New Patient Information Form

Please Print or Type

Advanced Behavioral Health Center
1799 Salk Avenue ~ Tavares, FL 32778
Tel: (352) 742-8300 ~ Fax: (352)742-8305

PATIENT INFORMATION

Last Name:______________________ **First Name:**__________________ **Middle Name:**________________

Suffix: JR SR III IV or______ **Nickname:**________________________ **Date of Birth:**________________

Gender: Male Female **Marital Status:** Divorced Married Separated Single Widowed

SSN:_____-_____-_____ **Spouse Name and Contact #:**____

Address:________________________________ **City:**_________________ **State:**______ **Zip:**____________

Email:________________________________ **Home #:**_____-______-______ **Mobile #**_____-_____-____

Work #:______-______-______ Other #:_____-______-______

REFERRAL INFORMATION

Source of referral: Internet Insurance Plan Friend Psychotherapist M.D.
Other: (specify):___________________________________

If M.D. (specify):__________________________ **Referred phone #**:________________________

Primary Care Physician:____________________ **PCP phone#:**_____________________________

EMERGENCY CONTACT INFORMATION

Contact Name:___________________________ **Relationship:**____________________________

Phone #:________________________________ **Mobile #:**________________________________

PREFERRED LAB AND PHARMACY INFORMATION

Lab: Quest Diagnostics Lab Corp Other (specify):___________________________________

Local Pharmacy: Walgreens Publix CVS Winn Dixie Mount Dora Tavares Pharmacy

Pharmacy Store #, Address or Phone:____

Mail Order Pharmacy: Express Scripts Optum Rx CVS Caremark PrimeMail Other:____________

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INSURANCE / FINANCIAL RESPONSIBILITY

Primary Payer: Self Pay BCBS United HealthCare (UBH) Medicare AARP Cigna Aetna
Health First Health Plans UMR GEHA Other:_____________________

Member Number (ID#)___________________________________ **Group #**:_________________________

Primary Insured Full Name:____

Primary Insured DOB:_____/______/______ **Primary Insured SS#**:_____-_____-_____

*****If through employer, please list employer:**____

Secondary Payer (if any)________________________ **Insureds SS #:**_____-_____-_____

Insurance ID #:________________________________ **Group #**:______________________

INSURANCE & MEDICARE ASSIGNMENT AND SELF PAY AGREEMENT AUTHORIZATION TO RELEASE

I certify that I have insurance coverage with the primary insurance company, if applicable, and the secondary insurance payer, if applicable, listed above. I assign directly to Advanced Behavioral Health Center all insurance payments, if any, otherwise payable to me for services rendered. I understand I am financially responsible for deductible, co-payments, co-insurances, non covered charges, and any and all balances not covered under a contractual agreement between Advanced Behavioral Health Center and my insurance or other third party payer. I authorize the use of my signature for all insurance submissions. I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to Advanced Behavioral Health Center for any services furnished to me by that provider.

If Self Pay, I understand it is my responsibility to pay for services rendered at the time of the visit.

I understand and agree that Advanced Behavioral Health Center may use my healthcare information to the above named insurance payer(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that if an authorization is needed from my insurance plan, it is my responsibility to obtain such authorization and provide this to Advanced Behavioral Health Center.

Signature of Patient, Parent or Personal Representative:
X____

Print Name of Patient, Parent or Personal Representative:
X____

Relationship To Patient Self Parent POA/Caregiver

Date:________________________________

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FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under the XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers for information needed for this or a related Medicare claim. I request the payment of authorized benefit mady on my behalf. I assign the benefits payable of physician services to the physician or organization furnishing the services, or authorize such physician or organization to submit a claim to Medicare payment to me.

X____ ____________________

Signature Date

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PATIENT CONSENT FOR RELEASE OF INFORMATION

____

Name Date of Birth

I allow Advanced Behavioral Health Center to release the following information to the name/names I have provided:

Appointment, medical and or billing information:

____

____

X____

Patient Signature **Date**

****

I authorize Advanced Behavioral Health Center to make the disclosure of the following information: dates of service, diagnosis and medications prescribed to my primary care physician.

Physician name:____ Phone:______________________

____

Patient Signature Date

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1966 (P.L. 104-191), 42 U.S.C. Section 132d, et Seq., and regulation promulgated there under, as amended from time to time (collectively referred to as HIPPA). This authorization affects your rights in the privacy of your personal behavioral health information. Please read it carefully before signing.

I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Advanced Behavioral Health Center will not condition treatment on your providing authorization for the requested use or disclosure. You may refuse to sign this authorization. You also have the right to revoke this authorization, in writing, at any time, except to the extent that Advanced Behavioral Health Center has taken action in reliance on it.

