gulfcoast BEHAVIORAL HEALTH
1938 SOULE ROAD, CLEARWATER, FL 33759 Ph. (727) 726-7442 F. (727) 288-1111 www.gulfcoastbh.com

Patient Information

Thank you for choosing our office. To serve you properly, we need the following information. All information will be confidential.

Requested Services:

[] Medication Management [] Talk Therapy

Patient Information

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ [] Home [] Mobile [] Work [] Other: _____ DOB: _____

Sex: [] Male [] Female [] Other: _____ Soc Sec #: _____

Marital Status: [] Single [] Married [] Other: _____ Email: _____

Spouse/Partner Name: _____ Phone #: _____

ER Contact Name: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Referred by: _____

Responsible Party

Name: _____ DOB: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Insurance Information

Insurance Company: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Member ID #: _____ Group #: _____ Plan #: _____

Name of Insured: _____ Relationship to patient: _____

DOB: _____ SSN: _____ Insured's Phone #: _____

I authorize release of my information concerning my healthcare, advice, treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____

Patient/Legal Guardian Signature Date

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Informed Consent

Please read each item and sign below acknowledging that you have read and understand.

I have chosen to receive psychiatric/therapeutic services from Gulf Coast Behavioral Health. My choice has been voluntary, and I understand that I may terminate treatment at any time.

I understand that there is no assurance that I will feel better, because medication management and therapy is a cooperative effort between the provider and myself. I will work with my Provider and the staff of Gulfcoast Behavioral Health in a cooperative, respectful manner to create solutions in my best interest.

I understand that during my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that all records are confidential and will be held and/or released in accordance with state laws regarding confidentially of such records and information. Psychiatric records are not released directly to patients/guardians. Requests for an exception may be made however, there is no guarantee the request will be approved.

I understand that state and local laws require that my provider report all cases of abuse or neglect of minors or the elderly. I understand that state and local laws require that my provider report all cases in which there exists a danger to myself and/or others. I understand that there may be other circumstances in which the law requires my provider to disclose confidential information.

I understand that my provider may disclose any/all records pertaining to my treatment to insurance companies, insurance representatives, or primary care physicians if such disclosure is necessary for claims processing, case management, coordination of treatment and/or utilization review purposes.

I understand that I can revoke this consent at any time, except to the extent that treatment has already been rendered or that action was taken in reliance on this consent and that if I do not revoke this consent, it will automatically expire one year after all claims for treatment have been paid as provided in the benefits plan.

I acknowledge that I am a resident of the state of Florida. I understand that all Providers at Gulfcoast Behavioral Health are licensed **only** in the state of Florida and cannot treat or prescribe medications outside of the state of Florida, even if I receive telehealth services.

By signing, I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Patient Name Date of Birth

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Office Policies

Hours of Operation:
Our office is open Monday through Thursday from 9:00am until 4:30pm and Friday from 9:00am until 3:00pm. We close for lunch from 11:30am until 1:00pm. Our office is closed on Saturday and Sunday.
_____ (Initial here)

Appointment Check-In:
Please arrive (or check-in if telehealth) 10-minutes prior to your scheduled appointment time. While we strive to be on-time, sometimes unexpected urgent matters arise, so please allow up to 60 minutes for your appointment. If you are unable to keep your scheduled appointment, our office requires a 24-hour notice. In the event you do not provide advanced notice, or you do not check-in for your appointment, you will be billed a fee outlined in Billing Guidelines. Late cancellation and no-show fees must be paid before future appointments can be scheduled.
_____ (Initial here)

Appointment Reminders:
Our office provides appointment reminder cards as well as automated appointment reminders. Automated reminders are sent by email and phone call or text message two (2) days prior to your scheduled appointment. You can also view upcoming appointments in your patient portal. Our appointment reminders are provided as a courtesy, ultimately it is the patient's responsibility to remember and attend appointments as scheduled.
_____ (Initial here)

Prescription Refills:
It is your responsibility to contact our office for prescription refills. Do not rely on your pharmacy to contact our office. Prescription refill requests are approved during your provider's office hours. Please allow 24-72 hours for our office to respond to your request before calling back. If you are out of medication due to a missed appointment, you will need to pay any outstanding fees and schedule a follow-up appointment. Depending on the Drug Classification, or Drug Schedule, of the requested medication needing refill, you may need to see another provider within our office for a one-time appointment before refills can be issued.
_____ (Initial here)

