Complete in full.

SPACE COAST PSYCHIATRY, INC.

DEMOGRAPHIC UPDATE 2025

Please Circle Primary Contact

PATIENT NAME:_____ DATE OF BIRTH:_____

STREET ADDRESS:_____ CITY:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____

EMAIL: _____ OK TO LEAVE A DETAILED MESSAGE: NO YES

SCHOOL/EMPLOYER:_____ GRADE:_____

ETHNICITY:_____ RACE:_____ MARITAL STATUS:_____

PARENT/GUARDIAN NAMES:_____/_____

PARENT/GUARDIAN PHONE:_____/_____

FINANCIAL GUARANTOR NAME:_____ PHONE:_____

GUARANTOR STREET ADDRESS:_____ CITY:_____ ZIP:_____
(If different from patient's address)

PRIMARY INSURANCE:_____ POLICY #:_____

NAME OF INSURED:_____ DATE OF BIRTH:_____

PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other:_____

INSURED'S ADDRESS:_____
(If different from patient's address)

SECONDARY INSURANCE:_____ POLICY #:_____

NAME OF INSURED:_____ DATE OF BIRTH:_____

PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other:_____

INSURED'S ADDRESS:_____
(If different from patient's address)

EMERGENCY CONTACT NAME:_____ PHONE:_____

PRIMARY CARE PROVIDER:_____ PHONE:_____

OUTPATIENT THERAPIST:_____ PHONE:_____

PHARMACY:_____ LOCATION:_____ PHONE:_____

ALLERGIES:_____

Please present your insurance card(s) to office staff.

Patient Name:

Office Policies 2025
Practice Expectations, Office Policies & Patient Bill of Rights
(Updated for January 1, 2025)

Welcome to Space Coast Psychiatry. Please read and acknowledge your understanding of and agreement to our Office Policies.

Office Hours (Subject to change)

Currently, the office is open Monday to Thursday 11 am to 5 pm. Starting in March 2025, our office hours will be Monday to Thursday from 10 am to 5 pm. Messages may be left after hours for urgent matters. Voicemails will be reviewed, and if deemed Urgent, a billable Telehealth session may be arranged to address treatment needs. Prescription Refill requests are NOT urgent. Non-urgent matters will be addressed at the MD's discretion or on the next business day.

Patient Portal

We are using a Patient Portal system associated with ICANOTES that will allow each client access to treatment, appointment reminders, forms, telehealth sessions and communication with the staff. Our staff will coordinate your access to the system.

Appointments

Depending upon the staff's discretion and insurance requirements, appointments may be face-to-face or via telehealth.

Telehealth appointments will be offered via a HIPPA compliant Telehealth platform. You will receive an invitation via email or text prior to your appointment. You will be expected to sign on at least 5 minutes prior to your appointment time. Our goal this year is to be able to complete any paperwork, submit payment, schedule the next appointment and have your session with Dr. Llinas all at the same time. Ultimately, it is your responsibility to arrange for payment and the follow-up appointment.

If you are unable to make your appointment, please contact us immediately and our staff will attempt to reschedule your appointment. Late cancellations (with less than 24-hour notice) or any missed appointment, will be charged a $200 fee, as this time has been dedicated to you. You can leave a message about a cancellation at any time. Appointments missed due to an emergency or illness will require documentation in order to waive this fee. Due to the high demand for appointments, "not showing" for an appointment may result in discharge from the practice permanently.

All minors (under the age of 18) must have a parent or legal guardian available so that decisions about treatment issues can be made. Please contact our office ahead of the scheduled appointment time to discuss any situations where this may not happen. Our office reserves the right to reschedule an appointment if a parent or legal guardian is not available. If a parent that does not attend the appointment, then requests a call from Dr. Llinas to discuss care, a private pay fee of $200 will be collected. We recommend that all parents or legal guardians arrange to attend all appointments.

Due to time constraints, we will not allow other providers (i.e., counselors, therapists, school officials, etc.) to attend regularly scheduled appointments with a patient or parent/legal guardian. Special arrangements must be made prior to an appointment, if this service is needed.

Working together is our priority. If at any time you, or your parent/guardian, fail to attend appointments regularly, become non-compliant with treatment recommendations, choose to discontinue treatment without discussing this plan with the doctor, or fail to pay your bill, you may be discharged from the practice and not be allowed to return. We will forward your records to another provider of your choice with a properly executed Authorization to Release Information.

