BayBrooke Center

for Independence & Wellness

NEW PATIENT INFORMATION SHEET

PATIENT'S NAME: _____ DOB: _____

ADDRESS: _____
(street) *(apt#)* *(city)* *(zip)*

PHONE: (CELL) _____ (WORK) _____

(EMAIL) _____ (EMERGENCY) _____

PATIENT SS#: _____ PATIENT DRIVER LIC# _____

PATIENT'S/GUARDIAN'S EMPLOYER: _____

FAMILY PHYSICIAN: _____ REFERRED BY: _____

FINANCIAL INFORMATION

RESPONSIBLE PARTY: _____ SS#: _____

ADDRESS (IF DIFFERENT FROM PATIENT): _____

PRIMARY INSURANCE CARRIER: _____ ID#: _____

SUBSCRIBER'S NAME: _____ DOB: _____

EMPLOYER: _____ PHONE: _____

SECONDARY INSURANCE CARRIER: _____ ID#: _____

SUBSCRIBER'S NAME: _____ DOB: _____

EMPLOYER: _____ PHONE: _____

I authorize treatment of the above named patient. I have reviewed the financial policies and procedures of the office. In consideration for clinician's services rendered for the above named patient by BayBrooke Center, I hereby assign BayBrooke Center the benefits due me under any medical insurance that is in effect during my treatment. I agree that if benefits are insufficient to cover the entire expense, or if the treatment is not covered by my insurance, I will be responsible for the payment of the entire bill. 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. I also authorize payment of medical benefits to the undersigned physician or supplier for services described.

Patient or Legal Guardian _____ Relationship: _____ Date: _____
signature

Witness _____ Date _____
signature

ADULT INTAKE FORM

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Date of Most Recent Marriage:_____Date Divorced/Widowed: _____

Other Marriages: _____

Household Members:

	Name	Age	Grade/Occupation	Relationship
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Are you currently under a doctor's care? Yes_____No_____Who

is your Primary Care Physician? _____

When was your last physical examination? _____

Other doctors involved in your care: _____

_____

Current Health Problems or Symptoms: _____

_____

Do you have any allergies or adverse reactions to particular drugs or substances?

_____

_____

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ADULT INTAKE FORM

Medications you are currently using and why:

Medication	Dosage	Doctor Prescribing	Reason Prescribed

Past Treatments for Medical Problems, Accidents or Injuries: _____

_____

_____

_____

Would you like your physician to be contacted by us or receive a copy of your treatment plan? Yes_____No ____

If so, please supply the physician's name, phone number, and/or fax number: _____

_____

Current alcohol or drug use? _____

Do you have any past history of problems related to alcohol or drug use? If so, please describe: _____

_____

_____

Have you been seen previously by a Psychologist, Psychiatrist or other Mental Health Professional? Yes No

Name of Clinician: _____

Address and Phone # if known: _____

_____

When? _____

Reason for prior counseling? _____

_____

_____

_____

Have you ever been hospitalized for treatment of emotional or substance abuse problems? Yes_____No _____

If so, when? _____

Do you have a past history of:

Sexual Abuse_____Physical Abuse _____

Emotional Abuse_____Other Trauma (specify) _____

_____

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ADULT INTAKE FORM

Do you have any history of, or current involvement in court proceedings? (i.e. divorce litigation, arrests or convictions for other than minor offenses) _____

_____

Are there any spiritual or cultural issues that might affect your treatment? _____

_____

Why are you seeking counseling at this time? _____

_____

_____

_____

_____

_____

_____

(This information will be held confidential and privileged)

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PRIVACY PROTECTION NOTICE

The passage of the Health Insurance Portability and Accountability Act (HIPAA) now extends similar privacy protection to all health care recipients. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of Personal Health Information (PHI) for treatment, payment, and health care operations. I want to briefly summarize the highlights of HIPAA and its application to your PHI. To request a copy of this document, please contact our office via phone, mail/email, or in person.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of Protected Health Information. These rights include requesting that I amend your record, requesting restrictions on what information from your Clinical Records is disclosed to others, having any complaints you make about my policy and procedures recorded in your records, and the right to a paper copy of this agreement. I am happy to discuss any of these rights with you. The law requires that I obtain your signature acknowledging that I have provided you with this information. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time.

HIPAA HIGHLIGHTS:

I may use or disclose your protected health information for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

"PHI" refers to information in your health care record that could identify you.
"Treatment" is when I provide, coordinate, or manage your health care and other services related to your health care.
"Use" applies only to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
"Disclosure" applies to activities outside of my practice group, such as release, transferring, or providing access to information about you or other parties.

HOW HIPAA AFFECTS YOU:

You should experience no changes in how your Personal Health Information is used or disclosed. Our minimum practice standards have always met the standards of HIPAA.

What actions have been taken by BayBrooke Center:
1. All staff has been educated about HIPAA. Employment policies have been updated.
2. Contracts with vendors have been revised to ensure compliance with HIPAA, including our computer consultants, answering service, and transcription service.
3. Copies of the Florida Notice Form are available upon request.

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CONFIDENTIALITY AND EMERGENCY PROCEDURES

CONFIDENTIALITY: All communication between therapist and client is held in strictest confidence as guaranteed by Florida Statutes #490.0147 and #490.503. In general, we prefer that you sign release forms allowing us to mutually exchange information with important referral sources (e.g. family physician, school officials) or with a previous therapist. Your insurance company and managed health care program (if applicable) will also request information regarding your treatment in order to process your insurance claim.

In cases of suspected child abuse or elder abuse/neglect, or if danger of violence is considered to be imminent, all licensed therapists are required by law to inform legal authorities. In addition, confidentiality cannot be guaranteed in cases where a judicial order is issued.

