ADVANCED PSYCHIATRIC GROUP

APG RESEARCH, LLC.

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MINOR PATIENT INFORMATION SHEET

PATIENT NAME: _____ _____ _____
LAST FIRST M.I.

PATIENT DOB: _____ _____
AGE

ADDRESS: _____

_____
CITY, STATE, & ZIPCODE

SOCIAL SECURITY #: _____

GENDER: □ M □ F □ Transgender

HOME TEL: _____

SCHOOL: _____

STATUS: □ FULL TIME
□ PART TIME
_____ GRADE

Do both parents live in the same home?
□ Y □ N

If no, list primary household:
_____

MOTHER'S NAME: _____

MOTHER'S CELL #: _____

MOTHER'S OCCUPATION: _____

FATHER'S NAME: _____

FATHER'S CELL #: _____

FATHER'S OCCUPATION: _____

PERSON RESPONSIBLE FOR ACCT: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS IF DIFFERENT: _____

CONTACT PHONE: _____

How were you reffered to this office?
_____

Have you been a patient here before?
□ Y □ N _____

Name & phone # of closest relative/ friend not living with you:
_____
_____

NAME OF POLICY HOLDER: _____ DOB: _____

POLICY HOLDER SSN#: _____ GENDER: □ M □ F □ Transgender

PLACE OF EMPLOYMENT: _____

NAME OF PRIMARY INSURANCE: _____

INSURANCE PHONE #: _____

POLICY/MEMBER ID #: _____

GROUP #: _____

AUTHORIZATION #: _____

MEDICARE PATIENTS ONLY

****We Do Not Bill Secondary Insurance****

Please make sure you have set up the cross over so that claims can be paid, otherwise it will be the patient's responsibility.

NAME OF SECONDARY INSURANCE: _____

INSURANCE PHONE #: _____

ID #: _____

GROUP #: _____

EMERGENCY CONTACT: _____

PHONE: _____

RELATIONSHIP TO PATIENT: _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

_____

Pharmacy Name: _____ Phone: _____

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT:

KINDLY GIVE **<u>48 HOURS</u>**** NOTICE**

OTHERWISE, A CHARGE MAY BE MADE FOR THE TIME RESERVED

PLEASE CONTINUE TO PAGE 2

Please remember that insurance is considered a possible source of reimbursement for the fees you pay to the Doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. **If the insurance company doesn't pay within 60 days the patient is responsible for any balance due.**

I understand that if my insurer or the company which manages my mental health benefits requires reports from my therapist, these reports will likely include a treatment plan and periodic updates of the treatment plan. The purpose of these reports is to monitor progress, assure quality and to insure appropriate utilization of services. These reports may require verbal and written summaries which include a statement of the problem, history, diagnosis, a formulation of the problem and the dynamics as well as a plan of treatment. If I am a member of a PPO / HMO this may require reporting to my primary care physician.

I hereby authorize payment directly to Advanced Psychiatric Group, P. A. of any insurance benefits otherwise payable to me and all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans. Any non-assignable benefits are to be made payable jointly to the above named group and myself. I also give the above named group authorization to file any and all claims on my behalf to the insurance commissioner regarding my insurance company.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize assignee to release all information necessary to secure payment.

I intend to pay medical expenses as follows (check one or more):

□ CASH/CHECK
□ AMEX/DISC/MC/VISA
□ MEDICARE
□ INSURANCE

_____ _____
SIGNATURE DATE

_____ _____
RESPONSIBLE PARTY DATE

In the unfortunate event that this account is assigned to any attorney for collection and/or suit, the prevailing party shall be entitled to any and all attorney's fees and costs of collection. Also, an additional fee of 40% of the amount owed will be added for collection charges.

IN THE EVENT THAT I CHOOSE TO DISCONTINUE TREATMENT AND I DO NOT FOLLOW UP WITH MY MEDICAL PROVIDER IN 6 MONTHS OR LONGER, THEN I UNDERSTAND I AM AUTOMATICLALY DISCHARGED AS A PATIENT FROM THIS PRACTICE.

I certify that all information on these two pages are true. I have read and understand and agree to the above.

SIGNED: _____ **DATE:** _____

HEALTH HISTORY

** CONFIDENTIAL **

_____ (NAME)

_____ (DATE)

_____ (AGE)

_____ (BIRTHDATE)

☐ M ☐ F ☐ Transgender (GENDER)

_____ (DATE OF LAST PHYSICAL EXAMINATION)

_____ (REASON FOR VISIT)

SYMPTOMS / Select symptoms <u>you have or have had in the past year</u>

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Numbness
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders
- ☐ Sweats

GENITOURINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

_____ (DATE OF LAST MENSTRUAL PERIOD)

_____ (DATE OF LAST PAP SMEAR)

_____ (HAVE YOU HAD A MAMMOGRAM)

_____ (ARE YOU PREGNANT)

_____ (NUMBER OF CHILDREN)

CONDITIONS / Select conditions <u>you have or have had in the past year</u>

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

HEALTH HISTORY CONT.

