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

CLIENT DATA

Name: _____ Date of birth: _____ Email: _____

Address: _____

City: _____ St: _____ Zip:_____ Phone #:_____

Sex: _____ Marital Status: _____ Soc Sec #: _____

Spouse/Partner: _____ Phone #: _____

ER Contact Name: _____ ER Contact Phone: _____

Primary Care Physician: _____ PCP Phone: _____ PCP Fax: _____

Pharmacy Name _____ Pharmacy Phone: _____

Physicians that client is currently receiving medical/psychiatric care from:

Physician Name:	Phone Number / Fax Number:	Reason:

Medication Allergies: _____

Briefly describe the reason(s) for seeking assistance: _____

_____

List current support systems (friends, family, clubs): _____

List interest and/or hobbies: _____

Health History: (Please check all that apply)

_____ Past Psychiatric/Psychological treatment

_____ Past drug and or alcohol treatment/use

_____ Past change in sleeping/eating patterns

_____ Past legal problems

_____ Past trauma/abuse

_____ Past medical problems

_____ Past suicidal thoughts/attempts

_____ Present Psychiatric Treatment

_____ Present drug/alcohol treatment/use

_____ Present change in sleeping/eating patterns

_____ Present legal problems

_____ Present trauma abuse

_____ Present medical problems

Please explain any items checked above: _____

_____

_____

Medications that client is currently taking (prescribed or over the counter):

Medication	Dosage	Frequency	How long	Prescribing Physician

PARENT/GUARDIAN DATA (For clients under 18 please complete, if over 18 sign bottom and continue to next page)

Custodial Parent(s) or Guardian: _____ Email : _____

Address: _____

City: _____ _____ St: _____ Zip:_____ Phone #:_____

Father: _____ DOB: _____ Living Deceased

Address: _____

City: _____ _____ St: _____ Zip:_____ Phone #:_____

Soc Sec #: _____ Marital Status: _____ Employer: _____

Briefly describe relationship between child/adolescent and father: _____

_____

Mother: _____ DOB: _____ Living Deceased

Address: _____

City: _____ _____ St: _____ Zip:_____ Phone #:_____

Soc Sec #: _____ Marital Status: _____ Employer: _____

Briefly describe relationship between child/adolescent and Mother: _____

_____

If the child/adolescent was not raised by both biological parents, please explain (include step-parents, foster or adoptive history:

_____

_____

_____

SCHOOL DATA

Name of School: _____

Type of Program: _____ Grade: _____ Academics : Poor Average Above average

Indicate behavioral problems in school, include consequences: _____

_____

_____

By signing below, I hereby acknowledge that I have read and received a copy of GCBH Client Contract, Informed Consent, Notice of Privacy Practice and Client Rights.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Office Staff Signature

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PARENTAL INFORMED CONSENT

Please read each item and sign below acknowledging that you have read and understand the parental informed consent.

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

I understand that there is no assurance that my child will feel better, because medication management and therapy is a cooperative effort between the provider, myself, and my child. I will work with my child's provider in a cooperative manner to resolve the difficulties.

I understand that during the course of my child's treatment, material may be discussed which will be upsetting in nature and that this maybe necessary to help my child resolve his/her 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. However, psychiatric records are not typically released directly to parents or patients without prior clinician approval to be made at the clinician's discretion.

I understand that state and local laws require that my child's provider report all cases of abuse or neglect of minors or the elderly.

I understand that state and local laws require that my child's provider report all cases in which there exists a danger to self and/or others. I understand that there may be other circumstances in which the law requires my child's provider to disclose confidential information.

I understand that my child's provider may disclose any/all records pertaining to my child's treatment to insurance companies, insurance representatives, primary care physicians, or pediatricians 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 expire automatically one year after all claims for treatment have been paid as provided in the benefits plan or once my child turns 18 years of age, whichever is sooner.

I have read and understand the basic rights of individuals (outlined below) who undergo treatment.

These rights include:

1. The right to be informed of the various steps involved in receiving services.
2. The right to confidentially under federal and state laws in relation to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make informed decisions whether to accept or refuse treatment.
5. The right to contact and consult with counsel and select practitioners of my choice and at my own expense

_____ _____

Parent/Guardian Signature Date

_____ _____

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CLIENT CONTRACT

Please read and sign below acknowledging that you have read, understand, and agree to the terms in this contract.