Dr. Llinas will not willingly participate in any court proceedings. This can interfere with the therapeutic relationship. If you, or a parent/legal guardian, is in need of this service, our office will assist you to locate a forensic provider. Please discuss any situations with Dr. Llinas, openly and immediately, to avoid being discharged from Space Coast Psychiatry. If, in the event that Dr. Llinas must participate in legal proceedings, a fee will be assessed at $400 per hour, minimum of 1 hour.

Confidentiality

All information between Psychiatrist/Therapist and Client is held strictly confidential UNLESS:

1. The Client authorizes a release of information with his/her signature.
2. A Court order signed by a Judge.
3. The Client presents a physical danger to self.
4. The Client presents a danger to others.
5. Child/Elder abuse/neglect are suspected.
6. In order to improve the quality of care, it may be necessary for professionals working at Space Coast Psychiatry to discuss information regarding your case.

In cases 4 and 5, we are required by law to inform the potential victims and legal authorities so that protective measures can be taken. If information is obtained via Telehealth, a home wellness call will be initiated.

Financial Terms:

All co-pays, co-insurances and deductibles will be collected at the appointment time. If an account balance occurs, it must be paid at the next appointment or within 30 days of receiving a statement from Space Coast Psychiatry. The office manager is available to discuss payment plans, if needed.

We will be using a payment request system at times which will allow us to contact you via email or SMS text to request payment if there is a balance due on your account.

We will attempt to verify your health plan/insurance coverage and policy limits. We will attempt to submit claims to your primary insurance carrier on your behalf, only if Space Coast Psychiatry/Dr. Llinas is an “in-network” provider. By signing below, you give Space Coast Psychiatry permission to release information to your insurance company and pharmacy on record to process claims and authorizations.

Secondary insurance will not be billed. You are responsible to pay any copays, deductibles and/or co-insurance for your primary insurance. You may request documentation to submit to your secondary insurance, once the primary EOB is received at our office. Please contact the office manager to make this request after you have received your EOB.

If your insurance changes, please make sure that you update your information with the office. If you are not eligible at the time services are rendered, you are responsible for full payment of the service at the private pay rate.

If a check is returned for insufficient funds, you will be given 10 business days to rectify your account. A $25 service fee will also be assessed. All future payments will have to be made via cash, money order or credit/debit card.

If an account becomes delinquent for more than 60 days, and efforts have been made to collect payment, you will be discharged from Space Coast Psychiatry, Inc. Please bring any financial concerns to the attention of the MD or Office Manager.

Prescriptions

Dr. Llinas' primary role in your care will be medication management. He will work closely with you to monitor the effectiveness of your medications. We ask that you take your medication only as prescribed, and that you communicate any problems or side effects to your doctor, as soon as possible. Messages can be left 24/7 at our office for these issues.

Dr. Llinas will be providing prescriptions via paper or electronically. As a patient, you understand and agree for Dr. Llinas and staff to monitor your medication history. Dr. Llinas attempts to provide you with enough medication to last until your next scheduled appointment. If circumstances arise that you will run out, we ask that you contact us during office hours, and in a timely fashion. It may take up to 72 hours to complete the process.

Some medications may require a Prior Authorization. We will work with your insurance to obtain these as soon as possible. Please have your pharmacy fax us notice for a prior authorization. It can take between 3 to 30 days for the process to be completed depending on your insurance.

Some medications are considered "controlled substances". Depending on your treatment plan, you may be provided up to 3 prescriptions to cover the 3 months between required appointments. The law requires you to see the doctor every 3 months for continued medical assessment. These prescriptions are date limited and will expire. You will need to submit these to your pharmacy in a specific order. If you reschedule or miss an appointment, these medications will not be refilled until you are seen by the doctor.

For all other prescriptions, if you miss an appointment due to a "no show", "late cancellation", or patient/parent requests to reschedule, there will be a $50 fee for each prescription refill requested. Fees will only be waived for "documented" emergencies or illnesses.

Letter Request/Forms Completion

We understand there may be a need to request a letter from the doctor or a form to be completed. If approved, a $25-$50 fee will be assessed depending on the amount of time necessary to complete. Please allow up to two (2) weeks for your request to be completed. Payment is expected upon completion. Completed forms will be uploaded to the Patient Portal for you to access.

If you have any questions, comments or concerns, please feel free to ask the doctor or the office manager at your appointment. You can also contact us at (321) 613-5595.

Patient's Bill of Rights and Responsibilities
Section 381.026, Florida Statutes

A PATIENT HAS THE RIGHT TO:

· Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.
· Receive a prompt and reasonable response to questions and requests.
· Know who is providing medical services and is responsible for his or her care.
· Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
· Know what rules and regulations apply to his or her conduct.
· Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
· Refuse any treatment, except as otherwise provided by law.
· Be given full information and necessary counseling on the availability of known financial resources for care.
· Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
· Receive prior to treatment, a reasonable estimate of charges for medical care.
· Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
· Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
· Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
· Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
· Express complaints regarding any violation of his or her rights.

