AFTER HOURS
PSYCHIATRY CARE

Patient Evaluation Form

This psychiatric urgent care is for non-life-threatening issues. ***If you are experiencing suicidal/homicidal thoughts or life-threatening emergencies, please stop and call 911 or go to your nearest emergency room***

Briefly state the reason for this evaluation:

_____

_____

Patient Name: _____ Date of Birth: _____

Patient SS#: _____ Sex: _____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Pharmacy (Name, Address, Phone):

_____

May we leave a message? Yes ___ No ___ What phone #?: _____

LEGAL GUARDIAN INFORMATION (IF NOT THE PATIENT)

Name: _____ Relationship to Patient: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Demographic Information

1. Race/Ethnicity: ___ American Indian/Alaskan Native ___ Asian ___ African-American
___ Hispanic ___ Caucasian ___ Other:_____

2. Current Marital Status: ___ Single ___ Married (living together) ___ Married (living apart)
___ Separated ___ Windowed ___ Divorced ___ Other: _____

3. If you are married or cohabitating with a partner, how long has it been? _____

4. Total Number of Marriages: _____ 5. How many children do you have? Age(s)?: _____

6. Spouse's/Partner's Name: _____

7. Who else lives with you?: _____

8. How many years of formal education have you completed?: _____

9. Highest Degree Obtained: _____

10. Employers Name: _____ 11. Occupation: _____

12. Employment Status: _____

Mental Health History

Are you currently seeing a therapist or psychiatrist? ___ Yes ___ No

If yes, Name and contact #: _____

Have you ever seen a psychiatrist/psychotherapist before? ___ Yes ___ No

If yes, please list: _____

Previous Psychiatric Conditions *(check all that apply):*

___ Depression ___ ADHD ___ Bipolar (Manic/Depressive) Disorder ___ Anxiety

___ Panic Attack ___ OCD ___ Anorexia/Bulimia ___ PTSD

___ Binge-eating ___ ECT ___ Schizophrenia ___ Alcohol

___ Drugs

Please list in chronological order all prior psychiatric hospitalizations (if any) below. Please indicate the reason for each hospitalization:

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself: ___ Yes ___ No

If yes, please list the occurrences below:

Approximate Date of Attempt	Method of Attempt

Please list all current medications below (including birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort, etc.):

Name of Medication	Dosage (Mg)	How many times a day?	How long on this medication?	Side Effects? If yes, what?	Prescribing Physician

Please review the following list of medications. If you have taken any of these medications, please fill out the specific boxes related to that medication.

Brand Name	Generic Name	√ if yes	How long did you take it?	Dosage	Did it help? √ if yes	How often in a day?	Side effects?
Selective Serotonin Reuptake Inhibitors (SSRIs)							
Luvox	**Fluvoxamine**						
Paxil	**Paroxetine**						
Paxil CR	**Paroxetine**						
Celexa	**Citalopram**						
Lexapro	**Escitalopram**						
Zoloft	**Sertraline**						
Prozac	**Fluoxetine**						
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)							
Effexor	**Venlafaxine**						
EffexorXR	**Venlafaxine**						
Pristiq	**Desvenlafaxin**						
Cymbalta	**Duloxetine**						
Other Antidepressants							
Desyrel	**Trazadone**						
Serzone	**Nefazodine**						
Wellbutrin XL/SR	**Bupropion XL/SR**						
Remeron	**Mirtazapine**						
Viibryd	**Vilazodone**						
Tricyclic Antidepressants							
Adapin	**Doxepin**						
Anafranil	**Clomipramine**						
Asendin	**Amoxapine**						
Elavil	**Amitriptyline**						
Ludiomil	**Maprotiline**						
Norpramin	**Desipramine**						
Pamelor	**Nortriptyline**						
Sinequan	**Doxepin**						
Surmontil	**Trimipramine**						
Tofranil	**Imipramine**						
Vivactil	**Protriptyline**						

