# Advanced Psychiatric Services of Central Florida

Name _____ Date of birth _____

Address _____ Social Security # _____

City, State, Zip _____

Phone Numbers: Home_____ Cell _____ Work _____

Please circle your preferred contact and/or message number.

Is it ok to leave appointment reminders and/or requests to call me on the number you circled above? Yes No

Primary Care Provider_____

It is often necessary to coordinate care with your primary care provider; May I have your permission to contact your primary care provider? Yes or No

Are you currently working or in school? Yes or No. Where? _____

## INSURANCE INFORMATION

**Medicare #** _____ Name as it appears on card _____

Part B, Medical effective date _____

**Medicaid #** _____ Name as it appears on card _____

**Private Insurance** Company Name _____ Phone _____

Policy Number _____ Group _____ Employer _____

Policy Holders Name _____ DOB: _____ SS#: _____

Place of Employment: _____ Relationship to Patient _____

Insurance Company Address _____

**What is your primary insurance?** _____

**Is there any other insurance we need to know about?**

We will bill your insurance. However, you are responsible for your co-pay. Accounts 90 days or more delinquent will not be able to schedule an appointment or get refills on prescriptions.

_____ _____

Signature Date

# Advanced Psychiatric Services of Central Florida

Current Medications:

| Medication | Dose | Directions |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Allergies:

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Preferred Pharmacy _____

_____ _____

Signature Date

# Advanced Psychiatric Services of Central Florida

**Medical History** _____

_____

_____

_____

_____

_____

_____

_____

**Psychiatric History**

Have you ever been treated for a psychiatric disorder? Yes or No

| Problem | Medications | Therapy | Provider |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Do you remember the medications you have tried? How did they work for you?

| Medication | Effective | Ineffective/ Side-effects |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever been admitted into the hospital for psychiatric problems?

| Problem | Hospital | Dates | Provider |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

_____ _____

Signature Date

# Advanced Psychiatric Services of Central Florida

There is no on-call for this practice, for emergencies you may call 911 or go to your nearest emergency room. For routine matters or to schedule an appointment, please call during regular business hours

Monday – Thursday 9 AM to 5 PM and Friday 9 AM to 12 PM

Phone: 863-382-PSYC (7792) Fax: 863-382-0015

Physician Responsibilities:

Provide skilled psychiatric evaluation and medication management. Provide enough refills to get patient from one appointment to the next.

***Any medication changes, refills etc. should be handled at an office appointment with the doctor. There should be no telephone calls or faxes requesting refills. Enough refills will be given at your appointment to last until your next appointment.

Client Responsibilities:

- To notify Advanced Psychiatric Services of Central Florida of any changes in their condition
- To follow their mutually agreed upon treatment plan or notify Advanced Psychiatric Services of Central Florida if unable to follow treatment plan.
- To call 911 or go to the closest emergency room if feeling suicidal or homicidal.

_____ _____

Signature Date

# Advanced Psychiatric Services of Central Florida

**Permission to pay Medicare benefits to Advanced Psychiatric Services of Central Florida**

- I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.
- I request the payment be made on my behalf.
- I also understand that I am responsible for any health insurance deductibles and co-pays.

**Client Responsibility for Payment**

- I understand that Advanced Psychiatric Services of Central Florida will promptly present claims for the payment of service rendered to my private insurance company (ies)
- I also understand that I am responsible for the entire bill or balance of the same bill as determined by Advanced Psychiatric Services of Central Florida, if submitted claims or any part of them are denied for payment.
- I understand that Advanced Psychiatric Services of Central Florida failure to request immediate payment does not release me or my estate from the obligation to pay Advanced Psychiatric Services of Central Florida. I understand that this consent can be revoked by me at **ANY** time.
- I agree to abide by all the conditions and I acknowledge that this agreement shall bind me, my heirs, executors, administrators and assigns.
- I hereby certify that I have read and understand the above agreement and I have executed said agreement of my own free will effective on the date below.