After-Hours/On-Call Provider:
If you are having a life-threatening medical emergency, please call 9-1-1 or go to the nearest hospital emergency room. For urgent, non-life-threatening emergencies, our After-Hours/On-Call Provider's phone number is: (727) 309-9082. Calls placed to the after-hours provider that are non-emergent in nature will not be returned.
_____ (Initial here)

Release of Records:
All patients (or legal guardians) must provide written consent authorizing the release of any information from our office. Verbal authorizations are not accepted. Record requests may take up to thirty (30) days for processing and pre-payment is required.
_____ (Initial here)

Confidentiality:
In accordance with moral, ethical, and legal guidelines regarding your rights to confidentiality, your personal information is carefully guarded. However, there are some exceptions which must be noted:

- If a patient poses a threat to his/her own safety, or the safety of others, we are required to notify concerned parties and local law enforcement,
- If a patient reports actual, or suspected, abuse of any individual, we are required to notify local law enforcement,
- In patient groups of two or more, including the lobby and check-in/out areas, confidentiality is urged but not guaranteed.

_____ (Initial here)

By signing, I hereby acknowledge that I have read, understand, and acknowledge all the above. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Patient Name Date of Birth

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Billing Guidelines and Financial Responsibilities

Administrative Fees:
The fees for items listed below, which are not covered by insurance, are the patient's responsibility. Fees for these items must be paid at the time services are rendered and prior to the next scheduled appointment:

- Medical records – $1.00 per page fee (first 25 pages/ $0.25 for each additional page)
- Returned checks (for insufficient funds)
    - $25 for checks of $49.99 or less
    - $35 for checks greater than $50 but less than $299.99
    - $45 minimum or 3% of the face value for checks over $300.

_____ (Initial here)

Appointment Cancellations/No-shows:
All no-show appointments are automatically assessed a fee outlined below per calendar year.

- Missed Evaluation Appointment: $75.00
- 1st Missed/Late Cancelled Follow-up Appointment: $40.00
- 2nd Missed/Late Cancelled Follow-up Appointment: $50.00
- 3rd Missed/Late Cancelled Follow-up Appointment: $75.00
- 4th Missed/Late Cancelled Follow-up Appointment: Automatic Discharge due to non-compliance

In the event of a true emergency, documentation will be required to request an exception to the fees.

_____ (Initial here)

Discharge from Practice:
The reasons outlined below are common reasons for termination from our practice. This list is not comprehensive, and the treating clinician has final authority on terminating treatment.

- Continuously cancelling or no call/no showing for scheduled appointments more than 3 times.
- Not following the mutually agreed upon treatment plan.
- Continuously requesting controlled medications too early or obtaining prescriptions for controlled medications from other providers.
- If the patient is not seen within one year, unless otherwise instructed by your provider (voluntarily terminated)

_____ (Initial here)

Divorce/Child Custody:
Gulfcoast Behavioral Health will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since GCBH is not a party to these Arrangements, we are not obligated to the financial terms of these Arrangements.

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at GCBH is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then GCBH will still collect the applicable co-pays, coinsurance, and deductibles at the time of service from the Presenting Parent. Upon request, GCBH will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

_____ (Initial here)

Electronic Signatures:
If you are unable to come to the office to sign documents or do not have the capability to print/sign/return, you can request that the form be sent to you electronically. The first e-signature envelope is free. Subsequent envelopes will incur a fee of $1.50 per envelope. To use this feature, you must have an active patient portal (the patient portal is free).

_____ (Initial here)

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Billing Guidelines and Financial Responsibilities

Insurance Billing:
Our office accepts most insurance plans. It is the patient's responsibility to notify us with any insurance changes. As a courtesy, our office will bill your insurance carrier on your behalf. Per our contractual agreements with insurance companies, we must collect any insurance deductibles, co-insurances, and/or co-pay at check-in. This ensures the financial obligation is met at the time of service. Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. However, each patient has the right to contact their insurance to inquire about their plan coverage and cost. **We do NOT accept Medicaid or Medicaid Managed Care plans. Should your insurance company not cover the service, the balance may become the patient's responsibility. Any balance due from the patient that is not paid within ninety (90) days will be referred to an outside collection agency. The patient is responsible for reasonable attorney fees or collection agency fees equal to 35%-50% of the total outstanding balance.**

_____ (Initial here)

Letters/Forms Preparations:
In the event you need for your clinician to write a letter or complete forms for disability, your employer, the Dept of Motor Vehicles, FMLA, etc. The fees outlined below are based on time and/or complexity of the paperwork. These letters/forms are done outside of appointments. A signed release of information and pre-payment will be required prior to the completion of the request. The turnaround timeframe for these requests are 7-10 business days.