** ALL INFORMATION IS STRICTLY CONFIDENTIAL **

FAMILY HISTORY / Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Select if your blood relatives had any of the following:

- □ Arthritis, Gout
- □ Asthma, Hay Fever
- □ Cancer
- □ Chemical Dependency
- □ Diabetes
- □ Heart Disease, Strokes
- □ High Blood Pressure
- □ Kidney Disease
- □ Tuberculosis
- □ Other

Relationship to you:

HOSPITALIZATIONS

Year	Hospital	Reasons for hospitalization and outcome

Have you ever had a blood transfusion? □ **Y** □ **N**

If yes, approximate dates: _____

SERIOUS ILLNESS / INJURIES

Description	Date	Outcome

PREGNANCY HISTORY

Birth Year	Sex	Complications *(if any)*

HEALTH HABITS

Select substances you use and describe how much you use

- □ Caffeine _____
- □ Tobacco _____
- □ Drugs _____
- □ Alcohol _____
- □ Other _____
- □ _____ _____

OCCUPATIONAL CONCERNS

Select any of the options that your work exposes you to

- □ Stress _____
- □ Hazardous Substances _____
- □ Heavy Lifting _____
- □ Other _____

Occupation: _____

MEDICATIONS / List any you are currently taking

_____

_____

Pharmacy Name: _____ Phone: _____

ALLERGIES / To medications or substances

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

SIGNATURE DATE

_____ _____

REVIEWED BY DATE

ADVANCED PSYCHIATRIC GROUP
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TREATMENT CONSENT FORM

NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE: _____

MOTHER

Explanation of Consent Form

This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed by the professional staff of Advanced Psychiatric Group. This form documents that the patient has consented to treatment at Advanced Psychiatric Group, including but not limited to medicine management, psychotherapy and counseling. This allows the professional staff at Advanced Psychiatric Group to provide services to you.

This form provides evidence that no guarantee is made by any professional at Advanced Psychiatric Group concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at Advanced Psychiatric Group. If you have any questions concerning this or any other matters, it is your responsibility to ask your psychiatrist or therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment

I _____ , for _____do hereby voluntarily consent to care and
(PRINT YOUR NAME) (PRINT THE CLIENT'S NAME)

treatment by Advanced Psychiatric Group, assistants and/or designees. I am aware that the practice of medicine, psychiatry, clinical psychology, and clinical social work is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the counseling process and that I share responsibility for my treatment. My responsibilities in treatment include informing the psychiatrist or therapist of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending in treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

_____ _____
SIGNATURE DATE

_____ _____
WITNESS DATE

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TREATMENT CONSENT FORM

NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE: _____

FATHER

Explanation of Consent Form

This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed by the professional staff of Advanced Psychiatric Group. This form documents that the patient has consented to treatment at Advanced Psychiatric Group, including but not limited to medicine management, psychotherapy and counseling. This allows the professional staff at Advanced Psychiatric Group to provide services to you.

This form provides evidence that no guarantee is made by any professional at Advanced Psychiatric Group concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at Advanced Psychiatric Group. If you have any questions concerning this or any other matters, it is your responsibility to ask your psychiatrist or therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment

I _____ , for _____do hereby voluntarily consent to care and
(PRINT YOUR NAME) (PRINT THE CLIENT'S NAME)

treatment by Advanced Psychiatric Group, assistants and/or designees. I am aware that the practice of medicine, psychiatry, clinical psychology, and clinical social work is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

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If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

_____ _____
SIGNATURE DATE

_____ _____
WITNESS DATE

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HIPAA

Consent to use and disclose your health information

This form is an agreement between you, _____ (Patient's name/Parent or Guardian name if Minor) and Advanced Psychiatric Group, P.A. If you wish to include the name(s) of an individual(s) (Ex: spouse, child, relative, other) to whom we can discuss your Private Health Information (PHI), please write their name here:_____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls PHI about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We also need it to arrange payment for your treatment.

By signing this form you are agreeing to let us use your information here and send it to others when the law requires us to use or share it. The Notice of Privacy Practices explains more in detail your rights and how we can use and share your information. Please read this before signing this Consent form. You can retrieve a copy of the NPP from the receptionist.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

If we want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this. In the future we may change how we use and share you information and so may change out NPP. If we do change it, you can get a copy from our office by calling us at 407-423-7149, or from our privacy officer.

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 wishes.

After you have signed this consent, you have the right to revoke it (by writing a letter telling 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.

