First Coast Psychiatric Services
1543 Kingsley Avenue, Suite 14
Orange Park, FL 32073
(904) 264-6977

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees
    i) This office participates in random urine drug screenings. In the event that the insurance carrier does not cover the cost of the urine drug screening, the patient will be responsible for payment.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I, the undersigned, acknowledge that First Coast Psychiatric Services and its providers will use and disclose my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to First Coast Psychiatric Services or benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized person to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and he Public health Department and appropriate counseling will be offered.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to First Coast Psychiatric Services.

I acknowledge that I have been given the First Coast Psychiatric Services Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initial: _____**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

I give permission for my protected health information to be disclosed for purposes of communicating results, finding and care decisions to the family members and others listed below:

Name: _____

Name: _____

_____ _____

Patient (or Responsible Party) Signature **Date**

First Coast Psychiatric Services
1543 Kingsley Avenue, Suite 14
Orange Park, FL 32073
(904) 264-6977

Patient Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: _____ DOB: _____ SSN: _____
(Last, First, MI)

Home Address: _____
(Street)

_____
(City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

E-mail address: _____

Are you a smoker?
☐ Current every day smoker ☐ Never Smoker ☐ Former Smoker ☐ Light Smoker
How many years of tobacco use? _____

Are you currently on any prescription medication? ☐ Yes ☐ No
Please list:

_____

Do you have any current medical conditions? ☐ Yes ☐ No
If yes, please list:

_____

Have you had any surgeries in the past? ☐ Yes ☐ No
If yes, please provide details:

_____

Preferred Pharmacy: _____
Address and Phone Number:

_____

Do you have any allergies? ☐ Yes ☐ No
If yes, please list: _____

Past Psychiatric History:

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No
Please list:

_____

Have you ever been hospitalized to a psychiatric facility? ☐ Yes ☐ No
If yes, please state the reason, where, and when.

_____

Have you ever attempted suicide? ☐ Yes ☐ No
If yes, please explain:

_____

Have you been seen by an outpatient Psychiatrist, Counselor, or Nurse Practitioner? ☐ Yes ☐ No
Please list the names and telephone numbers:

_____

Have you ever been involved with any type of illicit drug use (cocaine, marijuana, etc.)? ☐ Yes ☐ No
Please list:

_____

Have you ever attended any type of rehabilitation program? ☐ Yes ☐ No
When, where, and how long?:

_____

Is there history of ADHD, mental illness, alcohol or drug abuse in your parents, grandparents, or siblings?
☐ Yes ☐ No
If yes, please fill out the following chart:

Affected Family Member	Type of Mental Illness or SA

Have you ever been diagnosed with any of the following disorders?

☐ ADD/ADHD	☐ GI Problems	☐ AIDS/HIV	☐ Headaches
☐ Amnesia	☐ Heart Problems	☐ Anxiety Disorder	☐ Hospitalized
☐ Asthma	☐ Learning Disorder	☐ Cancer	☐ Depression
☐ Liver Disease	☐ Brain Injury	☐ COPD	☐ Seizures/Epilepsy
☐ Psychiatric/Mental Health Condition	☐ Auditory Hallucinations	☐ Developmental/ Behavioral disorder	☐ Stroke
☐ Diabetes	☐ Thyroid Disease	☐ Eating Disorder	☐ Tourette Syndrome
☐ Fibromyalgia	☐ Vision/Eye Problems	☐ GERD/Reflux	☐ Visual Hallucinations

Please check the current symptoms you are experiencing:

☐ Depressed mood	☐ Racing thoughts	☐ Excessive worry
☐Unable to enjoy activities	☐ Impulsivity	☐ Anxiety attacks
☐ Sleep pattern disturbance	☐ Increase risky behavior	☐ Avoidance
☐ Loss of interest	☐ Hallucinations	☐Concentration/forgetfulness
☐ Decrease need for sleep	☐ Suspiciousness	☐ Change in appetite
☐ Excessive energy	☐ Excessive guilt	☐Increased irritability
☐ Fatigue	☐ Crying spells	☐ other: _____

Patient Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	❍	❍
...you were so irritable that you shouted at people or started fights or arguments?	❍	❍
...you felt much more self-confident than usual?	❍	❍
...you got much less sleep than usual and found you didn't really miss it?	❍	❍
...you were much more talkative or spoke much faster than usual?	❍	❍
...thoughts raced through your head or you couldn't slow your mind down?	❍	❍
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❍	❍
...you had much more energy than usual?	❍	❍
...you were much more active or did many more things than usual?	❍	❍
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❍	❍
...you were much more interested in sex than usual?	❍	❍
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❍	❍
...spending money got you or your family into trouble?	❍	❍
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	❍	❍
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	❍	❍
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	❍	❍

