



**Unclouded Mind LLC**  
Aundrea Sponsel, APRN-BC  
955 East Martin Luther King Jr. Drive Suite E  
Tarpon Springs, FL 34689  
Phone: 727-487-7066  
[Office@uncloudedmind.net](mailto:Office@uncloudedmind.net)

1

### PATIENT INFORMATION

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Referred By: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_

ST: \_\_\_\_\_ Zip: \_\_\_\_\_

If minor, parent's name: \_\_\_\_\_

Parent's employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Person to contact in case of an emergency: \_\_\_\_\_

Phone #: \_\_\_\_\_

Credit Card: \_\_\_\_\_ EXP: \_\_\_\_\_

CVV: \_\_\_\_\_ Zip assoc. w/ card: \_\_\_\_\_

Appointment Deposit: \$50 (only charged if no show) / Missed appt without 24 hr. notice \$50.

*I understand and agree that regardless of insurance status, I am ultimately responsible for the balance on my account for professional services rendered. (For patients whose insurance is a managed care plan, only the co-payment and charges for non-covered services are due.) I certify that the information provided above is true and correct. I will notify you of any changes to the above information.*

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Parent's signature if patient is a minor.

### INSURANCE INFORMATION

Currently taking Aetna, Aetna Better Health, Cigna, FL  
Medicare, FL Medicaid, Optum, Tricare, UMR, &  
United.

Name of insured: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_ Plan Name: \_\_\_\_\_

*I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of medical benefits to go to Aundrea Sponsel, ARNP for services provided.*

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Parent's signature if patient is a minor.

### CURRENT HEALTH

Reason for Visit:    Anxiety (   ) Depression (   ) ADHD (   ) Med refills (   )

Sleep problems (   ) FMLA/disability (   ) Other: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Medications you are currently taking: \_\_\_\_\_

Medical illnesses you currently have: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medical History:

Past medical illnesses: \_\_\_\_\_

Past surgery: \_\_\_\_\_

Major medical illnesses know to blood relatives: \_\_\_\_\_

### MINOR PATIENTS ONLY

When prescribing minors certain medications, it is a requirement by the pharmacy that we have a current height and weight. Please list your child's current height and weight in the space provided below.

- Height:
- Weight:

### Authorization for Release of Psychiatric/Psychological Information

Patient's name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

*I hereby authorize Aundrea Sponsel, APRN to obtain or release medical records/information to/from:*

For the purpose of: Continuity of care:

May we contact your PCP? YES ( ) NO ( ) or I do not have one ( )

If yes, please provide the PCP's name and phone number:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Office: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_ Zip: \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Parent's signature if patient is a minor.

## WAITING ROOM POLICIES

1. All patients must notify us of your presence when arriving at the office.
2. New patients must fill out necessary paperwork and present any Insurance card information.
3. Patients with a change of address or insurance information should notify the staff when arriving for an appointment.
4. Children may not be left unattended at any time unless prior arrangements are made.
5. Please keep conversation at a low volume so as not to disturb other patients while they are in sessions or waiting.
6. When using a cell phone please be courteous to others around you. All cell phones should be on silent while in the office. No cell phones are to be used in the appointment unless otherwise directed by your provider.

## APPOINTMENTS

Please make all follow-up appointments before leaving the office to ensure availability of your next appointment. Tele-psych Services are offered using Setmore/Zoom/phone call.

## CANCELLATION OF APPOINTMENTS

1. Please help us serve you better by keeping your regularly scheduled appointment.
2. All cancellations must be made 24 hours in advance. This will allow us time to schedule that appointment for someone else.
3. Any appointment not canceled 24 hours in advance is subject to a \$50.00 charge.
4. We understand that emergencies arise, please call the office as soon as possible.

## FORMS

Due to the increased request to complete forms, there is a **minimum charge of \$25.00** for Aundrea Sponsel to complete forms for Social Security, Disability and any other forms or letters.

## PAGING

Please reserve paging the provider for emergencies only. Appointment changes or prescription refills are not considered emergencies. Please call back during normal office hours. M-F 9-5.

## REFILLS

### Early refills for medication will not be approved.

1. Follow-up appointments are made 2-3 days early to avoid running out of medication. It is important that you keep your scheduled appointment.
2. If you must reschedule an appointment and will be out of medication before the next visit, please call our office 5 days before you run out to allow enough time for us to approve it.
3. It is the policy of the practice that we **do not reissue lost prescriptions for medications. If we have to replace a prescription, there will be a charge of \$5.00 for each script. If the medication is stolen, we must have a police report before we replace the prescription.** Please be advised that we encourage you to not lose, drop, misplace, ruin, crush or otherwise not be able to get your prescription filled, or not to finish your medicine. In addition, we do not refill prescriptions on the weekends beginning at 12 noon Fridays until 9am on Mondays. Please allow our office 48 to 72 hours to review/approve a refill before you run out.

## PAYMENT FOR SERVICES

Payment for your visit is due at the time of service. There is a service charge of \$30.00 for all returned checks. We will verify your insurance coverage and will file your insurance, but **you are responsible** if your insurance company does not pay your claim for any reason. If there are any delays on the part of your insurance company in the processing of the claim, it is your responsibility to contact the insurance carrier. We will expect payment in full from you if the insurance does not pay within 60 days of the service date. Any balance remaining after your insurance pays will be due and payable upon receipt of a bill. Credit card charges will appear on statements as Unclouded Mind Behavioral Health LLC. Please know if you have met your deductible so that you can anticipate any unpaid balance/charges for services.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Parent's signature if patient is a minor.**

*My signature confirms that I have read and agree to the above statement.*

Services provided: Medication management in-person or telepsych using Setmore/Zoom/Phone call, Psychotherapy, and Genesight testing.

Address: 955 East Martin Luther King Jr. Drive Suite E Tarpon Springs,  
FL 34689

Website: <https://uncloudedmind.net>

Fax: 727-342-6836

Phone number: (727)487-7066

**Please call or text 727-487-7066 to schedule or cancel an appointment or speak with staff regarding any questions you may have.**