New Patient Registration

INTRODUCTION Date Completed: _____

The following necessary information will help make your first session most productive. If your first appointment with us is for psychiatric evaluation for medication management, **please bring all of your medication bottles to your first appointment.** If you have a **family law, criminal, or civil case** active or forthcoming and it is relevant to you obtaining services, or if you are court-mandated to receive services, please bring all related court and historical documents to your first appointment. Please fill out this form **COMPLETELY**.

PATIENT DEMOGRAPHICS

Last Name	First	Middle	Date of Birth	Age
Street Address	City	State	Zip Code	
Phone Number (Cell)	Home	Email	Social Security Number	

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other: _____

CARE COORDINATION AND EMERGENCY CONTACT

Primary Care Physician: _____ ☐ Do not have PCP
Name City Phone Number

Preferred Pharmacy: _____
Name City Phone Number

Emergency Contact: _____
Name Relationship Phone Number

PRESENTING PROBLEM

Why are you seeking treatment at this time? *(include symptoms, onset, duration, frequency, etc.)*

_____

_____

_____

Check all problematic experience areas or events within the past six (6) months?

☐ Abuse/Domestic Violence	☐ Depression	☐ Hospitalization	☐ Sleep Problems
☐ Academic Problems	☐ Developmental Delay	☐ Hyperactivity/Impulsivity	☐ PTSD/Trauma
☐ Addiction/Dependency	☐ Employment Problems	☐ Intrusive Thoughts	☐ Relationship Stress
☐ Anger Management	☐ Extramarital Affair	☐ Legal Problems	☐ Self-injury
☐ Anxiety/Panic Attack	☐ Family/Parenting	☐ Mood Swings	☐ Suicidal Thoughts
☐ Behavior/Poor Decisions	☐ Fire Setting	☐ Obsessive Thoughts	☐ Suicide Attempts
☐ Concentration/Focus	☐ Grief	☐ Paranoia/Delusions	☐ Thoughts of Harming Others
☐ Cruelty to Animals	☐ Hallucinations	☐ Physical/Medical Problems	☐ Weight Gain/Loss

PSYCHIATRIC HISTORY

At your comfort, briefly describe (Yes) answers:

Have you ever received counseling before?	☐ Yes ☐ No	_____
Do you have any previous psychiatric diagnoses?	☐ Yes ☐ No	_____
Do you have history of emotional trauma?	☐ Yes ☐ No	_____
Have you ever experienced suicidal or homicidal thoughts?	☐ Yes ☐ No	_____
Have you ever intentionally harmed yourself?	☐ Yes ☐ No	_____
Have you ever been hospitalized for mental health reasons?	☐ Yes ☐ No	_____
Does anyone in your **family history** have mental health problems?	☐ Yes ☐ No	_____

MEDICAL HISTORY

Check **BOX** ☒ for all conditions that applies to your **personal medical history**.

Bubble **CIRCLE** ● for all conditions that applies to your **family medical history** *(mother, father, siblings, grandparents)*.

☐ ○ ADHD	☐ ○ COPD	☐ ○ High Blood Pressure	☐ ○ Sensory Loss
☐ ○ Alcohol/Substance Abuse	☐ ○ Depression	☐ ○ HIV/AIDS	☐ ○ Seizures
☐ ○ Alzheimer's	☐ ○ Diabetes	☐ ○ IBS	☐ ○ Sleep Apnea
☐ ○ Anemia	☐ ○ Fibromyalgia	☐ ○ Kidney Disease	☐ ○ Speech/Language Impaired
☐ ○ Anxiety	☐ ○ GERD	☐ ○ Migraine	☐ ○ Stroke
☐ ○ Asthma	☐ ○ Head injury	☐ ○ Muscular Disease	☐ ○ Other: _____
☐ ○ Bleeding Abnormality	☐ ○ Heart Disease	☐ ○ Parkinson's	☐ ○ Other: _____
☐ ○ Cancer	☐ ○ Hepatitis	☐ ○ Pituitary Disease	☐ ○ Other: _____
☐ ○ Chronic Pain	☐ ○ High Cholesterol	☐ ○ PCOS	☐ ○ Other: _____

Surgical history: _____

MEDICATIONS

List ALL medications that you **currently** take, including any vitamins and/or herbal supplements. ☐ I am not taking any medications.

CURRENT Medications Prescribed *Example: (Zoloft)*	**Dosage** *(50mg)*	**Time of day taken** *(Every morning)*	**Provider** *(Dr. Nick Riviera)*

List ALL psychiatric medications that you have **previously** tried. ☐ I have never taken psychiatric medications.

PAST Psychiatric Medication *Example: (Lexapro)*	**Length of time taken** *(Three months)*	**Why you stopped taking the medication** *(It made me too drowsy)*

ALLERGIES ☐ I have no known allergies.

