gulfcoast BEHAVIORAL HEALTH
1938 SOULE ROAD, CLEARWATER, FL 33759 Ph. (727) 726-7442 F. (727) 288-1111 www.gulfcoastbh.com

Thank you for your interest in Gulfcoast Behavioral Health!

We respectfully request that you complete our intake forms attached and return all required documentation prior to us scheduling an appointment. Please complete, sign, and return to our office as soon as possible. Once received and your insurance information verified, a member of our staff will give you a call to schedule your first appointment.

The first page is to be signed by the Group Home Manager; the remaining pages are to be signed by the patient or his/her legal guardian. When returning to us, please be sure to include:

1. Clear, colored photos of the front and back of all insurance cards except Medicaid – our office does not accept Medicaid!
2. Release of Information for the group home as well as the consumer's primary care provider and any other provider he/she has seen within the last 3 years
3. Clear, colored photos of the patient's government issued photo ID
4. Copies of any official document(s) appointing guardianship, if necessary
5. Clear, colored photo of guardian's government issued photo ID, if necessary
6. Group Home's Consumer Record with clear, color photo of consumer
7. Current Medication Administration Record (MAR)

You can return the documentation by email to intake@gulfcoastbh.com or by postal mail. Our office address is:

Attn: Intake Dept.
Gulf Coast Behavioral Health
1938 Soule Rd
Clearwater, FL 33759

If you have any questions, please do not hesitate to give me a call at 727-726-7442.

We look forward to seeing you soon!

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Group Home Information

Patient Information

Patient's Name: _____ DOB: _____

Preferred Name: _____ Soc Sec #: _____ Sex: [] Male [] Female [] Other: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Medication Allergies: _____

Legal Guardian Information

Name: _____ DOB: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Sex: [] Male [] Female [] Other: _____ Email: _____

Responsible Party

Name: _____ DOB: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Insurance Information

Insurance Company: _____

Member ID #: _____ Group #: _____ Phone #: _____

Policyholder's Name: _____ Relationship to patient: _____

DOB: _____ SSN: _____ Policyholder's Phone #: _____

Group Home Information

Home Name: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Fax #: _____

Home Manager: _____ Phone #: _____

I acknowledge, understand, and agree that I am responsible for the above-named individual. **I will present a Medication Administration Record (MAR) for my client's provider to review at every appointment.** I acknowledge and understand that failure to provide this information will cause a delay in prescriptions being sent to the pharmacy.

I acknowledge and understand that for Gulfcoast Behavioral Health to protect my client's privacy, I will be required to provide three identifying pieces of information when contacting the office by telephone and/or email. I understand and agree that if my client moves out of my group home, I will notify Gulfcoast Behavioral Health of the change.

I acknowledge and agree that the above information is true to the best of my knowledge. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____

Group Home Manager Signature Date

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Adult Clinical History

Patient Name: _____ Date of Birth: _____

Introductory Information

What is the reason(s) for seeking services?

_____

_____

When did you first notice this(ese) issue(s)?

_____

_____

List interest and/or hobbies: _____

Evaluations/Assessments:

Have you ever received any of the following assessments/evaluations?
(Please check all that apply) IF APPLICABLE, PLEASE SEND REPORT(S) PRIOR TO APPOINTMENT

- ☐ Learning/academic/IQ
- ☐ Psychological
- ☐ Physical
- ☐ Occupational
- ☐ Audiology
- ☐ Psychiatric
- ☐ Developmental
- ☐ Neuropsychological
- ☐ Speech & language
- ☐ Neurological (e.g., MRI, CAT scan, EKG, etc)

Medication History

Medication Name	Dose	How long? (months)	End Date	Side Effects?	Reason for stopping?	Prescribing Provider
1.						
2.						
3.						
4.						
5.						

Current Physical Health & Healthcare

Would you like us to contact your primary care provider? ☐ Yes ☐ No

What was the date of your last physical exam? _____Was blood work done? ☐ No ☐ Yes

Do you see any specialists for chronic or severe health conditions? ☐ No ☐ Yes
If yes, what is the name of specialist? _____

Allergies

Do you have any known allergies to medications, foods, animals, etc.? ☐ No ☐ Yes

If yes, please describe: _____

Pharmacy Information

Pharmacy Name: _____ Address: _____ Phone #: _____

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Informed Consent

Please read each item and sign below acknowledging that you have read and understand.

