Family Psychiatry Services
Adly Thebaud, MD, PA

Axis I Behavioral Center
Adly Thebaud, MD, PA

PATIENT INFORMATION FORM

NAME: _____Age: _____

IF CHILD, GUARDIAN'S NAME: _____

DATE OF BIRTH: _____ SSN: _____ Sex: _____

MARITAL STATUS: _____ PRIMARY CARE PHYS: _____

DRIVER'S LICENSE #_____ STATE_____

ADDRESS: _____

_____
City State Zip Code

PHONE: _____
Home Phone Cell Phone Other

EMAIL: _____

EMPLOYER: _____ PHONE: _____

REFERRED BY: _____

EMERGENCY CONTACT: _____
Relationship to Patient

Phone#_____

FPS SANFORD: 1403 Medical Plaza Drive, Ste 202, Sanford, Florida 32771 | Phone: (407) 322-3096 | Fax: (407) 321-5655
FPS ORANGE CITY: 2725 Rebecca Lane, Ste 107, Orange City, Florida 32763 | Phone: (386) 775-0736 | Fax: (386) 775-0738
AXIS I Behavioral Center: 2725 Rebecca Lane, Ste 103, Orange City, Florida 32763 | Phone: (386) 775-5299 | Fax: (386) 218-0037

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WELCOME

Thank you for choosing Family Psychiatry Services or Axis I Behavioral Center. Our practices are committed to take care of our patients' needs as much as possible. Our providers have reserved time especially for you to address your needs. Please take the time to review and sign the new patient paper work.

Wait Time

The length and frequency of the therapy sessions depend on many factors. New patient appointment time is typically 45 minutes long. We value your presence and we understand that your time is important. For that reason, we ask for you to plan to be in the office for at least **1 ½ to 2 hours**. We also want to express the importance of a patient visit which may result for their time to be extended due to the circumstances. Our commitment to deliver quality care may, at times, include going beyond the scheduled appointment time with a particular patient, as well as being available for emergencies. If you are unable to wait for your appointment, our front desk staff will be happy to reschedule an appointment for a more convenient time. We kindly ask that you extend them the same courtesy that you expect from them.

Appointment Reminder

We truly appreciate your cooperation in confirming your appointment. You will be contacted by an automated service provider via California to remind you of your appointment. Be advised that our courtesy calls are indeed a courtesy. It remains the responsibility of the patient/patient's guardian to remember and maintain their appointments.

Would you prefer a **text message** reminder? **Yes** [ ] **No** [ ]

☐ **Acknowledgement:** I have read and understood the above information regarding appointment reminders and wait time.

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PAYMENT POLICY & CANCELLATION POLICY

Thank you for trusting your medical care to Family Psychiatry Services and AXIS I Behavioral Center. When you schedule an appointment with Family Psychiatry Services and AXIS I Behavioral Center we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Late Cancellation, Cancellation and No Show Policy below:

- For new self-pay patients visit a **$75.00 charge** will be required at the time of scheduling to hold the new patient slot. This is a **non-refundable** charge if a new patient does not come in for their scheduled appointment. When the new patient arrives for their schedule appointment they will then only be responsible to pay the remaining self-pay fee of **$175.00** for a Medical Provider session or **$50.00** for a Therapist session.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- Any established patient who fails to show for an appointment and has not contacted our office with **at least 24 hours' noticed** will be considered as a No Show and charged a **$75.00 cancellation fee**.
- If an established patient calls in the same day of their appointment that will be considered as a late cancellation and will be charged a **$50.00 late cancellation fee**.
- If a **third** No Show or cancellation/reschedule occurs due to not providing our office with a 24 hour notice the patient may be **discharged** from Family Psychiatry Services and AXIS I Behavioral Center.
- You will receive a reminder courtesy call the day before your first appointment to confirm your initial appointment.

Insurance

As the patient, it is your responsibility to know your particular insurance policy and its obligations. This includes your obligations to see a participating physician, know your coverage and its limitations, and be prepared to pay any out-of-pocket expenses at the time of your visit.

Copayment

Health care regulations require us to collect all co-payments, deductibles, balances and non-covered service fees. Failure on our part to collect co-payments and deductibles from patient can be considered as fraud. **All co-payments and deductibles must be paid at the time of service.** By signing this consent, you understand that your payment is for the professional service carried out by your providers (MD, ARNP, LCSW, LMHC, Therapy Counselors). You understand that your payment is non-refundable and does not depend on your acceptance of the treatment plan or not. The fee collected is for your evaluation, treatment plan, and time spent writing your report.

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PAYMENT POLICY & CANCELLATION POLICY - - - Continued

Proof of Insurance
All patients must provide proof of insurance before seeing the doctor. Proof of insurance consists of a copy of your driver's license and a current valid health insurance card. If you fail to provide the correct insurance information in a timely matter, you may be responsible for the full balance of your visit.

Nonpayment
If your account is over 90 days past due, you will be receiving a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Your account will be referred to a collection agency if your balance remains unpaid. Unpaid accounts may result in termination of services from our practice. If this occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. Our practitioners will only be able to treat you on an emergency basis at that time.

