

*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:**

| <b><u>Name</u></b> | <b><u>Relationship</u></b> |
|--------------------|----------------------------|
| _____              | _____                      |
| _____              | _____                      |

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 by Patricia Buescher, PMHNP-BC, I understand that I will be provided with an explanation of assessment and treatment procedures and their purposes.

Psychiatric services may include, but are not limited to:

- Comprehensive psychiatric evaluations
- Diagnostic assessments
- Medication management
- Brief psychotherapy and supportive counseling, when appropriate
- Development and modification of individualized treatment plans
- Coordination of care with primary care providers, specialists, therapists, pharmacies, and other healthcare professionals with appropriate authorization
- Ordering and reviewing laboratory studies, imaging, electrocardiograms (EKGs), genetic testing, and other diagnostic testing when clinically indicated
- Referrals to specialists or higher levels of care when medically appropriate

I understand that psychiatric 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 psychiatric 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.

## **CONTROLLED SUBSTANCE/STIMULANT AGREEMENT**

If I am prescribed a controlled substance, including stimulant medications, benzodiazepines, or other controlled medications, I understand and agree that:

- These medications are regulated by federal and state law.
- I will take medication only as prescribed.
- I will not share, sell, trade, or give my medication to another person.
- I will not increase or decrease my dose without Provider approval.
- Lost, stolen, damaged, or misplaced prescriptions or medications may not be replaced before the next scheduled refill.
- The Provider may review the Florida Prescription Drug Monitoring Program (PDMP) before prescribing controlled substances.
- Pill counts, urine drug screening, laboratory testing, or additional medical evaluations may be requested when clinically indicated.
- Receiving controlled substances from multiple prescribers without disclosure, medication diversion, misuse, forgery, or repeated violations of this agreement may result in discontinuation of controlled substance prescribing or discharge from the practice.

Patients on controlled substances such as stimulants (i.e. Adderall, Ritalin), benzodiazepines (Ativan, Xanax), hypnotics (Ambien) and other potentially addictive medications, need close monitoring along with frequent follow-up. **These prescriptions cannot be refilled without an appointment** in order to comply with State and Professional regulations for usage of these medications. Controlled substance refills are not routinely provided after hours, on weekends, or holidays. Early refill requests are generally not granted.

Practice standards require all patients to be seen in person, at minimum, every three months. The exception to this is **patients on Stimulants (Adderall, Vyvanse) will be seen every month.**

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

\_\_\_\_\_  
**Date**

## **MEDICATION REFILL AND REQUESTS**

Prescription refills require:

- Appropriate follow-up appointments
- Compliance with treatment recommendations
- Refill requests should be submitted during normal business hours with adequate notice.
- Completion of required laboratory or medical monitoring when applicable

Prescriptions are written to take the patient from appointment to appointment. If refills are needed in-between appointments due to missed appointments – there could be a fee of \$30.

**Any medication requests need to allow 24-48 hours to be processed.**

Please be aware of policy regarding controlled substances.

**These may not be refilled without an appointment.**

**Initial Here:** 

## **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 –

**1<sup>st</sup> offense - \$75,**

**2<sup>nd</sup> offense - \$200,**

**3<sup>rd</sup> 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 CONFIDENTIALITY**

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