J. RODERICK HUNDLEY, M.D., P.A.
1177 LOUISIANA AVE, SUITE 113
WINTER PARK, FL 32789
407-629-4466 Fax 407-629-5584

Diplomate, American Board
of Psychiatry and Neurology

NEW PATIENT INFORMATION SHEET

Name: _____

Address: _____

City/State/Zip Code: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Home Phone: _____ Work Phone: _____

Date of First Appointment: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____

Home Phone: _____ Work Phone: _____

REFERRED BY: _____

FINANCIAL RESPONSIBILITY

Payment is requested and expected at the time of your appointment. Each appointment is a reserved time for you. If the session is missed a $75 charge is due for that time or if a session is not cancelled within 48 hours notice a $50 charge is due for that time.

Person Responsible for payment of bill: _____

Billing Address (if different from above): _____

Signature _____Date _____

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CONSENT FOR CONSULTATION

I hereby request a psychiatric consultation with Dr. Hundley. If treatment is recommended, I understand that Dr. Hundley and I may decide to begin a physician/patient treatment relationship and a schedule of follow-up visits. I understand that I may refuse any or all services at any time and may choose to pursue treatment with another psychiatrist or mental health professional.

I understand that Dr. Hundley is not providing hospital services and does not maintain hospital privileges. If I should require hospitalization, I agree to have another psychiatrist provide the treatment during the hospital stay.

I understand that prior to beginning any treatment; I will receive an explanation of the nature and purpose of the treatment, alternatives, probable risks and side effects. I understand that while all reasonable efforts will be made to accomplish mutually agreed upon treatment goals, there is no guarantee that the desired results will be obtained.

PAYMENT AND APPOINTMENT AGREEMENT

I understand that Dr. Hundley appreciates the opportunity to provide me with high quality, personalized psychiatric care and that payment in the form of a check, credit card or cash is expected at the time of service. I will review any questions or special circumstances with the office staff. I understand that there will be a $30.00 fee for returned checks.

I understand that Dr. Hundley has reserved my therapy time and will not schedule other patients in my time slot until such time as I no longer reserve it. I also understand that in order for Dr. Hundley to reserve my time slot that I am responsible for full payment for the appointment time whether I keep my appointment or not. Dr. Hundley will attempt to fill my appointment time if I give him notice that I am unable to keep it and an alternative appointment cannot be arranged during the same week.

My signature below indicates that I understand the information above and I will discuss any additional questions with Dr. Hundley or his staff:

_____ _____
Signature of Patient Date

_____
Print Patient Name

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PRIVACY POLICY

Our policy is to protect the privacy of your medical records to the extent permitted by law. We require your signed authorization before we send records to other individuals or organizations. Please note the following exceptions when Dr. Hundley would be obligated to provide confidential information or records without your written authorization. Those situations are:

- Suspected child/elderly abuse or neglect
- Specific threats to your safety or another person's safety
- A court order signed by a judge
- Special circumstances indicated in federal law (i.e. public health risks; national security)

Also note that you may receive correspondence from this office at the address you provide, such as a letter or a bill for services. We also may need to contact you by telephone for appointment reminders or other reasons. If you plan to seek reimbursement through insurance, that company may require you or Dr. Hundley to provide a diagnosis (or other information) in order for you to receive coverage for treatment.

Please fill in the telephone number to leave a message for a reminder before my appointments:

_____ (or circle) DO NOT CALL.
Telephone number

Other special instructions or requests: _____

_____

My signature below indicates that I understand the information above and I will discuss any additional questions with Dr. Hundley or his staff:

_____ _____
Signature of Patient Date

_____
Print Patient Name

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PRESCRIPTION POLICY

Please obtain your prescription(s) during your visit, take the new prescription(s) to your local pharmacy or send them to your mail-in pharmacy and schedule your next visit prior to the time you should run out of medication. Routine telephone or Fax refill requests, replacement of lost prescriptions, etc. will result in a charge of $15 during business hours and $25 after hours or on weekends per request.

FORMS AND LETTERS POLICY

There will be a charge for the time required to fill out forms or compose letters on your behalf. This charge will be discussed with you and payment required prior to completing the document(s).

_____ _____
Signature of Patient Date

_____
Print Patient Name

381.026 Florida Patient's Bill of Rights and Responsibilities.

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health care practitioner, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of s. 456.41.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Additional Copies Available
Upon Request

_____

Patient Signature & Date