By signing this authorization I acknowledge and agree that any information used or disclosed pursuant could be at risk of re-disclosure by the recipient and longer protected under HIPPA. This authorization will expire on ________________(date). If I fail to specify expiration date this authorization will expire one year from the date on which it was signed.

This information has been disclosed to you for record protected by 42 CR Part 2. The Federal Rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

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PATIENT CONSENT FOR EVALUATION OR TREATMENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION CONSENT FOR OFFICE POLICIES AND PROCEDURES

Medical / Psychiatric care and treatment at Advanced Behavioral Health Center may be provided by Physicians, Licensed Clinical Social Workers (LCSW), Licensed Mental Health Counselors (LMHC), or other State of Florida recognized behavioral health practitioners. I hereby authorized Advanced Behavioral Health Center to evaluate, diagnose and render appropriate treatment to the patient designated below. This consent is knowingly and freely given. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Center of Medicare and Medicaid services, my Medigap insurer and their agents, any information needed to determine these benefits for related services.

I hereby give my consent for Advanced Behavioral Health Center (such as, but not limited to, medical billing company, EHR vendor, collection agency, automated appointment reminder vendor, dictation service, and electronic prescription vendor) to use and disclose protected health information (PHI) about me to carry out treatment, payment and **health care operations (TPO).** You can ask for a copy of the Notice of Privacy Practices provided by Advanced Behavioral Health Center which describes such uses and disclosures in detail.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Behavioral Health Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Privacy Officer at 2033 Wood Street, Ste 220, Sarasota, FL 34237.** You can also pick up a copy in our office. With this consent, Advanced Behavioral Health Center may communicate to me in reference to any times that assist the practice in carrying out TPO, such as, but not limited to, appointment reminders, billing statements, insurance issues and any messages pertaining to my clinical care, including laboratory test results, among others by use of phone calls to my home, mobile or other alternative location and speak or leave a message; SMS/Text message, Email, and/or postal delivery.

It is further understood that all information given by the patient or family member to a treating clinician is ***confidential*** and will not be released, except under special circumstances, without patient consent or consent of legal guardian as describe in details in the Notice of Privacy Practices. You can authorized us to release information relating to your treatment to another person, provider or company by signing a Release of Information (ROI) form provided by our office.

By signing this form, I am consenting to allow Advanced Behavioral Health Center to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Behavioral Health Center may decline to provide treatment to me.

I understand and agree with all the preceding information unless otherwise indicated in writing. I agree and accept the terms of all these documents. Copies of these documents are available at your request in or office or by downloading them from our website, www.AdvancedBehavioralHealthCenter.com

X____
Signature of Patient, Parent, Guardian or Personal Representative **Date**

x____
Print name of Patient, Parent, Guardian or Personal Representative

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UNIFORM OFFICE POLICY INFORMATION

Appointments are to be made and kept in a timely manner, **the patient is responsible** to keep track of his/her scheduled appointments:

If you can not keep your scheduled appointment, please give the **office at least 24 hours notice** to avoid a **$50.00 cancellation fee.**

Please call to confirm **ALL** scheduled appointments.

If you fail to keep your scheduled appointment, you will be charged a **$50.00 no show fee.**

If you fail to no show 3 appointments in a row or cancel 3 appointments late you may be discharged from our practice.

***** I understand that as a UBH/Medicaid patient I will be discharged from the practice for missing any appointment.*****

Please be advised that all **deductible, coinsurance and copayment fees** are expected to be paid before your visit.

For all payments, we accept Visa, MasterCard, Discover, Cash or Checks
*****We do not accept personal checks on the initial visit and consultation*****

If the outstanding balance **is not paid in full within 10 days** from your first statement, you will receive an **additional $5.00 collection fee** up to and including your third and final notice after which if not paid in full, **will be submitted to a collections agency for collection.**

Please **do not use cell phones in or office**; it interferes with our work and patient privacy.

It is the **patient's responsibility** to notify our office of **changes** to your insurance coverage. Please make sure we always have your **up-to-date insurance card** to file the claims to the correct company. I understand that if my insurance does not pay for my visit, I **agree to take responsibility for it** and pay Advanced Behavioral Health Center directly.

I have read and understand the information listed above and agree to comply with its contents. **I accept financial responsibility** for services rendered.

X____

Signature Date

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HEALTH SCREENING INFORMATION

The following information is provided by: Patient Parent Family Member Other________________________

1) Chief Complaint: What is the reason for your visit?

