

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 made 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 Irritability Isolation Mania Medication Effects Memory problem Obsession
- Panic Attacks Paranoia Phobia Self-injury Suicidal Thoughts Tearfulness 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Hallucinogens	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
IV Drug Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Pain Pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

Periods of Abstinence: _____

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

Withdrawal symptom	Experienced	What Substance(s)?
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
D.T.'s (delirium tremens)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tremors	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tachycardia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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



CARRIER

HEALTH INSURANCE CLAIM FORM

PCIA

1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> CHARITY (Charity's #) <input type="checkbox"/> GROUP (Group #) <input type="checkbox"/> FECA (FECA #) <input type="checkbox"/> FECA (FECA #) <input type="checkbox"/> OTHER (Other #) <input type="checkbox"/>		16. INCURRED I.D. NUMBER (FOR PROGRAMS OTHER THAN FECA)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/YY) <input type="checkbox"/> SEX (M <input type="checkbox"/> F <input type="checkbox"/>	
3. PATIENT'S ADDRESS (No., Street)		4. PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
4. PATIENT'S CITY		5. PATIENT'S STATE	
5. PATIENT'S ZIP CODE		6. PATIENT'S OCCUPATION (Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
6. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		7. INSURED'S ADDRESS (No., Street)	
7. OTHER INSURED'S POLICY OR GROUP NUMBER		8. INSURED'S CITY	
8. OTHER INSURED'S DATE OF BIRTH (MM/YY) <input type="checkbox"/> SEX (M <input type="checkbox"/> F <input type="checkbox"/>		9. INSURED'S STATE	
9. EMPLOYER'S NAME OR SCHOOL NAME		10. INSURED'S POLICY GROUP OR FECA NUMBER	
10. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S DATE OF BIRTH (MM/YY) <input type="checkbox"/> SEX (M <input type="checkbox"/> F <input type="checkbox"/>	
11. INSURANCE PLAN NAME OR PROGRAM NAME		12. EMPLOYER'S NAME OR SCHOOL NAME	
12. INSURANCE PLAN NAME OR PROGRAM NAME		13. INSURED'S POLICY GROUP OR FECA NUMBER	
13. INSURANCE PLAN NAME OR PROGRAM NAME		14. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 1-4	
14. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		15. INCURRED I.D. OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits other than Social Security to the party who accepts responsibility.)	
15. INCURRED I.D. OR AUTHORIZED PERSON'S SIGNATURE		16. INCURRED I.D. OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits other than Social Security to the party who accepts responsibility.)	
16. DATE OF CURRENT ILLNESS (MM/YY) <input type="checkbox"/> IF PATIENT HAS HAD ILLNESS OR INJURY (Specify date) (MM/YY)		17. DATES PATIENT ELIGIBLE TO WORK IN CURRENT OCCUPATION (FROM MM/YY TO MM/YY)	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/YY TO MM/YY)	
18. RESERVED FOR LOCAL USE		19. OUTSIDE LAB? (YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES	
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1-13 OR 4 TO ITEM 24 BY LINE)		20. MEDICAL REGISTRATION CODE (ORIGINAL REF. NO.)	
20. MEDICAL REGISTRATION CODE		21. PRIOR AUTHORIZATION NUMBER	
21. FEDERAL TAX I.D. NUMBER (SEE INSTRUCTIONS)		22. PATIENT'S ACCOUNT NO.	
22. PATIENT'S ACCOUNT NO.		23. ACCOUNT GUARANTEE (IF YOU OWE, SEE INSTRUCTIONS) (YES <input type="checkbox"/> NO <input type="checkbox"/>	
23. ACCOUNT GUARANTEE		24. TOTAL CHARGE	
24. TOTAL CHARGE		25. AMOUNT PAID	
25. AMOUNT PAID		26. BALANCE DUE	
26. BALANCE DUE		27. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
27. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		28. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
28. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		29. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
29. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		30. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION