Psychology Associates of Brevard
6767 N WICKHAM RD, SUITE 306
MELBOURNE, FL 32940
(321) 751-1925 Fax (321) 751-9261

PATIENT Information: (Please Print Clearly) **Date: _____**

Name: _____ _____ ____
Last First Middle Initial

Address: _____ Sex: **M** **F**

_____ Date of Birth: ____ / _____ / _____

_____ SS#: _____ / ____ / _____

Check one preferred method of automated **reminder calls**: *please note, reminders are not guaranteed*

____ 1) message on Home # ____ 2) message on Cell # ____ 3) text message on Cell #

Home Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: **S M W D** Spouse's Name: _____

Referral Source: _____

Guardian/Responsible Party (if someone other than patient - ex: guardian, parent, etc.)**:**

Name: _____ Relationship to patient: _____

Phone: _____ Address: _____

Employer: _____ _____

INSURANCE Information:

Primary INS: _____ Member ID#:_____

Policy Holder: _____ Relationship to patient: _____

Date of Birth: _____ / _____ / _____ Employer:_____

* Secondary INS: _____ Member ID#:_____

I have provided a copy of the front and back of my insurance card **Initial Here**:_____

Primary Care Physician: _____May we communicate with PCP? ___**Y** ___**N**

Individuals that I approve to share information with:

Name	**Relationship**
_____	_____
_____	_____

With my written authorization, the provider may communicate with my primary care provider, specialists, therapists, pharmacies, hospitals, school staff members, or other healthcare professionals involved in my care.

I AUTHORIZE & ACCEPT RESPONSIBILITY FOR PAYMENT ON THIS ACCOUNT

Sign Here:_____

CONSENT FOR EVALUATION AND TREATMENT

I understand and voluntarily agree to participate in the evaluation and treatment; I understand that I will be provided with an explanation of assessment and treatment procedures and their purposes.

Psychological services may include, but are not limited to:

- Comprehensive neuropsychological evaluations
- Diagnostic assessments
- Psychotherapy and supportive counseling
- Development and modification of individualized treatment plans
- Coordination of care with primary care providers, specialists, therapists, pharmacies, and other healthcare professionals with appropriate authorization

I understand that diagnosis and treatment involve clinical judgment and that no guarantees can be made regarding diagnosis, treatment response, or outcomes.

X _____ _____

Signature of patient, or legal guardian **Date**

In signing, I certify that I am legally authorized to consent to my own treatment. If I have appointed a legally authorized healthcare surrogate, guardian, or healthcare proxy, I agree to notify the Provider and provide any applicable legal documentation.
If my legal decision-making authority changes during treatment, I agree to notify the Provider promptly and provide updated legal documentation when applicable.

FINANCIAL ARRANGEMENTS

As a courtesy, we will file your insurance claim for you. However, the information you provide us is important in filing the claim correctly. We cannot be responsible for any misinformation provided. Actual coverage and payment provided by the insurance company cannot be determined accurately until your insurance company provides an *Explanation of Benefits* (EOB).
You are responsible for any fees not covered or paid by your insurance carrier. It is your responsibility to ensure all preauthorization is received prior to any visit. Co-payments, deductibles, or any out-of-pocket expenses are **due at the time of service**, unless previous arrangements have been made with the office.

I hereby authorize this office to file my insurance on my behalf and assign all benefits to which I am entitled to the provider. I authorize release of any information necessary to process my claim.
I have read the above information, and I understand that I am financially responsible for all charges not covered or paid by my insurance carrier.

Initial Here: _____

As stated above, we do offer to file your insurance when appropriate. However, there are certain requests and services that are not covered by insurance, and thus would then be patient responsibility. Examples of some of these services:

* **letters** and/or **forms** to employers, insurance, or disability carriers… * **etc**.

Regarding Disability evaluations - Neither this office, nor our providers, participate in Disability Evaluations. Should disability forms come to our office within the first 12 months of your care, our provider may choose to not participate. If the provider does participate, there will be a minimum charge of $350 (not billable to insurance).

Initial Here:_____

All of these services require the time of the provider for which they need compensation. The patient may also be asked to schedule an appointment, which would allow them to clearly communicate the needs of these services.

I hereby confirm that I understand that requesting some of these services listed above may result in charges that fall to patient responsibility – due at the time of service.

Initial Here: _____

Credit Card Information and Policy

We do not accept American Express.