_____ _____

Signature of Client/Guardian Date

_____ _____

Relationship to Patient if unable to sign Reason unable to sign

_____ _____

Signature of Witness Date

# Advanced Psychiatric Services of Central Florida

PLEASE CROSS OUT ANY ARTICLE WHICH DOES NOT APPLY OR IS NOT CONSENTED TO

## I. REQUEST FOR TREATMENT AND AUTHORIZATION TO TREAT

I hereby request evaluation and treatment by Advanced Psychiatric Services of Central Florida and consent to such care and treatment.

## II. ASSIGNEMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Advanced Psychiatric Services of Central Florida.

I hereby agree that Advanced Psychiatric Services of Central Florida may receipt for any such payment, and that its receipt shall be in conclusive acknowledgement by me that I have received benefits from the insurance company in the sum specified in such receipt and agree that such payment shall discharge the insurance company of any an all obligations under the policy to the extent of such payment. I understand that I am financially responsible to Advanced Psychiatric Services of Central Florida for charges not covered by this assignment.

## III. MEDICARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.

## IV. PLAN OF TREATMENT AND GOALS

My Psychiatrist reviewed the Plan of Treatment, risks and benefits of treatment, and goals with me and/or my significant other. I am in agreement with the plan and treatment goals.

## V. PATIENT RIGHTS

I certify that I have received and reviewed a copy of the Patient's Rights, and I understand them.

_____ _____

Signed Relation Date

_____ _____

Witnessed Date

# Receipt Notice of Advanced Psychiatric Services of Central Florida Privacy Practices

Patient Name: _____ Date of intake: _____

My signature on this form acknowledges that I have received a copy of Advanced Psychiatric Services Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Advanced Psychiatric Services of Central Florida and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I have regarding the privacy of my health information.

_____ _____

Patient's Signature Date

_____ _____

Signature of Patient's Representative if Patient is Unable to sign Date

## TO BE COMPLETED BY CLINICIAN IF FORMS IS NOT SIGNED

1. Was the patient provided with a copy of the Advanced Psychiatric Services of Central Florida of Privacy Practices? ☐ Yes ☐ No
2. Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of Notice and explain why the patient was not able or willing to sign this form.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Signature of Clinician Date

# Advanced Psychiatric Services of Central Florida

There is no on-call for this practice, for emergencies you may call 911 or go to your nearest emergency room. For routine matters or to schedule an appointment, please call during regular business hours

Monday – Thursday 9 AM to 4 PM and Friday 9 AM-12 PM

Phone: 863-382-PSYC (7792) Fax: 863-382-0015

Physician Responsibilities:

Provide skilled psychiatric evaluation and medication management. Provide enough refills to get patient from one appointment to the next.

***Any medication changes, refills etc. should be handled at an office appointment with the doctor. There should be no telephone calls or faxes requesting refills. Enough refills will be given at your appointment to last until your next appointment.

Client Responsibilities:

- To notify Advanced Psychiatric Services of Central Florida of any changes in their condition
- To follow their mutually agreed upon treatment plan or notify Advanced Psychiatric Services of Central Florida if unable to follow treatment plan.
- To call 911 or go to the closest emergency room if feeling suicidal or homicidal.

_____ _____

Signature Date

- **THIS IS YOUR COPY TO KEEP**

# Notice of Advanced Psychiatric Service of Central Florida

# Privacy Practices

**THIS IS YOURS TO TAKE**

This notice describes how medical information about you may be used and disclosed and how you get access to this information. Please review it carefully.

**Use and Disclosure of Health Information**

Advanced Psychiatric Services of Central Florida may use your health information, information that constitutes protected health information as defined in the Privacy rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for purposed of providing your treatment, obtaining payment for your care and conducting health care operations.

**The following is a summary of the circumstances under which and purposed for which your health information may be used and disclosed.**

**To Provide Treatment:**

Advanced Psychiatric Services of Central Florida may use your health information to coordinate care within the entity and with others involved in your care, such as your such as your attending physician, members of Advanced Psychiatric Services of Central Florida in coordinating care. Advanced Psychiatric Services of Central Florida also may disclose your health care information to individuals outside of the entity involved in your care including family members, pharmacist, suppliers of medical equipment or other health care professionals.