I have chosen to receive psychiatric/therapeutic services from Gulf Coast Behavioral Health. My choice has been voluntary, and I understand that I may terminate treatment at any time.

I understand that there is no assurance that I will feel better, because medication management and therapy is a cooperative effort between the provider and myself. I will work with my Provider and the staff of Gulfcoast Behavioral Health in a cooperative, respectful manner to create solutions in my best interest.

I understand that during my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that all records are confidential and will be held and/or released in accordance with state laws regarding confidentially of such records and information. Psychiatric records are not released directly to patients/guardians. Requests for an exception may be made however, there is no guarantee the request will be approved.

I understand that state and local laws require that my provider report all cases of abuse or neglect of minors or the elderly. I understand that state and local laws require that my provider report all cases in which there exists a danger to myself and/or others. I understand that there may be other circumstances in which the law requires my provider to disclose confidential information.

I understand that my provider may disclose any/all records pertaining to my treatment to insurance companies, insurance representatives, or primary care physicians if such disclosure is necessary for claims processing, case management, coordination of treatment and/or utilization review purposes.

I understand that I can revoke this consent at any time, except to the extent that treatment has already been rendered or that action was taken in reliance on this consent and that if I do not revoke this consent, it will automatically expire one year after all claims for treatment have been paid as provided in the benefits plan.

I acknowledge that I am a resident of the state of Florida. I understand that all Providers at Gulfcoast Behavioral Health are licensed **only** in the state of Florida and cannot treat or prescribe medications outside of the state of Florida, even if I receive telehealth services.

By signing, I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Patient Name Date of Birth

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Office Policies

Hours of Operation:
Our office is open Monday through Thursday from 9:00am until 4:30pm and Friday from 9:00am until 3:00pm. We close for lunch from 11:30am until 1:00pm. Our office is closed on Saturday and Sunday.
_____ (Initial here)

Appointment Check-In:
Please arrive (or check-in if telehealth) 10-minutes prior to your scheduled appointment time. While we strive to be on-time, sometimes unexpected urgent matters arise, so please allow up to 60 minutes for your appointment. If you are unable to keep your scheduled appointment, our office requires a 24-hour notice. In the event you do not provide advanced notice, or you do not check-in for your appointment, you will be billed a fee outlined in Billing Guidelines. Late cancellation and no-show fees must be paid before future appointments can be scheduled.
_____ (Initial here)

Appointment Reminders:
Our office provides appointment reminder cards as well as automated appointment reminders. Automated reminders are sent by email and phone call or text message two (2) days prior to your scheduled appointment. You can also view upcoming appointments in your patient portal. Our appointment reminders are provided as a courtesy, ultimately it is the patient's responsibility to remember and attend appointments as scheduled.
_____ (Initial here)

Prescription Refills:
It is your responsibility to contact our office for prescription refills. Do not rely on your pharmacy to contact our office. Prescription refill requests are approved during your provider's office hours. Please allow 24-72 hours for our office to respond to your request before calling back. If you are out of medication due to a missed appointment, you will need to pay any outstanding fees and schedule a follow-up appointment. Depending on the Drug Classification, or Drug Schedule, of the requested medication needing refill, you may need to see another provider within our office for a one-time appointment before refills can be issued.
_____ (Initial here)

After-Hours/On-Call Provider:
If you are having a life-threatening medical emergency, please call 9-1-1 or go to the nearest hospital emergency room. For urgent, non-life-threatening emergencies, our After-Hours/On-Call Provider's phone number is: (727) 309-9082. Calls placed to the after-hours provider that are non-emergent in nature will not be returned.
_____ (Initial here)

Release of Records:
All patients (or legal guardians) must provide written consent authorizing the release of any information from our office. Verbal authorizations are not accepted. Record requests may take up to thirty (30) days for processing and pre-payment is required.
_____ (Initial here)

Confidentiality:
In accordance with moral, ethical, and legal guidelines regarding your rights to confidentiality, your personal information is carefully guarded. However, there are some exceptions which must be noted:

- If a patient poses a threat to his/her own safety, or the safety of others, we are required to notify concerned parties and local law enforcement,
- If a patient reports actual, or suspected, abuse of any individual, we are required to notify local law enforcement,
- In patient groups of two or more, including the lobby and check-in/out areas, confidentiality is urged but not guaranteed.

