance upon this authorization, or (b) the release of information pursuant to this authorization.

By signing below, I understand this authorization form in its entirety and have been provided with the opportunity to ask my health care provider or its representative or affiliates for additional clarification. I authorize the person or entity named above to release health care related information about me as described above. I agree that a signed photocopy in lieu of this original may serve as a valid release-of-information form.

Patient Signature: _____ **Date/Time:** _____

If patient is a minor or incapacitated adult:

Representative Signature: _____ Date/Time: _____

Relationship to Patient: _____ Printed Name: _____

Witness Signature: _____ Date/Time: _____

PHQ-9 and GAD-7

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or over eating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ9 – Total Score: _____

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

GAD7 – Total Score: _____

Name: _____ DOB: ___/___/_____ Today's Date: ___/___/_____