**To Obtain Payment:**

Advanced Psychiatric Services of Central Florida may include your health information in invoices to collect payment from third parties for the care you receive from us. For example, Advanced Psychiatric Services of Central Florida be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or ourselves. Advanced Psychiatric Services of Central Florida may need to obtain prior approval from your insurer and may need to explain to the insurer your need for psychiatric or mental health services that will be provided to you.

**To Conduct Health Care Operations:**

Advanced Psychiatric Services of Central Florida may use and disclose health information for its own operations in order to facilitate the function of the entity and as necessary to provide quality care to all of our patient's. Health care operations include such activities as:

1. Quality Assessment and improvement activities
2. Activities designed to improve health or reduce health care costs
3. Protocol development, case management and care coordination.
4. Conducting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment
5. professional review and performance evaluation
6. Training programs including those in which students, trainees or practitioners in health care learn under supervision. I.e. Student nurses, medical students or residents.
7. Training of non-health care professionals
8. accreditation, certification, licensing or credentialing activities
9. review and auditing, including compliance reviews, medical reviews, legal services and compliance programs

10. Business planning and development including cost management and planning related analyses and formulary development
11. Business management and general administrative activities of Advanced Psychiatric Services of Central Florida.

For example, Advanced Psychiatric Services of Central Florida may use your health information to evaluate its staff performance, combine health information with other clients in evaluating how to more effectively serve all clients, disclose your health information to staff and contracted personnel for training purposed, use your health information to contract you as a reminder regarding an appointment.

Federal privacy rules allow Advanced Psychiatric Services of Central Florida to use or disclose your health information without your consent or authorization for a number of reasons.

**When Legally Required:**

Advanced Psychiatric Services of Central Florida may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth, death and conduct of public health surveillance, investigations and interventions.

- To report adverse events, product defects, to track products of enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration

- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading disease

- To an employer about and individual who is a member of the workforce as legally required

**To Report Abuse, Neglect, or Domestic Violence:**

Advanced Psychiatric Services of Central Florida is allowed to notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. Advanced Psychiatric Services of Central Florida will make this disclosure only when specially required or authorized by law or when the patient agrees to the disclosure.

**To Conduct Health Oversight Activities:**

Advanced Psychiatric Services of Central Florida may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Advanced Psychiatric Services of Central Florida, however may not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care of public benefits.

**In Connection with Judicial and Administrative Proceedings:**

Advanced Psychiatric Services of Central Florida may disclose your health information in the course of any judicial or administrative proceeding in response to an order of the court or administrative tribunal as expressly authorized by such order in response to a subpoena, discovery request or other lawful process, but only when Advanced Psychiatric Services of Central Florida makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

**For Law Enforcement Purpose:**
Advanced Psychiatric Services of Central Florida may disclose your health information to a law enforcement official for law enforcement purposes as follows:

1. As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant subpoena or summons or similar process
2. For the purpose of identifying or locating a suspect, fugitive, material witness or missing person
3. Under certain limited circumstances, when you are the victim of a crime.
4. To a law enforcement official if Advanced Psychiatric Services of Central Florida has a suspicion that your death was the result of a criminal conduct including criminal conduct at this facility.
5. In an emergency in order to report a crime.

**To Coroners and Medical Examiners:**
Advance Psychiatric Services of Central Florida may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.

**To Funeral Directors:**
Advanced Psychiatric Services of Central Florida disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, may disclose your health information prior to and in reasonable anticipation, of your death.

**For Organ, Eye or Tissue Donation:**
Advanced Psychiatric Services of Central Florida may use or disclose your health information to organ procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

**For Research Purposes:**
Advanced Psychiatric Services of Central Florida may, under select circumstances, use your health information for research. Before we disclose any of your health information for such research purposes, the project will be subject to an extensive approval process. Advanced Psychiatric Services of Central Florida will ask your permission if any researcher will be granted access to your individually identifiable health information.

**In the Event of a Serious Threat to Health or Safety:**
Advanced Psychiatric Services of Central Florida may, consistent with applicable law and ethical standards of conduct disclose your health information if we believe, in good faith, that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health of safety or to the health and safety of the public.