At BayBrooke Center (BBC), we are a team of professionals with considerable training and experience in the field. This is a valuable resource in delivering the best care. On occasion, your therapist may find it helpful to consult with other professionals about your care. Efforts are made to keep your identity confidential during these consultations, and the consultants are also legally bound to maintain confidentiality of the information your therapist shares.

Emergency Procedures: Because BayBrooke Center is an outpatient practice, we cannot guarantee that we can respond to emergencies (e.g. where there is a risk that someone will be harmed.) We suggest that you contact the nearest emergency room or call your managed care company for direction. If you have any questions regarding emergency procedures, we encourage you to talk with your therapist at the beginning of treatment.

I have read and fully understand that Confidentiality and Emergency Procedure Policies of BayBrooke Center.

_____ _____

Signature of client or guardian Date

_____ _____

Witness Date

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FINANCIAL POLICY

In order to promote an atmosphere of understanding and trust, we have detailed our financial policy below. We ask that you carefully read and then sign this financial agreement. If you have any questions, please discuss them during your first session.

I. PAYMENT: Full payment is due at the time of service. We accept cash, checks and most credit cards. Any other financial arrangement must be made with your therapist and specified in writing.

II. CANCELLATION POLICY: Continuity of treatment is essential in order for you to benefit from your sessions. Since your treatment requires that your therapist reserve a significant amount of time exclusively for your benefit, cancellations and missed appointments necessitate a policy that is fair to both you and your therapist. In the event that your health, family, work responsibilities, or other reasons require you to cancel an appointment, there will be no charge for cancellations made **AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT.** Such notification will allow your therapist to schedule other commitments. If insufficient notice is provided, 50% of your total fee will be charged. These charges cannot be submitted to your insurance company. This policy applies to all clients of BayBrooke Center.

III. INSURANCE: Once we have proof of your insurance coverage, we will verify your benefits. However, we cannot guarantee the amount of reimbursement you will receive from your insurance company. We file paper insurance claims twice a month and electronically every day to companies that allow for it. We will be happy to file your claim for you, unless your therapist is not a participating provider in your managed care plan. You will receive a statement from us that will allow you to submit your own claims. In all cases, you are ultimately responsible for all charges in our office. Please remember that insurance is primarily a contract between you and your insurance company. We cannot become involved in disputes about coverage, deductibles, secondary insurance, or other matters beyond supplying factual information as required.

IV. BILLING: BayBrooke Center does not do any billing. Full payment is expected at the time of your appointment. BayBrooke Center reserves the right to report seriously delinquent accounts to a collection agency of our choosing.

V. ENDORSEMENT: I have carefully read and fully understand this financial agreement.

_____ _____

Signature of client/guardian Date

_____ _____

Witness Date

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MANAGED CARE NOTICE

According to the information which you have provided, your services in our office may be eligible for reimbursement under an Employee Assistance Program or a Managed Care Program. Payment for services must be authorized in advance by your managed care program case manager. The EAP or Managed Care authorization process will require that we provide information regarding your reasons for seeking treatment, the plan of care, which we recommend, and your cooperation with our recommendations. Coordination of care with a primary care physician or any other mental health providers whom you are currently seeing may also be required. If you have questions about this policy, please address it with your therapist in the first session.

It is important for you to be well-informed about the specific coverage limitations of your EAP or Managed Care Plan. The number of sessions, the type of services, and the frequency of sessions may be limited by your Managed Care case managed based upon his/her interpretation of your insurance contract. There may be services which we recommend based upon your needs but which may not be authorized by your Managed Care Plan. We will make every effort to notify you in advance if your Managed Care Plan denies a request for service. You may still choose to receive these services at your own expense. Please discuss these situations with your therapist so that you can make an informed decision.

Our office staff will be happy to answer questions about your insurance coverage. The information we can provide is based upon the information we obtain from your insurance company when we verify benefits. Most companies, however, have a disclaimer that the information is not a guarantee of payment. Therefore, we recommend that you discuss these issues directly with your insurance company.

I have read and understand that my services are part of an EAP or Managed Care Plan.

_____ _____

Signature of client/guardian Date

_____ _____

Witness Date

BayBrooke Center • 4995 49th Street North • St. Petersburg, FL 33709 • Tel: 727.827.7890 • Fax: 727.279.4631 • info@baybrookecenter.com

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CREDIT CARD AUTHORIZATION

If I miss an appointment without notification per this agreement, 50% of the fee for my scheduled appointment may be charged to the following credit card:

____ VISA ____ MasterCard

____ Discover ____ American Express

Card Number: _____

Name as it appears on the card: _____

Expiration Date: _____

Security code (3-4 digits on the back of your card): _____

Billing zip code: _____

Signature: _____

Once an appointment has been scheduled and attendance to the appointment has been made, payment for the services rendered is required. Co-Pays, Cost-Shares, and Patient Payment Responsibilities are expected at the time of appointment. In the event that the insurance does not establish the amount for co-pay until after services are rendered, the client's signature on this page authorizes BayBrooke Center to charge the card listed above for the services rendered.

A typical session is 50 minutes long, and is $90. Phone consultations between sessions, or responding to emails that take more than 10 minutes are billed at a prorated rate.

You may schedule appointments by phone. I realize that schedules change and things happen-- if you need to reschedule an appointment, please do so 24 hours in advance. If you fail to reschedule, or simply do not show up for your scheduled time, you will be charged for the session. You are required to keep a current credit card number on file with the office (it will be kept in a secure place.)

I accept credit cards, checks, or cash. Please make checks payable to BayBrooke Center. A non-refundable fee of $35 will be charged for all returned checks and all future payments must be made in either cash or by credit card.

I have read and understand the policies set in place by BayBrooke Center.

_____ _____

Signature of client/guardian Date

_____ _____

Witness Date

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