OFFICE HOURS: Our phones are answered Monday – Thursday 9:00am - 5:00pm, Friday 9:00am - 3:00pm. We are closed daily from 12:00pm - 1:00pm. Our office is closed Saturday & Sunday**.**

APPOINTMENTS: If you are unable to keep your scheduled appointment we require a 24-hour notice. In the event you do not give a 24-hour notice you will be billed a fee. **All fees must be paid before future appointments can be scheduled**. See schedule of fees on page 2.

EMERGENCY CONTACT NUMBERS: The emergency phone numbers provided on the office voicemail are for after-hours emergencies only. These numbers should not be used during business hours or for appointment requests or prescription refill request. **Clients who choose to contact a provider after hours for a non-emergency will be billed for a phone consultation. Phone consultations are not paid by insurance companies.**

PRESCRIPTION REFILLS: Prescription refill request are approved during office hours only. All refill requests must come directly from your pharmacy via fax or phone or from yourself and require 3 business days for processing. If you are out of medication due to a missed appointment you will need to pay your missed appointment fee and schedule an appointment in order to receive a refill. All medication samples and prescriptions must be picked up during office hours by the client or their legal guardian.

INSURANCE & CLIENT RESPONSIBILITY: It is the client's responsibility to notify us with any insurance changes and to obtain any required authorizations. Our office will submit claims to the insurance company we have on file. Per our contractual agreement with insurance companies we must collect all co-payments, co-insurances and deductibles due from the client. Payments are due at the time of service unless other arrangements have been made in advance. **Should the insurance company not cover the service, the balance may become payable by you. Any balance due from the client that is not paid within 90 days will be referred to a collection agency. The client is responsible for reasonable attorney fees or collection agency fees equal to 35% to 50% of the total outstanding balance.**

RELEASE OF RECORDS: All clients or their parent/legal guardian must sign a release authorizing the release of any information. No information will be released without a properly executed consent. Record requests may take up to 30 days to process and pre-payment is required.

FEES NOT COVERED BY INSURANCE: Fees for the items listed below are not covered by insurance companies and are the clients's responsibility. Fees for these items must be paid at the time the service is rendered and prior to the next scheduled appointment.

- Fees for medical records sent to attorneys or other agencies
- Fees for no shows or cancellations less than 24 hours before the appointment
- Fees for returned checks
- Fees for disability forms, FMLA forms, or letter preparation

REASONS FOR TERMINATION: The reasons outlined below are common reasons for termination from our office. This list is not comprehensive and the treating provider has final authority on terminating treatment.

- Continuously canceling or not showing for scheduled appointments
- Not following the recommended treatment plan
- **If the client is not seen within 6 months, unless otherwise instructed by your provider, your file will be closed (voluntarily terminated) and no prescriptions will be authorized for refills until you are seen.**

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

- If a client poses a threat to his or her own safety or the safety of others, we are required to notify concerned parties and the authorities.
- If a client reports actual or suspected abuse of any individual, our office must notify the proper authorities.
- In client groups of two or more, including the lobby and check-out, confidentiality is urged but not guaranteed.

AUTHORIZATION & SIGNATURE ON FILE: By signing this form, I authorize Gulf Coast Behavioal Health to release all necessary information to insurance companies to process claims or obtain authorization 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 authorize that a copy of the signature below may substitute as the original.

I have read, understood and agree to follow all terms and conditions of this contract.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Office Staff Signature

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FEE SCHEDULE:

The fees outlined below are effective February 1st, 2021 and may be changed at any time.

This is not a comprehensive list of all fees in this office; please inquire about current fees prior to authorizing any service that is not covered by your insurance company. **Please initial EACH item**.

_____ ❖ $25 Return Check fee for checks of $49.99 or less

_____ ❖ $35 Return Check fee for checks greater than $50 but less than $299.99.

_____ ❖ $45 minimum or 3% of the face value Return Check fee for checks over $300.

_____ ❖ $40 No show or late cancellation fee

_____ ❖ $75 No show or late cancellation fee for initial evaluations

_____ ❖ $25 Letter preparation fee

_____ ❖ $1 per page fee (first 25 pages / $0.25 for each additional page) for Records (waived if sent directly to another provider, hospital, or insurance company)

_____ ❖ $50 - $100 Disability and/or FMLA Form preparation (1-2 pages) - subject to provider discretion based on time and/or complexity of paperwork.

_____ ❖ $75 - $125 Disability and/or FMLA Form preparation (3+ pages) - subject to provider discretion based on time and/or complexity of paperwork.