Clinical Notes

SUBSTANCE USE HISTORY

Describe any substance use history, including casual or recreational: *(include alcohol and tobacco usage)*

FAMILY HISTORY

Describe who you were **raised by** and the family relationship:

Describe the relationship with your **siblings**: *(with names and ages)*

☐ not applicable

Describe the relationship with your **spouse or partner**: *(with name and age)*

☐ not applicable

Describe the relationship with your **children**: *(with names and ages)*

☐ not applicable

SOCIAL HISTORY

Who is your support system?

Describe activities/relationships you have recently started or stopped:

Describe your leisure/recreational activities:

DEVELOPMENTAL HISTORY

Were there any known problems during mother's pregnancy or your birth? ☐ Yes ☐ No

Did you experience any developmental delays as an infant or young child? ☐ Yes ☐ No

(eating, talking, sleeping, walking, potty train):

EDUCATIONAL / OCCUPATIONAL HISTORY

What is your highest level of education? ☐ Student

Where are you presently employed? ☐ Unemployed

Military or First Responder employment history: ☐ No history

LEGAL HISTORY

Have you ever been arrested for any reason? ☐ Yes ☐ No

Are you currently on probation or community supervision/control? ☐ Yes ☐ No

Are you under court order or other requirement to obtain services? ☐ Yes ☐ No

Will you require progress notes for probation or other supervision? ☐ Yes ☐ No

Are you involved in an active or forthcoming family law and/or child custody case? ☐ Yes ☐ No

Are you and your family involved in a Department of Children and Families investigation? ☐ Yes ☐ No

Please describe details of any (yes) answers:

STRENGTHS / LIMITATIONS

What strengths or limitations should we be aware of that may help us with your treatment plan?

SANTA ROSA COUNSELING CENTER
Therapy & Psychiatric Services

Authorization for Release of Confidential Information

INTRODUCTION

This document authorizes Santa Rosa Counseling Center, LLC to release and obtain protected and confidential information including, but not limited to, medical, mental health, substance abuse treatment, legal, academic, and vocational records as specified below. The release of third-party information, including records received from other providers, is authorized unless otherwise specified or prohibited. Information may be released verbally, in copy form, or electronically to include fax and/or computer transmission. The records owner or custodian is authorized to act on behalf of a copy of this original form.

PATIENT INFORMATION

Last Name _____ First _____ MI _____ Date of Birth _____ SSN _____

Persons and Agencies to Obtain and/or Release Information *(may include multiple parties)*

- ☐ Baptist Hospital / Lakeview Center, Inc.
- ☐ Santa Rosa Medical Center
- ☐ West Florida Hospital / The Pavilion
- ☐ Sacred Heart Hospital
- ☐ Health Insurance Provider / EAP
- ☐ Department of Children and Families
- ☐ FamiliesFirst Network
- ☐ Guardian ad litem Program
- ☐ County and State Court / Probation _____
- ☐ Primary Care Provider _____
- ☐ Psychiatric Provider _____
- ☐ Attorney _____
- ☐ Other _____
- ☐ Other _____

The entirety of my record may be released/obtained. Otherwise, the following limitations of disclosure are as follows:

_____

I acknowledge that I am giving permission to disclose or obtain Protected Health Information. I understand that I may refuse to sign this authorization or that I may revoke this authorization in writing at any time except for that action which has already been taken to comply with it. I understand that treatment may not be conditioned on whether I sign this authorization, but that in certain limited circumstances I may be denied treatment if I refuse to sign this authorization. There is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPPA Privacy Rule. I understand that if I am a criminal justice system referral, this consent will remain in effect and cannot be revoked by me until there has been a formal termination of my probation, parole, conditional release, or other proceeding under which I was mandated into treatment.

This authorization is valid until termination of services unless specified: _____

Patient Name _____ Patient / Guardian Signature _____ Date _____

Witness Name _____ Witness Signature _____ Date _____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Informed Consent for Services

INTRODUCTION

Santa Rosa Counseling Center is a multispecialty group practice of mental health professionals providing therapy, psychiatric care, medication management, and other services. Our providers are committed to ensuring that each and every individual receives the highest quality of care and services possible. This legal document establishes guidelines for your participation in services with us. Please read it carefully and discuss any questions or concerns with office staff and/or the mental health professional before signing.

CONSENT TO TREATMENT

Your signing of this document provides Informed Consent for examination, diagnostic procedures, and treatment, including therapy, psychiatric services, and medication management deemed advisable from the mental health professionals at Santa Rosa Counseling Center. Our mental health professionals include licensed mental health counselors, clinical social workers, psychiatric mental health nurse practitioners, and registered and student interns. Medical care, including therapy and psychiatric services, is not an exact science and no guarantees are made as to the result of such examinations, treatment, and/or diagnostic procedures. While the course of treatment is designed to be helpful, it may be difficult or uncomfortable.