__Addiction __ADHD __Anger/Temper __Anxiety __Concentration is poor __Confusion __Depression
__Energy level decreased __Grief __Guilt __Hallucination __Helpless __Homicidal Thoughts __Hopeless
__Impulsivity __Irritablility __Isolation ___Mania __Medication Effects __Memory problem __Obsession
__Panic Attacks __Paranoia __Phobia __Self-injury __Suicidal Thoughts __Tearfullness __Worthlessness
__Other, please explain:

____

____

2) Psychiatric History:

Have you ever been treated for Mental Health Issues? __Yes __No

If YES, then answer the Treatment History below. If NO, then skip to the next question on Stressors.

INPATIENT TREATMENT HISTORY IN HOSPITAL OR PARTIAL HOSPITALIZATION:

Facility Name	Dates of Treatment	Reason or Explanation
______________________	______________	____________________

OUTPATIENT TREATMENT HISTORY:

Psychiatrist/Mental Health Provider	Dates of Treatment	Reason or Explanation
______________________	______________	____________________

STRESSORS:

__Disability __Educational Problems __Family __Financial Problems __Health Problems __Housing Problems
__Limited Resources __Marriage __Peer/Friendship __Support System __Work Issues

__Other:____

____

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3) Substance Abuse History:

Have you ever been treated for alcohol or drug use or abuse? __Yes __No

Substance	Have you tried before	Age Started	Last Used	Frequency
Alcohol	__Yes __No	____________	__________	______________
Caffeine	__Yes __No	____________	__________	______________
Tobacco	__Yes __No	____________	__________	______________
Cocaine	__Yes __No	____________	__________	______________
Hallucinogens	__Yes __No	____________	__________	______________
Heroin	__Yes __No	____________	__________	______________
IV Drug Use	__Yes __No	____________	__________	______________
Marijuana	__Yes __No	____________	__________	______________
Pain Pills	__Yes __No	____________	__________	______________
Other:____________	__Yes __No	____________	__________	______________

Periods of Abstinence:____

Have you experienced any of the following withdrawal symptoms and on what substances?

Withdrawal symptom	Experienced	What Substance(s)?
Anxiety	__Yes __No	____________________________________
D.T.'s (delirium tremens)	__Yes __No	____________________________________
Seizures	__Yes __No	____________________________________
Tremors	__Yes __No	____________________________________
Tachycardia	__Yes __No	____________________________________
Other:___________________	__Yes __No	____________________________________

SMOKING STATUS:

___ Current everyday smoker ___ Current some day smoker ___ Former smoker ___ Never Smoked

4) Medical History:

Please check beside any illness you have now or have had in the past.

__Arthritis __Blood Disorders __Bowel Problems __Cancer __Chest Pain __Chronic Pain __Diabetes __Glaucoma/Vision Problems __Heart Attack __Hepatitis __High Blood Pressure __Liver Disease __Lung Disease/Breathing Problems __Migraines __Seizures/Epilepsy __Stomach Problems __Stroke __Thyroid Disease __Ulcer
__Other:____

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SURGICAL PROCEDURES:

Type of Procedure	Date Occurred

SERIOUS INJURY/ACCIDENT:

Type of Injury/Accident	Date Occurred

ALLERGIES:

____
____
____

MEDICATIONS:

CURRENT MEDICATION	DOSE	FREQUENCY	LAST TAKEN

Have you ever discontinued or altered the prescribed dose of your medication without the recommendation of your treating physician? __YES __NO

If YES, please explain____

____

____

FOR WOMEN ONLY:

Date of last menstrual period:____________________________.

Are you currently pregnant or do you think you might be pregnant? __YES __NO

Are you planning to get pregnant in the near future? __YES __NO

Birth control method:____.

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5) Family History

Has anyone in your family ever been treated for any of the following, and which member?

ADHD____
Alzheimer's Disease______________________________________
Anxiety / Panic Attacks___________________________________
Bipolar Disorder____
Depression____
Heart Disease____
Schizophrenia____
Seizures____
Stroke____
Substance Abuse____
Suicide Attempts____

NUTRITIONAL ASSESSMENT:

Height:______________________ Current Weight________________

Without wanting to, have you lost / gained more than 10 pounds in the last 6 months? __YES __NO
If YES, Amount Lost:__________ Amount Gained:__________

Sleep Patterns: Hours each night:______ __Awakens Frequently __Difficulty returning to sleep __Difficulty falling asleep

FUNCTIONAL ASSESSMENT:
Have you experienced a recent loss of independence in caring for yourself? __YES __NO
If YES, please explain:____

Comments - In your own words, please describe why you have sought services with us?
____
____

Any additional information you care to share with us?
____
____

>>> Please bring this completed new patient paperwork with you at your first appointment or fax/send to us before your first appointment. Also, remember to bring your photo ID and insurance cards, if applicable. Thank You.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

8. PATIENT STATUS Single Married Other
Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______________________ DATE ______________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . ___ 3. ___ . ___
2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# | GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)