# GOAL PSYCHIATRIC ASSOCIATES

## PATIENT REGISTRATION /Please answer all questions if not applied answer N/A

### PATIENT INFORMATION

Date _____

Patient Name_____

Address _____

City _____ State _____ Zip _____

Phone (hm) _____ _____ _____

Phone (cell) _____ _____ _____

**How do you prefer to be contacted**? Phone _____ Text _____

E-mail _____

Birthdate _____ Age _____ Sex ☐M ☐F
SS# _____ Race _____
☐ Single ☐ Married ☐ Minor ☐ Separated
☐ Divorced ☐ Widowed ☐ Partnered for _____ years

Religion _____
Occupation: ☐ Student ☐ Disabled ☐ Unemployed ☐ Retired
☐ Employer _____

☐ School _____ Grade _____

**Are you pursuing any of the following claims?**
☐ Workman's Comp ☐ Legal ☐ Disability ☐ Social Security

Referral Source: _____**How do you hear about us**? Website _____ Magazine _____

Psychotherapist _____ Other _____

**In case of emergency contact**:

Name_____

Relationship _____ Phone _____

### IF PATIENT IS A MINOR

Ages that child: Crawled _____ Walked _____

Talked _____ Potty Trained _____

### CUSTODIAL INFORMATION

Who currently has legal custody of this child? _____
☐ Both Parents ☐ Mother ☐ Father ☐ Other
**Brief Description of Custodial**

**Arrangements:** _____

_____

_____

_____

Due to the complexity of the marital structure and the implicit issues that arise during and following the process of a separation and divorce. If legal documents exist regarding custodial agreements it is required that a copy be on file with this office, and that the identified parent responsible for scheduling and billing update this as required.

I understand that if I am unwilling or unable to follow this agreement, ongoing care will need to be transferred to an alternate treatment provider.

_____ _____
Patient/Guardian Signature Date

### INSURANCE INFORMATION

Who is responsible for this account? _____
Relation to the Patient _____
Insurance Company _____ Employer _____
Policy # _____
Group # _____ Policy Holder's Birthdate _____
SS # _____ Does your insurance company require pre-authorization for mental health benefits?

Is patient covered by additional insurance? ☐ Yes ☐ No

### SELF ASSESSMENT

What is the chief complaint for which you came today? _____

_____

My symptoms include (please check all that apply)
☐ Depression ☐ Anxiety ☐ Insomnia ☐Sadness ☐ Hopelessness ☐ Crying spells ☐ Headaches ☐ Suicidal thoughts ☐ No pleasure
☐ No energy ☐ Drug abuse ☐ Can't sit still ☐ Troubling thoughts ☐ Can't concentrate ☐ Can't work ☐Can't eat ☐ Eating too much
☐ Sleeping too much ☐ Pain ☐ Worrying too much ☐Weight loss ☐ Often confused/forgetful ☐ Hearing voices
☐Alcohol abuse ☐ Feeling paranoid ☐ Feeling out of control ☐ Thought to harm others ☐ Distrustful ☐ Weight gain
Symptoms began: ☐ _____ Weeks ☐ _____Months ☐ _____ Years ago ☐ _____ Lifelong

Are you currently seeing another Psychiatry, Therapist, or Psychologist? ☐ Yes ☐ No Last Visit _____
If yes, please list name and phone No. _____ _____

Primary Care Doctor Name: _____ _____

| PSYCHIATRY HISTORY (Please include dates and explanation) |
|---|
| ☐ **NONE** |
| Inpatient: |
| Outpatient (Therapy or Medication Management) |
| Suicide Attempt(s): ☐ Yes ☐ No<br><br>Drug/Alcohol Rehab: ☐ Yes ☐ No (if yes please explain) |

| PAST PSYCHIATRIC MEDICATIONS |
|---|
| 1.<br>2.<br>3.<br>4. |
| **CURRENT PSYCHIATRIC MEDICATIONS** |
| 1.<br>2.<br>3.<br>4. |

| HOSPITALIZATION OR SURGERY (Please use the back of this page if you need more space) Include date and reason | |
|---|---|
| 1. | 3. |
| 2. | 4. |
| **MEDICATION ALLERGIES**: ☐ Yes ☐ No | |
| **WOMEN:** Pregnant? (Please circle one) Yes No Planning Pregnancy? (Please circle one) Yes No | |

## MEDICAL ASSESSMENT

| | | |
|---|---|---|
| Diabetes | ☐ Yes | ☐ No |
| Hypertension | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Seizures | ☐ Yes | ☐ No |
| Head Trauma | ☐ Yes | ☐ No |
| Migraines | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No |
| Heart Disease | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No |
| Low Blood Pressure | ☐ Yes | ☐ No |
| Weight Loss, unexplained | ☐ Yes | ☐ No |
| Ulcers | ☐ Yes | ☐ No |

Other (explain): _____
_____

**PAIN ASSESSMENT** ☐ **NONE**

☐ Location: _____

Severity: _____/10 Meds: _____

**PSYCHIATRIC FAMILY HISTORY** (Please list medical issues)

Father:

Mother:

Children:

Siblings

## CURRENT SUBSTANCE USE

Alcohol: _____drinks / day

Cigarettes: _____ packs / day

Coffee: _____ cups/ day

Drugs: _____

_____

_____

## TREATMENT CONSENT

I consent and give my permission for evaluation and medically necessary treatment by the professional staff of GOAL PSYCHIATRIC ASSOCIATES, LLC. No guarantee is being made to me about the results of treatment. I can terminate this consent for treatment at any time.