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

First Coast Psychiatric Services
1543 Kingsley Avenue, Suite 14
Orange Park, FL 32073
(904) 264-6977

First Coast Psychiatric Services Policies

1. All co-pays, deductibles, and co-insurance are due at the time of service. If you have an outstanding balance, you will be required to pay it in full prior to being treated in the office
2. Cancellations and no-shows with less than 24 hours' notice are subject to the charge of $50 for this service. (Subject to change according to each appointment)
3. In the event I receive direct payment from my insurance provider, I agree to endorse payment to First Coast Psychiatric Services.
4. I understand that I am financially responsible for all charges regardless of insurance coverage.
5. A charge will be assessed for preparation of all FORMS and LETTERS, ATTORNEY FEES, or COLLECTION AGENCY FEES applied to your account balance.
6. I agree to provide First Coast Psychiatric Services with a release of information to access previous medical, psychiatric, and psychological records so that he/she can make informed decisions regarding my care.
7. I understand that at our first visit with First Coast Psychiatric Services is acting as a consulting physician and reserves the right to direct me to more appropriate treatment if he/she feels that he is unable to provide me with the care I require.
8. I agree to participate in the information of the treatment plan and to the best of my abilities follow the treatment plan. I will consult First Coast Psychiatric Services for making any changes in the treatment plan. I will obtain requested labs and studies in a timely fashion as they are meant for my safety.
9. I will treat First Coast Psychiatric Services, the office staff, and other patients with respect. I will refrain from yelling or using obscene language while at First Coast Psychiatric Services.
10. Normal business hours are from 9:00 a.m. to 5:00 p.m. The office will be available during these hours to return phone calls. In non-emergent cases, First Coast Psychiatric Services will make their best effort to return your phone call within one (1) business day.
11. If you believe you have a life-threatening emergency it is imperative that you access emergency care in a timely fashion. Please call 911 and initiate access to emergency treatment.

I have read and agree to abide by First Coast Psychiatric Services' office policies.

Patient Signature: _____ Date: _____

Printed Name: _____

First Coast Psychiatric Services
1543 Kingsley Avenue, Suite 14
Orange Park, FL 32073
(904) 264-6977

Patient Rights

1. I have the right
    A. To receive medical care with respect for cultural and ethnic identity, religion, gender, age, marital status, disability, source of payment and sexual preference.
    B. To have my treatment and personal information kept private.
    C. My records may not be released without member permission, unless required by law.
    D. To a physical environment that is safe, sanitary, and conducive to effective treatment, which appropriately safeguards the privacy and confidentiality of doctor/patient program.
    E. To easy access to care in a timely fashion, treatment choices with regard to cost or coverage by my insurance plan.
    F. To participate in the development of my Plan of Care with regards to my needs.
    G. To receive information in a language I can understand.
    H. To clear explanations of my conditions and treatment options.
    I. To information pertaining to my insurance and their role in the treatment process.
    J. To information regarding clinical guidelines used to providing and managing my care.
    K. To obtain my doctors medical training and work history.
    L. To knowledge about advocacy and community groups and prevention service.
    M. To resources available for communicating to make concerns/questions and/or resolving disputes, conflicts, or grievances.
    N. To knowledge about the laws that relate to my rights and responsibilities in the treatment process.

I have read and understand my patient rights.

Patient Signature: _____ Date: _____

Printed Name: _____

First Coast Psychiatric Services
1543 Kingsley Avenue, Suite 14
Orange Park, FL 32073
(904) 264-6977

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Patient Signature: _____ Date: _____

First Coast Psychiatric Services
1543 Kingsley Avenue, Suite 14
Orange Park, FL 32073
(904) 264-6977

Patient Financial Responsibility Statement

Patient Name: _____ DOB: _____

Thank you for choosing First Coast Psychiatric Services as your healthcare clinic. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

The patient is ultimately responsible for the payment for his/her treatment and care. We are pleased to assign you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, credit cards, and checks at our office.

Patient signature: _____ Date: _____

Payment Policy: The co-payments if required are expected at the time of service. Thank you for your cooperation in this matter.

In case of nonpayment of bill for three months, we will report your account to a collection agency and you will be responsible for the balance as well as the collection agency charges.

Patient Signature: _____ Date: _____

Self-Pay: As I do not have a health insurance and will be responsible for the full and entire amount of treatment given to me.

Patient Signature: _____ Date: _____

Cancellation / NO Show Policy: If there is no show or the psychiatric appointments that are cancelled less than 24 hours in advance will be charged $50.00. Please call during business hours to change any appointments.

Patient Signature: _____ Date: _____