HEALTH INSURANCE BENEFITS AND AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Our providers are preferred network providers with most Health Insurance Plans and Employee Assistance Programs (EAP). Copayments and deductibles are paid at the time of service as part of the insurance provider contract. Payment in full is required when your benefits are not able to be verified. Service claims sent to your insurance provider require disclosure of Protected Health Information including, but not limited to, identifying information, diagnosis, service date, service type, and fees. In some instances, your insurance provider may require documentation such as the treatment plan and clinical notes. Your signing of this document provides specific authorization for the release of this information. Your insurance provider may need you to supply certain information directly. It is your responsibility to comply with these requests. Please notify us of insurance changes before your next visit. Knowing your insurance benefits is your responsibility. **You are responsible for any balance not covered by or paid by your insurance company for any reason.**

NON-DISCRIMINATION

Santa Rosa Counseling Center does not discriminate in the provision of services to an individual because the individual is unable to pay, because payment for those services would be made under Medicare, Medicaid or the Children's Health Insurance Program (CHIP), or based upon the individual's race, color, sex, national origin, disability, religion, or sexual orientation.

APPOINTMENT REMINDERS AND THERAPYPORTAL

We provide appointment reminders by text message, voice, and/or email using the contact information you provide during registration. This service is a courtesy. Please do not rely upon electronic reminders as the sole reminder for your appointments. To opt out of this feature for security and confidentiality purposes, inform the office staff or your provider. You will be registered with our TherapyPortal for online scheduling, billing, electronic document sharing and signature features. Your signing of this document authorizes the use of your contact information for the purposes of appointment notifications and TherapyPortal features.

CONFIDENTIALITY

We are committed to the confidentiality of your Protected Health Information by the ethical guidelines and legal requirements of our profession. Information will not be released without your written consent except under certain circumstances required by law: Known or suspected abuse, abandonment, or neglect of a child or vulnerable adult must be reported to the appropriate state or county agency (Fla.

Stat. § 415.504 and 415.1034); A provider may have a legal obligation to take protective action if there is reason to believe that there is clear and immediate probability of physical harm to the patient, to other individuals, or to society (Fla. Stat. § 491.0147); and, In certain cases, a judge may issue a court order for the release of Protected Health Information.

When participating in **couples or family therapy**, that treatment unit is considered to be the patient. Requests for treatment records requires authorization from all participants before releasing information. The provider may share information from an individual with all participants when clinical judgment determines it is in the interest of helping the treatment unit. This *no-secrets policy* is intended to mitigate risk of a conflict of interest between the individual and the treatment unit. If an individual has a prevailing interest of confidentiality, the provider may need to refer the individual to another provider or recommend termination of treatment. Confidentiality is encouraged amongst **couples, family, and group therapy** members but is cannot be enforced by the facilitator or Santa Rosa Counseling Center.

REQUESTS FOR DISABILITY

Santa Rosa Counseling Center does not accept patients seeking treatment for the sole purpose of obtaining disability benefits or patients seeking long-term disability benefits. It is possible that after evaluating you your provider may be willing to complete short-term disability paperwork on your behalf; however, your provider is not required to do so and may decline to assist with such a request. Your provider may also require you to schedule a separate follow-up appointment for this purpose. Additional fees are assessed for these services.

MEDICATION MANAGEMENT

To ensure the best reaction to any prescribed medications, please observe the following procedures:

- Always notify your provider of any side effects or problems with medications you are experiencing.
- Never stop or change the dose of a medication without first discussing with your provider.
- Suddenly stopping medication can cause medical problems. For this reason, do not allow yourself to run out of medication.
- If you need a refill before your next scheduled appointment, please call our office 72 hours prior to running out of your medication.
- Keep your scheduled appointments. Although your provider will prescribe you adequate medication until your next visit, cancelled or missed visits can prevent you from having sufficient amounts of medication and make it difficult for your provider to monitor your progress and any complications.
- If you do cancel or miss a visit, be sure to reschedule your next visit before you run out of medication. In general, we will insist that you see your provider before refilling your medication.

PROVIDERS AND STAFF

Your care will be managed by your personal provider or other providers who are not employed by Santa Rosa Counseling Center, but have privileges to care for patients at this center. Your provider's care is supported by a variety of individuals employed by Santa Rosa Counseling Center, including secretarial and billing staff. Your provider may also decide to call in consultants who practice in other specialties and may be involved in your care. Like your provider, those consultants have privileges to provide services for patients at this center but are not employed by Santa Rosa Counseling Center. Santa Rosa Counseling Center supports several graduate programs by providing on-site training and precept opportunities to students.