_____ (Initial here)

By signing, I hereby acknowledge that I have read, understand, and acknowledge all the above. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Patient Name Date of Birth

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Billing Guidelines and Financial Responsibilities

Administrative Fees:
The fees for items listed below, which are not covered by insurance, are the patient's responsibility. Fees for these items must be paid at the time services are rendered and prior to the next scheduled appointment:

- Medical records – $1.00 per page fee (first 25 pages/ $0.25 for each additional page)
- Returned checks (for insufficient funds)
  - $25 for checks of $49.99 or less
  - $35 for checks greater than $50 but less than $299.99
  - $45 minimum or 3% of the face value for checks over $300.

_____ (Initial here)

Appointment Cancellations/No-shows:
All no-show appointments are automatically assessed a fee outlined below per calendar year.

- Missed Evaluation Appointment: $75.00
- 1st Missed/Late Cancelled Follow-up Appointment: $40.00
- 2nd Missed/Late Cancelled Follow-up Appointment: $50.00
- 3rd Missed/Late Cancelled Follow-up Appointment: $75.00
- 4th Missed/Late Cancelled Follow-up Appointment: Automatic Discharge due to non-compliance

In the event of a true emergency, documentation will be required to request an exception to the fees.

_____ (Initial here)

Discharge from Practice:
The reasons outlined below are common reasons for termination from our practice. This list is not comprehensive, and the treating clinician has final authority on terminating treatment.

- Continuously cancelling or no call/no showing for scheduled appointments more than 3 times.
- Not following the mutually agreed upon treatment plan.
- Continuously requesting controlled medications too early or obtaining prescriptions for controlled medications from other providers.
- If the patient is not seen within one year, unless otherwise instructed by your provider (voluntarily terminated)

_____ (Initial here)

Divorce/Child Custody:
Gulfcoast Behavioral Health will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since GCBH is not a party to these Arrangements, we are not obligated to the financial terms of these Arrangements.

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at GCBH is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then GCBH will still collect the applicable co-pays, coinsurance, and deductibles at the time of service from the Presenting Parent. Upon request, GCBH will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

_____ (Initial here)

Electronic Signatures:
If you are unable to come to the office to sign documents or do not have the capability to print/sign/return, you can request that the form be sent to you electronically. The first e-signature envelope is free. Subsequent envelopes will incur a fee of $1.50 per envelope. To use this feature, you must have an active patient portal (the patient portal is free).

_____ (Initial here)

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Billing Guidelines and Financial Responsibilities

Insurance Billing:
Our office accepts most insurance plans. It is the patient's responsibility to notify us with any insurance changes. As a courtesy, our office will bill your insurance carrier on your behalf. Per our contractual agreements with insurance companies, we must collect any insurance deductibles, co-insurances, and/or co-pay at check-in. This ensures the financial obligation is met at the time of service. Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. However, each patient has the right to contact their insurance to inquire about their plan coverage and cost. **We do NOT accept Medicaid or Medicaid Managed Care plans. Should your insurance company not cover the service, the balance may become the patient's responsibility. Any balance due from the patient that is not paid within ninety (90) days will be referred to an outside collection agency. The patient is responsible for reasonable attorney fees or collection agency fees equal to 35%-50% of the total outstanding balance.**

_____ (Initial here)

Letters/Forms Preparations:
In the event you need for your clinician to write a letter or complete forms for disability, your employer, the Dept of Motor Vehicles, FMLA, etc. The fees outlined below are based on time and/or complexity of the paperwork. These letters/forms are done outside of appointments. A signed release of information and pre-payment will be required prior to the completion of the request. The turnaround timeframe for these requests are 7-10 business days.