- Letters $25.00
- Forms (1 page) $50.00
- Forms (2 pages) $75.00
- Forms (3-4 pages) $100.00
- Forms (5+ pages) $150.00

_____ (Initial here)

Telehealth Appointments:
If you are unable to come into the office for an appointment, telehealth is available to established patients only, whose insurance covers telehealth appointments or are self-paying. **Telehealth appointments must be done through real-time audio-visual communication only; telephone calls are not appointments**. It is the responsibility of the patient (or legal guardian) to check-in for the scheduled telehealth appointment. Federal laws that protect privacy and confidentiality also apply to telehealth appointments, therefore, you will need to be in a confidential area where there are no outside distractions. If you are not in a confidential area, your provider may cancel the appointment and the appropriate late cancellation fee will be applied. Examples of non-confidential areas include driving a car/riding public transportation, at the hair/nail salon, at the beach, at a restaurant, at a grocery/convenient/department store, etc.
_____ (Initial here)

By signing this form, I authorize A&M Psychiatric Services d/b/a Gulfcoast Behavioral Health to release all necessary information to insurance companies to process claims or obtain authorizations for treatment. I authorize payments be made to A&M Psychiatric Services from insurance companies, government agencies, or any other agency providing benefits for services rendered. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Patient Name Date of Birth

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Privacy Policy

This explains HIPAA laws and when and how our office can release information about you or your child.

Protected health information includes descriptive information that can be used to identify a person and that relates to the treatment for a mental health condition. The protected health information includes information from the past, present, or future. The right to privacy continues after death.

Gulfcoast Behavioral Health doesn't release health information about people who receive services from our office. This means our office cannot release:

- Information that will tell people who you or your child are or where you and your child live
- Information about you or your child's mental health or condition
- Information about any of the services you or your child are receiving
- Information about how you or your child's services are paid for

If you choose to sign a consent form for a particular person or facility; our office can release the requested information to only that person or facility.

I understand that all records are confidential and will be held and/or released in accordance with state laws regarding confidentially of such records and information. However, psychiatric records are not typically released directly to parents or patients without prior clinician approval to be made at the clinician's discretion.

There are some special circumstances when our office is required to release information about you or your child, even if you haven't given us permission to do so.

For example:

- If you or your child are sick or hurt
- If you are not safe to take care of yourself or your child
- If you or your child try to hurt someone, or someone is trying to hurt you/them
- If you or your child tell us about child abuse
- Under a court order

This policy also pertains to and is enforced for telehealth including but not limited to any virtual/video and telephonic communications.

By signing this form, you are stating that you have read and understand the terms stated within. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

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Controlled Substance Consent

The administration of **ANY** controlled substance is strictly decided by the provider. If in the instance a controlled medication is prescribed, the following guidelines must be understood and followed by all patients.

The risks of taking a controlled substance include, but are not limited to, drug dependency, addiction, respiratory problems, depression, liver and/or kidney damage, death, etc.

Patients agree to take medications only as prescribed **and** agree to notify the provider if the patient does not comply. By agreeing to take the medications as directed, patient is agreeing to random urine drug screens and/or blood tests to assess compliance.

Patient understands that random urine drug screens may be performed at any given office visit to monitor prescribed medication. Patient must understand that the insurance company may not cover a drug screen and that they will be responsible for the full amount that is not covered at the time of the office visit.

Patients understand that the test results and interpretation will become part of the medical record. Patient's insurance company may discover the results of this test by obtaining a copy of patient's medical records.

Lost, stolen, or misplaced prescriptions will **NOT BE REPLACED**. If a patient needs a refill on a controlled substance, they **MUST** schedule an office visit. The provider will **NOT** refill controlled substance prescriptions over the phone or without seeing the patient in the office or by telehealth. Controlled substance prescriptions **CANNOT** be sent out of the state of Florida.

Patients agree that if they deviate from the above guidelines that the provider owns the right to taper off or discontinue the prescription. Failure to comply with the guidelines also could result in immediate termination from this practice.

By signing this, I express understanding and agree to comply with these guidelines. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Patient Name Date of Birth

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Adult Clinical History

Patient Name: _____ Date of Birth: _____

Introductory Information

What is the reason(s) for seeking services?

_____

_____

When did you first notice this(ese) issue(s)?