Other Psychotropics (Have you taken any of these?)				
Abilify	**Buprenorphin**	**Dexedrine**	**Ambien**	**Klonopin**
Emsam	**Provigil**	**Thorazine**	**Risperidal**	**Campral**
Adderall	**Buspar**	**Ativan**	**Nardil**	**Depakote**
Dalmane	**Invega**	**Antabuse**	**Vyvanse**	**Restoril**
Xanax	**Parnate**	**Lithium**	**Orap**	**Geodon**
Suboxone	**Strattera**	**Sonata**	**Hydroxyzine**	**Halcion**
Lamictal	**Navane**	**Zyprexa**	**Naltrexone**	**Concerta**
Buspar	**Valium**	**Niravam**	**Phentermine**	**Trilafon**
Seroquel	**Ambient CR**	**Halcion**	**Vistaril**	**Tranxene**
Tegretol	**Mobane**	**Symbyax**	**Valproic Acid**	**Focalin**
Atarax	**Methadone**	**Cylert**	**Topamax**	**Stelazine**
Clozapine	**Adderall XR**	**Ritalin**	**Librium**	**Synthoid**
Viibryd	**Mellaril**	**Haldol**	**Rozerem**	**Metadate**
Daytrana	**Lunesta**	**Meridia**	**Saphris**	**Loxitane**
Prolixin				

Family History: Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate indicate paternal and maternal)

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparents
Depression								
Anxiety								
Panic Attack								
PTSD								
Bipolar/Manicdepression								
Schizophrenia								
Alcohol problems								
Drug problems								
ADHD								
Suicide attempts								
Psychiatric hospital stay								

Medical History: Do you have, or have you ever had any of the following (please check all that apply)?

	√		√		√
High Blood Pressure		Gastrointestinal problems (ulcer,pancreatitis, etc.)		Viral Illness (herpes, hepatitis, etc.)	
Lung Disease		Arthritis or Rheumatoid		Cancer	
Diabetes		Liver Damage or Hepatitis		Genital problems	
Heart Disease		Endocrine/Hormone problems		Eating Disorder	
Thyroid Disease		Neurological problems (stroke, brain tumor, etc.)		Eye problems	
Anemia		Gynecological/Hysterectomy		Chronic pain	
Asthma		Urinary Tract/Kidney problems		Fibromyalgia	
Skin Disease		Migraine or Cluster Headaches		HIV Positive or AIDS	
Seizures		Ear/Nose/Throat problems		Head injury	
Other: _____		High Cholesterol		Sleep apnea	

Regarding alcohol, when was your last drink? _____

In the past 30 days, about how many of those days have you had at least one alcoholic drink? _____

What is the maximum number of drinks you have had in one day in the past month? _____

Have you had a DUI? _____

Have you had a DWI? _____

Have you had any public intoxication? _____

Have you had seizures? _____

Have you had DT's? _____

Please check the appropriate boxes that apply to you for abuse of the following substances:

	Never used	Age first used	Last used	Age Peak use	History of abuse?	Current Use and frequency
Cocaine						
Amphetamine or speed						
Marijuana						
Diet pills						
Hallucinogens (LSD, Mushroom, etc.)						
Ecstasy						
Diuretic						
Tranquilizers						
Pain pills						
Inhalants						
Sleeping pills						
Laxatives						
Cigarettes, cigars, tobacco						
PCP or Angel Dust						
IV Drug use						
Heroin						
GHB						
Anabolic Steroids						
Caffeine (coffee, tea, cola, etc)						
Benzodiazepines (xanax, valium, etc.)						
Other: _____						

List all prior surgeries and hospitalizations for medical illnesses:

_____

_____

Are you allergic to any medication or food? If so, please list below:

_____

Last menstrual period (if applicable): _____

Contraceptive method: _____

Patient-Provider Communications Agreement

Purpose
This Agreement outlines the use of asynchronous electronic communications (including email and text messages) and clarifies policies regarding other communications (telephone and video conferencing) between you and After Hours Psychiatry Care ("**Provider**"). Asynchronous communications are limited to non-emergent, non-urgent, and non-critical matters. Real-time telehealth sessions are governed by the separate Telehealth Consent Form.