Returned check
If your check is returned for any reason you will be charged $25.00.

Acknowledgment
I have read the above, and understand my responsibilities regarding my insurance coverage and payment policy.

Cancellation
You must give at least 24 hours' notice if you need to cancel an appointment in order to avoid a NO SHOW FEE of $75. Cancellation on the day of the appointment is considered a late cancellation with a fee of $50. Note, you can leave a message with the answering service after business hours and on weekends at FPS Sanford (386) 322-3096, FPS Orange City (386) 775-0736 or Axis I (386) 386-775-5299. Continued failure to cancel appointments within 24-hours or frequent rescheduling of appointments may result to termination of services.

☐ **Acknowledgement:** I have read and understand my responsibilities regarding my insurance coverage and the payment and cancellation policy.

Signature _____Date_____

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HIPAA NOTICE OF PRIVACY ACT

We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. This Notice of Privacy Practices describes how we may use and disclose your **protected health information (PHI)** to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.
Please refer to Family Psychiatry Services or Axis I Behavioral Center Notice of Privacy Practices, for a more complete description of such uses and disclosures. Note that you have the right to review the Notice of Privacy Practices prior to signing the consent.

- With my consent, Family Psychiatry Services or Axis I Behavioral Center may use and disclose protected health information (PIH) about me to carry out treatment, payment and healthcare operations.

- With my consent, Family Psychiatry Services or Axis I Behavioral Center may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assists the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, insurance items and any call pertaining to my clinical care including laboratory results among others.

- With my consent, Family Psychiatry Services or Axis I Behavioral Center may mail to my address any item that assist the practice in carrying out treatment, payment and healthcare operations such as welcome letters, appointment reminders cards, and patient statements, as long as they are marked Personal and Confidential.

- With my consent, Family Psychiatry Services or Axis I Behavioral Center can use and disclose my PHI to carry out treatment, payment and healthcare operations.

All other uses and disclosures will be made only with your signed consent or authorization. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization. If I do not sign this consent, Family Psychiatry Services or Axis I Behavioral Center may decline to provide treatment to me.

☐ **Acknowledgement:** I have read and understand the above HIPAA Notice of Privacy.

LIMITS OF CONFIDENTIALITY

The information that you share with your Mental Health Provider is considered to be confidential. In most cases, information cannot be released to another party without your written consent. However, in certain circumstances, information can be shared legally without your permission. These circumstances include:

1. Suicide: If you are assessed to be a danger to yourself; cannot guarantee your physical safety against the intention of suicide; and/or have immediate suicidal plans, this information is not considered to be “confidential”. Actions may be taken to ensure your safety.

2. Homicide: If you are assessed to be a danger to others; cannot guarantee their safety; and have immediate, specific plans to cause fatal injury/harm to another person, this information is not considered to be “confidential”. Actions may be taken to protect the safety of others. The police may be notified of your intentions as well as the intended victim.

3. Court order/subpoena: Your Mental Health Provider(s) can be required to relinquish a copy of your written Mental Health Record to the appropriate Courts. Mental Health Providers can also be subpoenaed to testify in court without your consent.

4. Neglect: If you disclose information about the abuse, neglect or exploitation of a child or aged/disabled adult.

5. Legal defense: If your mental or emotional condition is a legal defense.

6. Legal complaint: If a civil, criminal or disciplinary actions arise from a complaint filed in your behalf against a mental health professional in which case disclosure of release of information shall be limited to that action.

☐ **Acknowledgement:** I have read and understand the above re: Limits of Confidentiality.

☐

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INFORMED CONSENT

1. I have the right to refuse or withdraw from any evaluation procedure, medication management and therapeutic counseling unless otherwise specified by law.

2. I have the right to question any procedure, intervention, rationale or discussion that is unclear or that I do not understand.

3. I understand the concepts and conditions of informed consent, privacy and confidentiality.

4. I understand that I have the opportunity to discuss these concepts and conditions and to ask for clarification of parts that I am concerned about or did not understand.

5. I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the psychiatric/psychological evaluation, medication management and therapeutic counseling process.

6. I understand the process of counseling, psychotherapy, medication management and therapeutic counseling process. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable, and at other times very fulfilling. I understand that there are no guarantees of positive outcomes of this process.

7. I understand that all communications will be private.

8. I understand that this consent may be withdrawn by me at anytime without prejudice and has to be completed in writing.

☐ **Acknowledgement:** I have read and understand the above and provide my consent.

Signature_____Date_____

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Thank you for choosing Family Psychiatry Services or Axis I Behavioral Center. Our practices also work with top research sponsors in conducting many **Clinical Research Trials**. Consider participating in one of our studies.

Why should you **participate in one of our studies?**

- ❖ You could have access to alternative treatment at no cost to you.
- ❖ You could help us make advancements in drug development.
- ❖ You help others by contributing to medical research.

Help us advance the field of medicine!

……

In the event that you are eligible for one or more of our studies, may we use your health information to notify you?

- ○ **YES**
- ○ **NO**

Name: _____Phone number: _____

HAVE A GREAT DAY! ☺

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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 was 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?	❑	❑