Name on Credit Card:_____

Credit Card Number:_____

Exp. Date:_____ Zip Code:_____ Three Digit Security Number: _____

With your permission this credit card information may also be on-file to pay your copay, co-insurance or patient responsibility for telehealth, early, or late-hour appointments.

Initial Here: _____

EMERGENCIES

ELECTRONIC COMMUNICATION
Telephone calls, text messaging (if utilized), and email are intended for routine, non-emergency communication only.
Medication changes generally require an appointment.
Electronic communication should never be used to report psychiatric emergencies or urgent medical concerns.

When you call our office after regular office hours, a voicemail will receive your call. You may leave a message to be handled when the staff returns, or if **your call is an emergency**; the voicemail will provide you with a number to our answering service. The answering service, in turn, will contact the doctor and have them return your call. Please be sure that you will be available at the number you have given.

Please acknowledge that the provider does not provide emergency services, should you be unable to wait for the provider to contact you, please go to the nearest emergency room or call 911.
If you experience suicidal thoughts, homicidal thoughts, psychosis, severe medication reactions, or any psychiatric emergency, immediately call 911 or go to the nearest emergency department.

Again, it is stressed that these after-hours calls are for extreme situations, and not to be substituted for an appointment. **The provider may charge the patient in such cases where it is determined that these privileges are being abused.**

Initial Here: _____

CANCELLATION POLICY

Your appointment represents a valuable period of time that obligated the presence of you and us. Should you need to change an appointment, please notify us at least 24 hours in advance, and please call if there is an emergency or other problem that prevents you from being at your appointment on time.

* I am aware that if I **cancel under 24** hours prior to an appointment, there is a *minimum* **fee of $75.** **Initial Here:** _____

* If I **No Show** for an appointment –
1st offense - $75,
2nd offense - $200,
3rd offense - I will be asked to transfer my records to another practice.

Initial Here: _____

TERMINATION OF CARE
The Provider reserves the right to terminate the treatment relationship in accordance with applicable laws and professional standards for reasons including, but not limited to:

- Failure to attend appointments
- Failure to comply with treatment recommendations
- Medication misuse or diversion
- Threatening or abusive behavior toward providers or staff
- Obtaining controlled substances from multiple prescribers without disclosure
- Failure to maintain an appropriate therapeutic relationship
- Failure to provide accurate information necessary for safe treatment

Reasonable notice and emergency resources will be provided when required.

Initial Here: _____

PATIENT RESPONSIBILITIES

I understand that successful treatment requires my active participation. I agree to:

- Provide complete and accurate medical, psychiatric, substance use, and medication history.
- Inform the Provider of changes in my health, medications, pregnancy status (if applicable), hospitalizations, or significant life events.
- Take medications exactly as prescribed.
- Notify my prescribing provider promptly of medication side effects or concerns.
- Attend scheduled appointments.
- Maintain current contact and insurance information.
- Follow recommended treatment plans and complete requested laboratory testing or medical evaluations.
- Provide accurate information regarding alcohol, cannabis, nicotine, and other substance use. I understand that active substance misuse may affect treatment recommendations, medication safety, and prescribing decisions.

ACKNOWLEDGEMENT OF HIPAA and CONDFIDENTIALITY

This signature confirms that the patient and/or patient guardian is aware that a copy of the HIPAA laws may be found in our lobby, and the patient could be provided a copy of their own upon request.

Mental health treatment is confidential as required by federal and state law. However, confidentiality may be limited under circumstances including, but not limited to:

- Risk of harm to self
- Risk of harm to others
- Suspected abuse, neglect, or exploitation of a child, vulnerable adult, or elderly person
- Court orders
- Other mandatory reporting requirements

By signing below, I acknowledge and certify that:

- I am legally authorized to consent to my own psychiatric treatment.
- I have read and understand the Consent to Evaluation and Treatment.
- I understand the responsibilities outlined in this agreement, including medication safety and controlled substance prescribing requirements.
- I voluntarily consent to psychiatric evaluation and treatment.
- I understand that I may withdraw my consent at any time, subject to applicable law and appropriate transition of care.

Patient/Guardian: _____

Please Print

Signature: X _____

Date:

Over the last 2 weeks, how often have you been bothered by the following problems?

PHQ-9	Not at all	Several Days	Over half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these made it for you to function, focus, and/or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____ Total Score: _____ Classification: _____Depression

Over the last 2 weeks, how often have you been bothered by the following problems?

GAD-7	Not at all	Several Days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any problems, how difficult have these made it for you to function, focus, and/or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____ Total Score: _____ Classification: _____Anxiety