These services are provided in compliance with Florida Statutes, Chapter 456.47 (Florida Telehealth Act) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Privacy and Security

- Provider protects your information in accordance with HIPAA's privacy and security requirements.
- Despite safeguards, electronic communications carry inherent risks, including misdirection, interception, or access by unauthorized persons.
- Standard consumer email accounts (e.g., Gmail, Yahoo) are not encrypted or secure and may be accessed by third parties, including employers if work email accounts are used.
- By choosing to use these forms of communication, you accept these risks.

Appropriate Uses

- Appointment scheduling or confirmation.
- Routine questions about medications or instructions.
- Non-urgent test results and interpretation.
- Referral contact information.
- Patient education materials.
- Provider-requested status reports (e.g., weight, blood pressure).

Inappropriate Uses

- **Emergencies or situations requiring a response in less than 72 hours.**
- **Suicidal thoughts, threats of harm to self or others, or any life-threatening issue. If you are experiencing an emergency, call 911 immediately or go to the nearest emergency department.**
- Highly sensitive matters (e.g., HIV status, substance use disorder treatment protected under 42 C.F.R. Part 2).
- Complex or detailed clinical issues best addressed in a telehealth session.

Patient Responsibilities

By signing below, you agree that:

- You will include your full name and date of birth in every message.
- You will categorize your message in the subject line (e.g., "Prescription," "Status Report," or "Other").
- You will acknowledge provider emails with a reply of "Received."
- If you do not receive a response within 72 hours and the matter cannot wait, you will contact Provider by telephone.
- You are responsible for safeguarding communications sent to and from your devices and accounts.

Termination of Consent

You may withdraw consent to electronic communications at any time by providing written notice to Provider via mail or the secure patient portal.

Acknowledgment and Release of Liability

I understand that while After Hours Psychiatry Care (“Provider”) uses reasonable safeguards in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), no electronic communication system can be guaranteed secure.

I acknowledge that the use of email, text messaging, or other electronic communications may carry risks, including but not limited to:

• Interception of messages by unauthorized persons;

• Misdelivery or misdirection of information;

• Access by third parties (including employers, if a work email account is used).

By signing below, I confirm that I accept these risks and consent to communicate with Provider electronically for non-emergent, non-urgent, and non-critical matters. I agree that Provider will not be liable for unauthorized access to my information that occurs despite its use of reasonable safeguards or for breaches that occur through systems not controlled by Provider (such as my personal email account, phone carrier, or employer’s network).

This acknowledgment does not waive any rights or remedies I may have under applicable federal or Florida law if Provider fails to comply with its legal duties of care, confidentiality, or privacy.

Patient/Authorized Representative Signature:_____

Patient/Authorized Representative Printed Name:_____

Date: _____

Treatment of Minors

Policy
To authorize mental health treatment for a minor child, you must have legal authority to consent under Florida Statutes, Chapter 743 and related provisions of Chapter 394 (Florida Mental Health Act). If you are separated or divorced, you must provide a copy of the most recent custody decree or court order demonstrating your authority to consent to treatment.

It is our general policy to notify and seek consent from both parents before initiating treatment for a minor child. We believe it is important that all parents agree that their child is receiving mental health evaluation or treatment, unless:

Dual Consent Policy
If you are separated or divorced from the child's other parent, our general policy is to notify and obtain consent from **both parents** before initiating treatment or prescribing psychiatric medication, unless:

- One parent has sole legal authority to consent, as demonstrated by a court order; or
- Exceptional circumstances exist (such as safety concerns, lack of contact, or urgent clinical need) that make obtaining dual consent impractical.

We believe it is in the child's best interest for both parents to be informed and in agreement regarding mental health evaluation and treatment.

Confidentiality
We respect your child's need for a "zone of privacy" where they feel free to discuss personal matters, which is particularly important for adolescents. We will provide you with general information about your child's treatment but will not share specific details disclosed by your child unless, in our professional judgment, disclosure is necessary to protect your child or others from a serious and immediate risk of harm.

Legal Involvement
Our role is limited to providing mental health treatment to your child. We do not provide evaluations, reports, or opinions regarding parental custody, visitation, or parental fitness in any legal proceeding.