_____ ❖ $20 per five minutes phone consultation fee, billed in 5-minute increments.

_____ ❖ $10 per Notary Stamp

_____ ❖ Self-pay appointment fees vary depending on Provider and/or service and range from $75 - $250. Self-pay arrangements can be made upon request, if needed.

By signing this form, you are stating that you have read, understand, and agree to the above fees.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Office Staff Signature

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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.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Office Staff Signature

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Telehealth Consent Form

Patient Name: _____ DOB: _____

I understand that telehealth is the use of electronic technology for communication for the purpose of providing healthcare services.

I understand that Gulfcoast Behavioral Health is based in Florida and likewise uses telehealth to conduct a consultation with their patients.

I understand that with the use of telehealth, the interaction shall be done through real-time audio-video communication. Our office utilizes Doxy for all telehealth appointments.

I understand that the laws that protect privacy and confidentiality, as well as the confidentiality of medical information through the Health Insurance Portability and Accountability Act (HIPAA) also apply to telehealth.

I understand that I am responsible for any payments (deductibles, co-payments, co-insurances, self-pay rates) that apply to my telehealth appointment. It is the responsibility of the policy holder to verify telehealth is a covered benefit on his/her insurance policy. Should the insurance company not cover the service, I understand the balance will be my responsibility.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment; I have the right to privacy where it shall be necessary to seek my consent to disclose my information unless those that are permitted by law to disclose without the need of my consent.

By signing this form, I have read and understand the information provided above, my rights, and obligations regarding telehealth. I have had the opportunity to ask questions and all of which were answered to my satisfaction. Therefore, I hereby give my consent to the use of telehealth for psychiatric care.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Office Staff Signature

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AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Name: _____

DOB: _____ SS#: _____

Phone: _____ Client Acct #: _____

I hereby give permission to Gulfcoast Behavioral Health to:

Release Information to: Yes ☑ No ☐

Receive Information from: Yes ☑ No ☐

Agency or Person: _____

Address: _____ City: _____ St: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

The specific information to be disclosed: Written ☐ Verbal ☐ or Electronic ☐

- ☐ Psychiatric Evaluation
- ☐ Medication Profile
- ☐ Treatment Plan
- ☐ Progress Notes
- ☐ Psychotherapy Notes
- ☐ Labs/Test Results
- ☐ Family History
- ☐ Treatment Summary
- ☐ Billing/Payments
- ☐ Appointments
- ☐ Other (Specify):_____

For the purpose: _____

I understand that I have the right to refuse to sign this authorization.

I further understand that I am agreeing to share confidential information that is protected by state and federal laws governing confidentiality of alcohol and drug abuse, mental health, and HIV client records (42 CFR Part2; FS 394; FS 381). Although anyone who receives my records from this organization is not permitted to release them to anyone else without additional written consent, I understand that Gulfcoast Behavioral Health cannot guarantee that subsequent re-disclosure will not occur. I hereby release Gulfcoast Behavioral Health from any liability which may arise as a result of the use of the information contained in copies of records released, as a result of this authorization, if such information is later used to my detriment.

This authorization is for a single ☐ or continuing ☑ disclosure, valid for two (2) years after the date of my signature as it appears below, or from _____, 20_____ to _____, 20_____.

This authorization may be revoked at any time upon written notification by the signatory or client, but revocation has no effect on action previously taken. I have been offered a copy of this authorization.

_____ _____
Client Signature **Date**

_____ _____
Legal Representative / Parent Signature **Date**

_____ _____
Office Staff Signature **Date**

Administrative Instructions

___ File Only

___ Send Records to Agency or Person

___ Request Records from Agency or Person

___ Send (form, letter, etc) Now

___ Other: _____

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CREDIT CARD AUTHORIZATION FORM

Patient Name:_____DOB: _____

Phone:_____Client Acct #: _____

○ VISA ○ ○ DISCOVER ○ AMERICAN EXPRESS

Credit Card Number _____

Expiration Date: _____

CVV Code: _____

Cardholder Name: _____

Billing Address: _____

_____ _____ _____
City State Zip Code

Phone Number: (_____)_____- _____

I,_____(Cardholder), authorize Gulfcoast Behavioral Health to charge my credit card for balances of charges for services rendered that were not paid by or covered by insurance within 90 days, as well as any balance resulting from missing appointments and/or late cancellations.

This agreement shall remain in effect until the Office is notified in writing by the Cardholder to cease all charges.

_____ _____
Cardholder Signature Date

_____
Witness