_____ _____
CLIENT SIGNATURE / PERSONAL REPRESENTATIVE DATE

_____ _____
CLIENT NAME / PERSONAL REPRESENTATIVE RELATIONSHIP TO CLIENT

_____
Description of personsal representative's authority

Date of NPP _____ Copy given to the client / parent / personal represenative.

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FINANCIAL POLICY

As part of an effort to provide the best possible medical care to you, we would like to explain our financial policies in advance.

1) Your health insurance is a contract between you, your insurance company, and your employer. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, or coordination of benefits. Our professional services are rendered to you, not the insurance company. Therefore, payment for services ultimately is your responsibility.

If you have a referral based on HMO or PPO insurance plan, it is your responsibility to obtain initial referrals or authorizations. Not all therapy services or psychiatric conditions are part of a covered benefit by all insurance plans. Please understand that if your insurance does not pay for a particular service, you will be responsible for the payment in full. It is your responsibility to understand your plan benefits. We only file with your primary insurance. It is the patient's responsibility to file any additional insurance.

Please inform the receptionist of ANY changes in your benefits or changes in the company that insures you PRIOR to your appointment. If by your failure to provide us with current information, your insurance company subsequently denies us payment, you may be held financially responsible for those unpaid charges.

Your deductible and co-payment are due at the time of your visit. For your convenience we accept cash, checks, American Express, Discover, Visa, and Master Card. All returned checks are subject to a returned check fee of $35.00. There will be a $10.00 fee for sending you a bill for any unpaid balance.

2) Completion of forms or requests for letters regarding such matters as employment, disability, education or legal issues will be subject to a minimum charge of $50.00 depending on the length of the letter/paperwork. We ask that you give us at least 5-7 working days advance notice so we have time to fulfill your request. We will not provide these additional services at the initial consultation.

3) We ask that you give us a 48 business hours prior notice of cancellation. You may be liable for the full cost of the time that is specifically set aside for your appointment if you do not. We cannot charge your insurance company for the no show or late cancellation therefore you may be charged the full office visit fee for the time reserved.

4) ALL prescription refills require 48 business hours notice and a consultation with the physician within the previous 90 days. If your prescription has run out as you did not keep a scheduled appointment, there will be a $35.00 charge for writing a renewal. No prescriptions renewal will be called in during the weekends.

5) Our providers will be happy to answer short questions over the phone or take a phone call for an emergency or medication issues. However, it is best to discuss more involved issues during an appointment. We will make every effort to accommodate you as soon as possible within the constraints of our schedule. Telephone consults of more than 5 minutes may be charged at our regular fee.

ACKNOWLEDGEMENT

I have read and understand the Financial Policy above.

_____ _____

CLIENT NAME DATE

_____ _____

CLIENT SIGNATURE / PATIENT / GUARDIAN IF MINOR DATE

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DISABILITY DISCLAIMER

Our office does not specialize in disability claims, therefore we advise you of this upon scheduling. We cannot guarantee that these additional services will be provided at the initial consultation or upon request.

I understand that Advanced Psychiatric Group, P.A. does not specialize in disability claims. I understand that I am a new patient and have elected to be seen for treatment only. Providers in this office will not complete FMLA paperwork, disability forms, or provide documentation to support medical leave from work for new patients.

ACKNOWLEDGEMENT

I have read and understand the Disability Disclaimer above.

_____ _____
CLIENT NAME DATE

_____ _____
CLIENT SIGNATURE / PATIENT / GUARDIAN IF MINOR DATE

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OFFICE POLICY CHECKLIST

1. Please make sure to get your prescriptions at the time of the your appointment. Any refill request prior to or after an appointment will be subject to a refill fee of $35.

2. Please give us **48 hours** (2 business days) to cancel or reschedule an appointment. Otherwise it will be subject to a **$50.00** fee or a **full office visit fee**. This also applies if you fail to show up to a scheduled appointment.

3. Please call us at least **48 hours** (2 business days) prior to your appointment if your insurance has changed. Not doing so can delay the verification process and you may be **subject to the full office visit fee**.

4. Phone consultations should be reserved for emergencies only. **This is not billable to insurance.**

5. Prior authorizations are needed for any medication, please have your health insurance fax us the "**Prior Authorization**" forms to fill out and fax back to the insurance (Prior Authorizations are only handled by fax). If we do this for you there will be a $25 fee.

6. If you need a form completed (e.g. medical leave, school), please call the office and set up a separate appointment for that. We need at least a 5-7 working days advanced notice to prepare the paperwork. There will be a minimum charge of $50 for each letter or form completed.

ACKNOWLEDGEMENT

I have read and understand the Office Policy Checklist above.

_____ SIGNATURE

_____ DATE