If compelled by court order, or if appropriate releases are signed, we may provide factual information to custody evaluators, guardians ad litem, or parenting coordinators.

If one of our providers is required to testify or otherwise participate in legal matters, the responsible party agrees to reimburse us at the rate of **$500 per hour**, billed in one-hour increments, for time spent on travel, review and preparation of documents, consultation with attorneys, testimony, or other case-related activities.

Acknowledgment
I have read and understood this Treatment of Minors policy and agree to its terms.

Name of Patient: _____ Date: _____

Signature of Parent/Legal Guardian:_____

Printed Name of Person Signing: _____

Relationship: _____

If the patient is younger than 18 years of age or cannot sign on his/her behalf, a parent or legal guardian must sign and shall be responsible for all financial obligations

Credit Card Chargebacks Acknowledgement

Policy
After Hours Psychiatry Care is a self-pay, telehealth-only practice committed to providing high-quality psychiatric care. Payment for services is due at the time of service via credit card. We strive to resolve legitimate billing disputes fairly but strongly discourage frivolous or unjustified chargebacks, which are disputes initiated with your credit card issuer to reverse a charge. Frivolous chargebacks disrupt our ability to provide care and may incur additional costs.

Agreement

By receiving telehealth services from After Hours Psychiatry Care (or for a child/ward for whom you are responsible), you agree:

• You understand that you are paying for the provider's professional time, clinical expertise, and judgment. Payment is for the service itself, not for a guaranteed satisfaction or a specific clinical outcome.

• You acknowledge your right to dispute charges under your cardholder agreement; however, you specifically agree that dissatisfaction with clinical services or outcomes is not a valid basis for a chargeback.

• You agree to contact us directly at ***info@afterhourspsych.com*** to resolve any concerns regarding billing errors or potential unauthorized charges before initiating any chargeback request.

- You understand that You understand that initiating a frivolous chargeback may result in additional administrative fees and that we reserve the right to pursue recovery of disputed amounts through all available legal remedies.
- You agree that initiating a chargeback for any rendered service, for any reason other than a legitimate, unresolved billing error or a fraudulent transaction, is a violation of this agreement. In such cases, a $100 administrative fee will be assessed per chargeback, and we reserve the right to pursue all available legal remedies to recover the disputed amount, plus interest at the maximum lawful rate, attorneys fees, and associated costs.

Acknowledgment

I have read and understood this policy. I agree that I am paying for the provider's professional time and judgment and that this payment is not contingent on my satisfaction with the outcome. I will contact the practice directly to resolve any billing errors and will not initiate a chargeback for services that have been rendered.

Patient Name: _____

Date:_____

Sign: _____

Name of Person Signing (if other than Patient):_____

Relationship to Patient: _____

If the patient is younger than 18 years of age or cannot sign on his/her behalf, a parent or legal guardian must sign and shall be responsible for all financial obligations

Consent to Treatment for Telehealth-Based Services
(via doxy.me)

Patient Name: _____ Date: _____

Introduction

After Hours Psychiatry Care provides psychiatric urgent care via telehealth only (using doxy.me) in compliance with Florida Statutes, Chapter 456.47 (Florida Telehealth Act) and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996), as amended (HIPAA).

Telehealth involves real-time evaluation, diagnosis, consultation, and treatment using audio, video, or other electronic media. All services are self-pay, with payment due at the time of service.

Risks and Responsibilities

• **Patient Location:** Telehealth services are provided by Florida-licensed providers in accordance with Florida law. **Patients must be physically located in Florida at the time of service.** If you are outside Florida, you must notify us before your session so we can determine if services can be legally provided under the laws of your location. For urgent care needs while outside Florida, contact your local provider, call 911, or visit an emergency room.

• **Identity Verification:** You may be required to present a valid photo ID at the beginning of your session to verify your identity.

• **Basis of Care:** Telehealth may not include an in-person physical examination, and your provider must rely on the information you provide. You agree to give a complete and accurate medical and mental health history.

• **Technical Issues:** Technical problems (e.g., internet or equipment failure) may interrupt a session and require alternative communication methods or a referral for an in-person evaluation.