**For Specified Government Functions:**
**I**n certain circumstances, the Federal regulations authorized Advanced Psychiatric Services of Central Florida to disclose your health information to facilitate specified government functions relating to military and veteran's national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

**For Worker's Compensation:**
Advanced Psychiatric Services of Central Florida may release your health information for worker's compensation or similar programs.

## AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORATION

Other than is stated above, Advanced Psychiatric Services of Central Florida will not disclose your health information other than with your written authorization. If you or your representative authorizes us to disclose your health information, you may revoke that authorization in writing at any time.

## YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following right regarding your health information that Advanced Psychiatric Services of Central Florida maintains:

### Right to Request Restrictions:

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit Advanced Psychiatric Services of Central Florida disclosure of your own health information to someone who is involved in your care or the payment of your care. However, we are not required to agree to your request. If you wish to make a request for restrictions, please contact Carlos Garcia-Prieto, MD.

### Right to Receive Confidential Communications:

You have the right to request that Advanced Psychiatric Services of Central Florida communicate with you in a certain way. For example, you may ask that this entity only conduct communications pertaining to your health information with you privately with you other family members present. If you wish to receive confidential communications please contact Advanced Psychiatric Services of Central Florida. Advanced Psychiatric Services of Central Florida will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

### Right to Inspect and Copy Your Health Information:

You have the right to inspect and copy your health information, including billing records. A request to a copy of your health information, Advanced Psychiatric Services of Central Florida may charge a reasonable fee for copying and assembling costs associated with your request.

### Right to Amend Health Care Information:

If you or your representative believes that your health information records are incorrect or incomplete, you may request that Advanced Psychiatric Services of Central Florida amend records. That request may be made as long as the information is maintained by Advanced Psychiatric Services of Central Florida. A request for an amendment of records must be made in writing to Advanced Psychiatric Services of Central Florida. Advanced Psychiatric Services of Central Florida may deny the request if it is not in writing or does include a reason for the amendment. The request also may be denied if your health information records were not created by this entity, if the records you are requesting are not part of Advanced Psychiatric Services of Central Florida records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of Advanced Psychiatric Services of Central Florida, the records containing your health information are accurate and complete.

### Right to Accounting:

You or your representative have the right to request an accounting of disclosures of your health information made by Advanced Psychiatric Services of Central Florida for reason other than for treatment, payment of health operations. The request for an accounting must be made in writing to Advanced Psychiatric Services. The request should specify the time period for the accounting starting on May 1, 2018. Accounting request may not be made for periods of time in excess of 6 years. Advanced Psychiatric Services of Central Florida would provide the first accounting, you request during any 12-month period without change.

**Right to a Copy of This Notice:**
You or your representatives have a right to a separate copy of this notice at any time even if you or your representatives have received this notice previously. To obtain a separate paper copy, please contact Carlos Garcia-Prieto M. D.

**DUTIES OF ADVANCED PSYCHIATRIC SERVICES F CENTRAL FLORIDA:**
Advanced Psychiatric Services of Central Florida is required by law to maintain the privacy of your health information and to provide to you and your representatives this notice of its duties and privacy practices. Advanced Psychiatric Services of Central Florida is required to abide by the terms of this notice as may be amended from time to time. Advanced Psychiatric Services of Central Florida reserves the right to change the terms of its notice and to make a new notice provisions effective for all health information that maintains. If Advanced Psychiatric Services of Central Florida its notice, we will provide a copy of the revised notice to you and your appointed representative. You or your personal representatives have the right to express complaints to Advanced Psychiatric Services of Central Florida and the Secretary of Health and Human Services if you or your representatives believe that your privacy rights have been violated. Any complaints to Advanced Psychiatric Services should be made in writing to Carlos Garcia-Prieto M.D. Advanced Psychiatric Services of Central Florida encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

**Contact Person:**
Advanced Psychiatric Services of Central Florida Contact person for all issues regarding patient privacy and your rights under Federal Privacy Standards is Carlos Garcia-Prieto M.D.