A PATIENT IS RESPONSIBLE FOR:

· Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
· Reporting unexpected changes in his or her condition to the health care provider.
· Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
· Following the treatment plan recommended by the health care provider.
· Keeping appointments and, when unable to do so, notifying the health care provider or facility.
· His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.
· Making sure financial responsibilities are carried out.
· Following health care facility conduct rules and regulations.

By signing below, you are acknowledging and agreeing to follow our Office Policies for 2025.

Patient or Parent/Guardian Signature:

Print Name of Person signing this form:

Date:

Disclosure of Information
Space Coast Psychiatry, Inc.

Client Name: _____ DOB: _____

Patient acknowledges and agrees that Space Coast Psychiatry and its staff, may disclose the Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient.

Please list the name and relationship to Patient:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

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Client Signature, or Parent/Guardian, if under 18: _____

Print Name: _____ Date: _____

Patient Name:

Preferences for Electronic Communication

By agreeing to the terms of this Electronic Communications Consent ("Consent"), you agree and consent to Space Coast Psychiatry Inc., its affiliates or agents involved in providing and supporting the Services for which you are enrolled, including the virtual clinical care support ("Telehealth Services") provided by Space Coast Psychiatry Inc. health care providers providing disclosures to you and communicating with you regarding your health, health plan, eligibility, health conditions, diagnoses, treatment, appointments, billing, and programs, benefits or services that may be of interest to you (collectively, "Communications").

METHODS OF COMMUNICATIONS

All Communications that we provide to you electronically will be provided either (i) directly to the email address provided by you; (ii) on our website; or (iii) directly by text to the mobile number provided by you. You understand that electronic communications have inherent privacy risks, including that unencrypted text messages and email communications are not secure and could be accessed by an unauthorized party, intercepted, or altered without your knowledge or authorization. You represent that you have the authority to agree to receive electronic communications at the telephone number or email address that you provided to us, or from which you sent a request to us. You agree to notify us regarding any changes to your telephone number or email address. Message frequency depends upon your activity.

We may be required by law to give you certain information "in writing" or electronically with your informed consent. You agree that we may electronically provide, send, disclose, or communicate to you any such information and any other Communications relating to your relationship with us to the mobile telephone number and/or email address that you have provided to us. Additionally, you have the right to request and receive certain documents either electronically or by paper copy.

ELECTRONIC SIGNATURES

By agreeing to this Consent, you are also agreeing to use electronic records and signatures throughout the course of our relationship. You understand that your electronic signature is the legal equivalent of your manual/handwritten signature and will be binding to the same extent as if you signed the document in writing. This Consent applies to all documentation relating to your relationship with us, including documentation relating to the registration and participation in our services, your use of our website, and any services we provide in association with such use.

WITHDRAWING OF CONSENT

You may revoke your agreement to this Consent by emailing spacecoastpsychiatry@aol.com.

Below are my preferences for Electronic Communications:

Email Address:

Mobile Phone Number:

By signing below, I acknowledge that I am providing this information.

Print the Name of the Individual Signing this form:

Date:

Telehealth Consent
Space Coast Psychiatry, Inc.

Client Name: _____DOB: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation using a HIPPA Compliant telehealth platform.

2. My health care provider, or the staff, have explained to me how the video conferencing technology will be used and I understand I will not be the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation.

6. In a crisis, I understand that the responsibility of the telemedicine specialist is to advise my local first responders, and coordinate any care deemed necessary to address my situation.

7. I have had a direct conversation with my healthcare provider, during which I had the opportunity to ask questions in regard to this process. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

8. I understand that Space Coast Psychiatry, Inc. will attempt to file claims to my current insurance plan. I agree to pay for all deductibles, co-insurances and co-pays resulting from insurance claims processing. If I am a private pay client, I agree to continue to pay for services at the current rate. I understand that if my insurance company denies payment for a claim, I will be responsible for the service at the current private pay rate.

9. I consent to my prescriptions being sent electronically to my pharmacy, unless discussed with my provider. I give consent to Space Coast Psychiatry, Inc. and its staff, to receive medication history records via electronic prescribing methods in order to assist with my treatment and care plan.

By signing this form, I certify:
*** That I have read or had this form read and/or had this form explained to me**
*** That I fully understand its contents including the risks and benefits of the procedure(s).**
*** That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.**

Client or Parent/Guardian Signature, If client is a minor: _____

Printed Name: _____ Date: _____