EMERGENCY

In the event of a mental health emergency and you are unable to contact our office, please contact your physician, emergency phone number 911, or go to the nearest emergency room. The National Suicide Prevention Hotline at 1-800-273-8255 is available 24/7.

INFORMED CONSENT ATTESTATION

I attest that I have read this document completely, fully understand it, and agree to all described herein. I have had the opportunity to discuss any questions regarding this document.

Patient Name Signature Date

If you are signing this document as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

Name Relationship Signature Date

SANTA ROSA COUNSELING CENTER
Therapy & Psychiatric Services

Financial Policy

INTRODUCTION

The purpose of this document is to explain payment responsibility, service rates, and appointment policies. This legal document establishes financial guidelines for your participation in services with us. Please read it carefully and discuss any questions or concerns with office staff and/or the mental health professional before signing.

PAYMENTS

All payments including, but not limited to, insurance copayments and deductibles are due at time of service. Accepted forms of payment are cash, check, money order, and credit card.

HEALTH INSURANCE BENEFITS

Our providers are preferred network providers with most Health Insurance Plans and Employee Assistance Programs (EAP). A portion or all of your service may be covered by your benefits. Copayments and deductibles are paid at the time of service as part of the insurance provider contract. Payment in full is required when your benefit coverage is not able to be verified. You are responsible for any balance not covered or paid by your insurance company for any reason.

FEES FOR SERVICE

Service	Psychotherapy	Psychiatric/Medication Management
Initial Evaluation	$125	$150
Follow-up session, Individual	$100	$75
Follow-up session, Family and Couples	$125	
Group Session	$35	

Professional services including report writing, telephone conversations, and consultation related to your care are billed at $100 per hour. When a provider is required to participate in legal proceedings, including, but not limited to, preparation, transportation, deposition, and court appearance, professional fees are billed at $150 per hour with a minimum of two hours. Professional fees are due by the patient or the parent/guardian of record, even if another party compels the provider to testify or participate in legal services. Professional fees are due prior and are non-refundable within 72 hours of the event.

CANCELLATION AND MISSED APPOINTMENT POLICY

If you are unable to make your scheduled appointment, we must be notified at least 24 hours in advance or the prior business day, whichever time is greater. Recognizing that appointment time may be limited, timely rescheduling allows our providers the opportunity to schedule another client without delay. If late notice of cancellation occurs or if the appointment is missed/forgotten, you will be charged $75 for the professional time that was reserved just for you. If you have an authorized card-on-file, the balance will be charged to the card for your convenience.

Initials	I understand that my provider's professional time is reserved just for me and that I will be charged $75 for missing an appointment or providing late notice of cancellation. The balance will be charged to the authorized card-on-file.

SLIDING FEES AND NON-DISCRIMINATION

It is the policy of Santa Rosa Counseling Center to provide mental health services regardless of the patient's ability to pay. For those who are uninsured and qualified, we offer sliding fees. Santa Rosa Counseling Center does not discriminate in the provision of services to an individual because the individual is unable to pay or because payment for those services would be made under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

NON-PAYMENT OF ACCOUNT

Failure to maintain your account in good standing may result in dismissal from the practice. Santa Rosa Counseling Center reserves the right to use a third-party collection agency and/or small claims lawsuit to resolve delinquent balances. The cost for pursuing action against a delinquent balance will be added to your bill and/or claims lawsuit. Checks returned for insufficient funds and bad-faith chargebacks are subject to a $25.00 administrative fee.

CREDIT CARD ON FILE

Santa Rosa Counseling Center requires a credit card authorization on file so that your balances can be settled as they occur. For your convenience, immediate authorized charges include any balance that is incurred as specifically defined in the subsections of this document. Eligibility of services may be re-evaluated without a valid credit card on file.

We utilize TransArmor which stores security tokens instead of sensitive credit card data. This system is certified PCI compliant.

CREDIT CARD ON FILE ATTESTATION

I authorize Santa Rosa Counseling Center to retain and charge my credit card on file for all valid assessed rates, fees, and late cancellation/missed appointment charges as specifically described in the subsections of this document. I understand that I must provide an updated valid card when my current card expires or does not have an available balance.

Last Four Card Digits				CVV	Exp. Date
					/

☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Name as it appears on card (please print) Signature of Cardholder/Authorized User Date

Revocation of this authorization must be submitted in writing.

OFFICE USE ONLY ☐ SWIPE ☐ MC/NR INIT _____

FINANCIAL POLICY ATTESTATION

I attest that I have read this document completely, fully understand it, and agree to all described herein. I have had the opportunity to discuss any questions regarding this document.

Patient Name Signature Date

If you are signing this document as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

Name Relationship Signature Date