- Letters $25.00
- Forms (1 page) $50.00
- Forms (2 pages) $75.00
- Forms (3-4 pages) $100.00
- Forms (5+ pages) $150.00

_____ (Initial here)

Telehealth Appointments:
If you are unable to come into the office for an appointment, telehealth is available to established patients only, whose insurance covers telehealth appointments or are self-paying. **Telehealth appointments must be done through real-time audio-visual communication only; telephone calls are not appointments**. It is the responsibility of the patient (or legal guardian) to check-in for the scheduled telehealth appointment. Federal laws that protect privacy and confidentiality also apply to telehealth appointments, therefore, you will need to be in a confidential area where there are no outside distractions. If you are not in a confidential area, your provider may cancel the appointment and the appropriate late cancellation fee will be applied. Examples of non-confidential areas include driving a car/riding public transportation, at the hair/nail salon, at the beach, at a restaurant, at a grocery/convenient/department store, etc.
_____ (Initial here)

By signing this form, I authorize A&M Psychiatric Services d/b/a Gulfcoast Behavioral Health to release all necessary information to insurance companies to process claims or obtain authorizations for treatment. I authorize payments be made to A&M Psychiatric Services from insurance companies, government agencies, or any other agency providing benefits for services rendered. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Patient Name Date of Birth

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Privacy Policy

This explains HIPAA laws and when and how our office can release information about you or your child.

Protected health information includes descriptive information that can be used to identify a person and that relates to the treatment for a mental health condition. The protected health information includes information from the past, present, or future. The right to privacy continues after death.

Gulfcoast Behavioral Health doesn't release health information about people who receive services from our office. This means our office cannot release:

- Information that will tell people who you or your child are or where you and your child live
- Information about you or your child's mental health or condition
- Information about any of the services you or your child are receiving
- Information about how you or your child's services are paid for

If you choose to sign a consent form for a particular person or facility; our office can release the requested information to only that person or facility.

I understand that all records are confidential and will be held and/or released in accordance with state laws regarding confidentially of such records and information. However, psychiatric records are not typically released directly to parents or patients without prior clinician approval to be made at the clinician's discretion.

There are some special circumstances when our office is required to release information about you or your child, even if you haven't given us permission to do so.

For example:

- If you or your child are sick or hurt
- If you are not safe to take care of yourself or your child
- If you or your child try to hurt someone, or someone is trying to hurt you/them
- If you or your child tell us about child abuse
- Under a court order

This policy also pertains to and is enforced for telehealth including but not limited to any virtual/video and telephonic communications.

By signing this form, you are stating that you have read and understand the terms stated within. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Patient Name Date of Birth

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Controlled Substance Consent

The administration of **ANY** controlled substance is strictly decided by the provider. If in the instance a controlled medication is prescribed, the following guidelines must be understood and followed by all patients.

The risks of taking a controlled substance include, but are not limited to, drug dependency, addiction, respiratory problems, depression, liver and/or kidney damage, death, etc.

Patients agree to take medications only as prescribed **and** agree to notify the provider if the patient does not comply. By agreeing to take the medications as directed, patient is agreeing to random urine drug screens and/or blood tests to assess compliance.

Patient understands that random urine drug screens may be performed at any given office visit to monitor prescribed medication. Patient must understand that the insurance company may not cover a drug screen and that they will be responsible for the full amount that is not covered at the time of the office visit.

Patients understand that the test results and interpretation will become part of the medical record. Patient's insurance company may discover the results of this test by obtaining a copy of patient's medical records.

Lost, stolen, or misplaced prescriptions will **NOT BE REPLACED**. If a patient needs a refill on a controlled substance, they **MUST** schedule an office visit. The provider will **NOT** refill controlled substance prescriptions over the phone or without seeing the patient in the office or by telehealth. Controlled substance prescriptions **CANNOT** be sent out of the state of Florida.

Patients agree that if they deviate from the above guidelines that the provider owns the right to taper off or discontinue the prescription. Failure to comply with the guidelines also could result in immediate termination from this practice.

By signing this, I express understanding and agree to comply with these guidelines. I agree that a copy and/or electronic signature below may substitute as the original and is the legal equivalent of my manual/handwritten/original signature.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Patient Name Date of Birth

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Credit Card Authorization

Please fill out the details as indicated below to place your credit card on file.

Patient Name: _____ Date of Birth: _____

Card Holders Name: _____
(Exactly as it appears on card)

Billing Address: _____

City, State, Zip _____

Card No: _____

Card Expiration Date: _____

CVV (Security Code): _____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ Am Ex ☐ HSA/FSA

Email address: _____

Terms of Authorization

I authorize A&M Psychiatric Services PA d/b/a Gulf Coast Behavioral Health to charge the above card for any outstanding balances. This includes co-pays, deductibles, and balances left after insurance processing (Explanation of Benefits).