• **Service Limitations:** If your provider determines that telehealth services are not adequate to meet your needs, you may be referred for in-person care with another provider.

• **Emergencies:** For urgent symptoms or emergencies that arise after your session, you agree to call 911, go to the nearest emergency department, or contact your primary care provider.

• **Confidentiality:** To protect your privacy, telehealth sessions are ***confidential and are not recorded***. Information from your sessions may be shared with your primary care provider when required by law or with your consent. You acknowledge receipt of our Notice of Privacy Practices.

• **Prescribing:** Prescriptions, when clinically appropriate, will be issued in compliance with all state and federal regulations governing the practice of tele-psychiatry.

Acknowledgment and Consent

By signing below, I acknowledge that I: Have read and understood this Consent to Treatment for Telehealth-Based Services; Have had the opportunity to ask questions about telehealth; Consent to receive psychiatric services via telehealth under the terms described above; Understand and accept the risks and responsibilities of telehealth; Accept that services are telehealth-only and self-pay; and If signing on behalf of a minor, represent and warrant that I have the legal authority to consent to treatment under Florida law.

Sign: _____

Print:_____ Relationship to Patient:_____

Patient Contact Number: _____ Patient E-mail:_____

A guardian or other legally authorized person signing hereby represents, warrants, and certifies that he or she has legal authority to sign and agree to this Consent on behalf of the patient. A parent signing below hereby represents, warrants, and certifies that both parents consent to the terms of this Consent or that such co-parents consent is not required.

Telehealth Services and Financial Responsibility Agreement

Nature of Services

After Hours Psychiatry Care provides psychiatric urgent care services **exclusively via telehealth** in compliance with the **Florida Telehealth Act (Florida Statutes §456.47)**. Services may include psychiatric evaluation, consultation, diagnosis, treatment planning, and medication management as clinically appropriate. You understand that:

- All services are **telehealth-only**; no in-person appointments are offered.
- Telehealth services may have limitations, including reliance on the accuracy of information you provide.
- If telehealth is not sufficient to meet your needs, you may be referred for in-person care with another provider.

Professional Fees and Self-Pay Policy

- All services are **non-refundable** and self-pay only. We do not bill or contract with any insurance providers.
- Payment is due at the time we schedule your appointment. ***Any cancellation or no show of your appointment will not be refunded. However, the payment will be applied as a credit valid for 15 days. After 15 days, the credit will expire.***
- Current rates:
  - Initial psychiatric evaluation: **$350.00**
  - Follow-up visit: **$250.00**
  - Court-related services (if required by subpoena or court order): **$500 per hour**, billed in one-hour increments, including preparation, travel, consultation, and testimony.
- Fees are subject to change with advanced notice.

Credit Card Authorization and Payments

- A v**alid credit card must be kept on file** as a condition of treatment.
- You authorize After Hours Psychiatry Care to charge your credit card for all services rendered, including fees for missed appointments or late cancellations (see below).
- If a card is declined, you agree to promptly provide updated payment information.

Credit Card Chargebacks Acknowledgment

- You are paying for the provider's professional time, clinical expertise, and judgment, not a guaranteed outcome. You agree to contact us directly to resolve any billing errors and will not initiate a chargeback for services that have been rendered. Improper chargebacks will result in a $100 administrative fee and may lead to legal action to recover interest, fees, and costs.
- You agree to first contact After Hours Psychiatry Care directly regarding any billing concerns or errors.
- Please see our Credit Card Chargebacks Acknowledgement that you signed for more information.

Confidentiality and Records

Your health information is confidential and protected under **HIPAA** and Florida law. Information may only be released with your written consent or as required by law (e.g., imminent risk of harm, child/elder abuse, or court order).

Acknowledgment

By signing below, you acknowledge and agree that: You have read and understood this Telehealth and Financial Services Agreement; You are financially responsible for all services provided; You consent to the storage and use of your credit card for payment of fee; You understand the policies regarding cancellations, chargebacks, and confidentiality.

Patient/Authorized Representative Signature:_____

Printed Name:_____

Date:_____