**Effective Date:**
This Notice is effective May 1, 2018.

**THIS IS YOURS TO TAKE.**

# Advanced Psychiatric Services of Central Florida
## Release of Information

*All portions of this form must be completed to be a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.*

_____ _____
Patient Name Date of Birth

_____ _____
Address Phone Number

**I authorize the use and disclosure of health information about me as described below:**

_____ _____
Facility authorized to release my health information Phone Number

**ADVANCED PSYCHIATRIC SERVICES OF CENTRAL FLORIDA**
5825 US HWY 27 NORTH SEBRING, FL 33870
PHONE: 863-382-7792 FAX: 863-382-0015

**Agency of individual (s) Authorized to receive my health information: _____**

Health Information that may be used/disclosed is limited to the following:

☐ Labs ☐ History and physical ☐ Discharge Summary ☐ Progress Notes
☐ Entire Record ☐ Medication Lists ☐ Other: _____

Health information that may be used/disclosed is limited to the following **treatment dates:** _____

Health information to be released to the above-named agency/individual is to be used/disclosed for the following **purpose(s):**

☐ Treatment/ consultation ☐ at request of the patient ☐ Research ☐ Marketing
☐ Billing claims payment ☐ other _____

Health information identifies you (the patient) by name and includes other demographic information about you. Health information may include, but is not limited to: medical records, tracings, strips, etc. I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses, compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility. Protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related health information is used or disclosed for continued research purposes, an expiration date or even does not apply.

**This authorization will automatically expire in 1 year after the date of signature below** (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have the right to revoke this authorization at any time, in writing, as stated in the notice of privacy practices, except where the facility has already made disclosures in reliance upon my prior authorization. Treatment, payment, enrollment r eligibility for benefits may not be conditioned on obtaining an authorization if the health insurance portability and accountability act (HIPAA) prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: this information is to be treated in accordance with health insurance portability and accountability act (HIPAA) privacy regulations.

_____ _____
Patient or authorized personal representative's signature date/ time

_____ _____
Relationship to patient/ authority to act on patient's behalf interpreter, if utilized

_____ _____
Witness's Signature EXPIRATION DATE OR EVENT

# Advanced Psychiatric Services of Central Florida
## Release of Information

*All portions of this form must be completed to be a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.*

_____ _____
Patient Name Date of Birth

_____ _____
Address Phone Number

**I authorize the use and disclosure of health information about me as described below:**

_____ _____
Facility authorized to release my health information Phone Number

_____
Address

_____

**Agency of individual (s) Authorized to receive my health information:** (**Primary care provider)**

_____

Health Information that may be used/disclosed is limited to the following:

☐ Labs ☐ History and physical ☐ Discharge Summary ☐ Progress Notes
☐ Entire Record ☐ Medication Lists ☐ Other: _____

Health information that may be used/disclosed is limited to the following **treatment dates:** _____

Health information to be released to the above-named agency/individual is to be used/disclosed for the following **purpose(s):**

☐ Treatment/ consultation ☐ at request of the patient ☐ Research ☐ Marketing
☐ Billing claims payment ☐ other _____

Health information identifies you (the patient) by name and includes other demographic information about you. Health information may include, but is not limited to: medical records, tracings, strips, etc. I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses, compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility. Protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related health information is used or disclosed for continued research purposes, an expiration date or even does not apply.

**This authorization will automatically expire in 1 year after the date of signature below** (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have the right to revoke this authorization at any time, in writing, as stated in the notice of privacy practices, except where the facility has already made disclosures in reliance upon my prior authorization. Treatment, payment, enrollment r eligibility for benefits may not be conditioned on obtaining an authorization if the health insurance portability and accountability act (HIPAA) prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: this information is to be treated in accordance with health insurance portability and accountability act (HIPAA) privacy regulations.

_____ _____
Patient or authorized personal representative's signature date/ time

_____ _____
Relationship to patient/ authority to act on patient's behalf interpreter, if utilized

_____ _____
Witness's Signature EXPIRATION DATE OR EVENT