_____

_____

List interest and/or hobbies: _____

Evaluations/Assessments:

Have you ever received any of the following assessments/evaluations?
(Please check all that apply) IF APPLICABLE, PLEASE SEND REPORT(S) PRIOR TO APPOINTMENT

[] Learning/academic/IQ
[] Psychological
[] Physical
[] Occupational
[] Audiology
[] Psychiatric
[] Developmental
[] Neuropsychological
[] Speech & language
[] Neurological (e.g., MRI, CAT scan, EKG, etc)

Medication History

Medication Name	Dose	How long? (months)	End Date	Side Effects?	Reason for stopping?	Prescribing Provider

Current Physical Health & Healthcare

Would you like us to contact your primary care provider? [] Yes [] No

What was the date of your last physical exam? _____Was blood work done? [] No [] Yes

Do you see any specialists for chronic or severe health conditions? [] No [] Yes

If yes, what is the name of specialist? _____

Allergies
Do you have any known allergies to medications, foods, animals, etc.? [] No [] Yes

If yes, please describe: _____

Pharmacy Information

Pharmacy Name: _____ Address: _____ Phone #: _____

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Credit Card Authorization

Please fill out the details as indicated below to place your credit card on file.

Patient's Name: _____ DOB: _____

Card Holders Name: _____
(Exactly as it appears on card)

Billing Address: _____

_____

Card No: _____

Expiration Date: _____

CVV: _____

Card Type: [] Visa [] MasterCard [] Discover [] Am Ex

Email address: _____

I hereby authorize Gulfcoast Behavioral Health to charge the credit card listed above for payment of any outstanding charges for services rendered that were not paid by or covered by insurance, as well as any balance resulting from missing appointments and/or late cancellations. In addition, I hereby authorize Gulfcoast Behavioral Health to charge the credit card listed above for any additional outstanding balances once they have received the Explanation of Benefits from my insurance carrier. I understand my Insurance Carrier will notify me with an Explanation of Benefits detailing the payment made and amount owed prior to GCBH receiving notification and processing my Credit Card on File. I hereby authorized GCBH to charge the credit card listed above up to the amount of $250. I understand that I will be notified by email on the day my Credit Card on File has been processed.
_____ (initial here)

This form will be kept on file and will remain in effect until the expiration of the credit card account or until revoked by applicant. I understand my card information will be kept in a secure encrypted format.
_____ (initial here)

Any questions regarding my account, my credit card, or any past due amount will be directed to info@gulfcoastbh.com. Additionally, I agree that the card listed above may be charged by Gulfcoast Behavioral Health to settle any outstanding balances. I understand that if a chargeback fee is incurred or a retrieval fee is incurred, I am responsible for these fees.
_____ (Initial here)

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Gulfcoast Behavioral Health for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Gulfcoast Behavioral Health and those attempts have failed.
_____ (Initial here)

_____ _____
Cardholder Signature Date

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Authorization for Release/Exchange of Information

Patient Name: _____ Date of Birth: _____

I voluntarily authorize the following named organization:

Gulfcoast Behavioral Health
1938 Soule Rd
Clearwater, FL 33759

Telephone Number: 727-726-7442
Facsimile Number: 727-288-1111
Email Address: INFO@GULFCOASTBH.COM

To release/discuss/obtain a copy of my Protected Health Information (PHI) to/from:

Name: _____ Phone #: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip: _____

For the purpose of: [ ] Personal [ ] Treatment (continued care) [ ] Other: _____

Form of Disclosure: [ ] Written [ ] Verbal [ ] Fax [ ] Email

Check all appropriate boxes below.

[ ] Office Notes [ ] Laboratory Results [ ] Admission/Discharge Summary

[ ] Complete Record [ ] Other (please describe): _____

EFFECTIVE TIME PERIOD: This authorization is valid for two (2) years after the date of my signature as it appears below; or the following specific date (optional): _____.

I understand that I am agreeing to share confidential information that is protected by state and federal laws governing confidentiality of alcohol and drug abuse, mental health, and HIV/AIDS client records (42 CFR Part2; FS 394; FS 381).

Anyone who receives my records from this organization is not permitted to release them to anyone else without additional written consent. I understand that Gulfcoast Behavioral Health cannot guarantee that subsequent re-disclosure will not occur. I hereby release Gulfcoast Behavioral Health from any liability which may arise because of the use of the information contained in copies of records released, because of this authorization, if such information is later used to my detriment. I understand that I need not sign this authorization to ensure treatment.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

By signing, I hereby acknowledge that I have read, understand, and acknowledge all the above. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____
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