I understand this card information will be kept in a securely encrypted format, and an automated transaction receipt will be transmitted electronically to me on the date any charge is processed to the email address I've provided above.

Prior to initiating a dispute or chargeback with my financial institution, I agree to contact the office directly to resolve any billing inquiries by email at billing@gulfcoastbh.com or by phone at (727) 726-7442. I understand any unjustified chargebacks may result in the assessment of additional administrative and retrieval fees.

I understand this authorization will remain valid until the card expires or I revoke it in writing by email to billing@gulfcoastbh.com or by mail to Gulf Coast Behavioral Health, Attn: Billing Department, 1938 Soule Rd, Clearwater, FL 33759.

By signing, I hereby acknowledge that I have read, understand, and acknowledge all the above. I agree that a copy of my signature, including an electronic or typed signature, has the same legal effect as my original handwritten signature.

_____ _____
Cardholder Signature Date

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Authorization for Release/Exchange of Information

Patient Name: _____ Date of Birth: _____

To ensure effective communication and continuity for myself/my child, I authorize the sharing of relevant treatment information between:

Gulf Coast Behavioral Health	Phone Number:	(727) 726-7442
1938 Soule Rd	Fax Number:	(727) 288-1111
Clearwater, FL 33759	Email Address:	info@gulfcoastbh.com

and the Individual, Physician/Treatment Provider, Office, or Hospital identified below:

Name/Organization: _____ Phone Number: _____

Specific information to be disclosed:
Check all appropriate boxes below:

☐ Office Notes ☐ Laboratory/Diagnostic Results ☐ Admission/Discharge Summary

☐ Complete Record ☐ Forms/Letter ☐ Other (please describe): _____

I understand that information disclosed under this authorization will be protected in accordance with applicable local, state, and federal privacy laws, including HIPAA. This authorization may include the release of confidential information related to mental health, substance use treatment, and HIV/AIDS records as permitted by law, including 42 CFR Part 2 and F.S. §382.010.

I understand that information released under this authorization may not be re-disclosed without my additional written consent unless otherwise permitted by law. Gulf Coast Behavioral Health cannot guarantee against unauthorized re-disclosure by the recipient.

I release Gulf Coast Behavioral Health, its employees, agents, and representatives from liability for the good-faith disclosure of information authorized herein.

I understand that I may revoke this authorization at any time by submitting a written request. Any revocation will not apply to information that has already been disclosed in reliance on this authorization. For minor patients, this authorization will terminate when the patient reaches the age of majority, unless otherwise authorized by law, whichever comes first.

By signing below, I acknowledge that I have read and understand this authorization and voluntarily consent to the release and exchange of the information described herein for treatment, care coordination, and continuity of care. I understand that a photocopy, facsimile, scanned copy, or electronic signature shall be as valid as the original and have the same legal effect. If the patient is a minor, I certify that I am the parent or legal guardian and have the legal authority to authorize the release and exchange of the minor's protected health information as described in this authorization. By signing below, I consent to the disclosure of such information on the minor's behalf.

_____ _____
Patient/Legal Guardian Signature Date

_____
Relationship to Patient

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Authorization for Release/Exchange of Information

Patient Name: _____ Date of Birth: _____

To ensure effective communication and continuity for myself/my child, I authorize the sharing of relevant treatment information between:

Gulf Coast Behavioral Health	Phone Number:	(727) 726-7442
1938 Soule Rd	Fax Number:	(727) 288-1111
Clearwater, FL 33759	Email Address:	info@gulfcoastbh.com

and the Individual, Physician/Treatment Provider, Office, or Hospital identified below:

Name/Organization: _____ Phone Number: _____

Specific information to be disclosed:
Check all appropriate boxes below:

☐ Office Notes ☐ Laboratory/Diagnostic Results ☐ Admission/Discharge Summary

☐ Complete Record ☐ Forms/Letter ☐ Other (please describe): _____

I understand that information disclosed under this authorization will be protected in accordance with applicable local, state, and federal privacy laws, including HIPAA. This authorization may include the release of confidential information related to mental health, substance use treatment, and HIV/AIDS records as permitted by law, including 42 CFR Part 2 and F.S. §382.010.

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I release Gulf Coast Behavioral Health, its employees, agents, and representatives from liability for the good-faith disclosure of information authorized herein.

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_____ _____
Patient/Legal Guardian Signature Date

_____
Relationship to Patient