_____ _____
Printed Name of the Patient Date of Birth

_____ _____
Signature of the patient / guardian / guarantor Date

# GOAL PSYCHIATRIC ASSOCIATES

## OFFICE POLICY STATEMENT
### Agreement to its Terms of Treatment

**Thank you** for visiting our office. As a patient of Goal Psychiatric Associates, LLC, you will enjoy medicine the way it should be practiced with the goal of developing a strong doctor-patient and the good health that relationship creates.
We work hard to create a positive and educational environment, and your comments are always welcome! Please also be aware of the following office policies.

## OUR GENERAL POLICIES

**CONFIDENTIALITY:** Issues discussed during the course of evaluation, treatment or therapies are confidential. No information will be released to anyone (including third party payers, physicians, schools, etc.) without written consent from the patient or if a minor, by the legal guardian of the patient. Often, third party payers will request information from the provider of services in order to determine eligibility for reimbursement. Please be sure to ask your insurance carrier about the type and amount of information that they might request before giving your written consent. It is important to understand that the release of confidential information with or without consent is required in situations of potential harm to oneself or others, in instances where the court may subpoena records and in cases of suspected child, adult, older abuse, or neglect. Whenever possible, you will be notified in advance prior to any such disclosure. The laws of the State of Florida require health professionals to report suspected cases of abuse (physical, emotional and/or sexual) and neglect to appropriate agencies.

**ETHICS AND PROFESSIONAL STANDARDS:** The doctor is committed to uphold the most responsible ethical and professional standards possible and is accountable to you. If you have any questions or concerns about your course of treatment please discuss them directly with the physician. By obtaining services here, you are agreeing that should you have any dissatisfaction or concerns about your evaluation or treatment or should you wish to change your medical provider, you will do your best to indicate that you are making a change and why you wish the change to be made. If you need help finding additional or alternative assistance, the doctor will do his best to help you locate a more suitable referral. If, during the course of your care and treatment, you have any questions about the nature of your treatment (i.e. goals, procedures, etc.) or our billing practices please feel free to ask.

**PRACTITIONERS ARE INDEPENDENT CONTRACTORS:** Our practitioners are independent contractors of Goal Psychiatric Associates, LLC. They and they alone are responsible for the care and treatment they render, and all clinical decisions are made by them.

**OFFICE HOURS:** Generally, Monday through Friday, 9: 00am to 6:00 pm except Thursday 9:00am to 5:00pm.

**TELEPHONE CALLS:** The doctor is available (on a call back basis) to patients for a short (5-10 minutes) telephone consult, however, telephone calls should not be used as a substitute for an office visit, Significant telephone calls will be billed by the doctor at the doctor's sole discretion.

**EXTENDED SESSIONS:** From time to time, particularly when an important issue is being explored, a session extends longer than originally planned or scheduled. Because psychiatry fees are based on time, in those instances when the session does run long the patient will be charged accordingly.

**PRESCRIPTION REFILLS**: Prescription refills are best obtained while you are at the office for an appointment and some circumstances do require this. Goal Psychiatric Associates **(WILL NO LONGER PHONE IN PRESCRIPTION REFILLS TO PATIENT PHARMACIES)**. In order to provide quality of care, it is imperative that patients be re-evaluated after taking prescription medicines. Effective immediately, Goal Psychiatric Associates will only write prescriptions with no refills or a maximum of one refill, in exceptional circumstances. However, in some cases, medications can be refilled in between appointments with the doctor's approval. It is the patient's responsibility to schedule a follow-up appointment so that the physician may monitor and document the effects of the medication prescribed. Please provide 72 hours notice before you will run out of medication. Please note in extraordinary circumstances may take at least 7-10 day in order to respond to a refill request. No refills will be called on in weekends, holidays or after hours. **AGAIN, expect 72 hours for all phone refill requests and plan accordingly.** _____ **(Initial here)**

**EMERGENCIES: In case of an emergency, call 911 or go to the nearest Emergency Room!** If you need to speak with someone urgently, please try the office telephone number. If you reach voicemail follow the instructions to leave an urgent message. If you reach a secretary/receptionist, urgent calls will be relayed to the doctor as soon as possible. The doctor will be in touch as soon as he is able. In the event you are unable to reach the doctor quickly enough and you feel your needs have become urgent please go to the emergency room of your local hospital.

## OUR FINANCIAL POLICIES

**Twenty-four (24) hours notice of cancellation of an appointment is required for all appointment. I agree to pay $25.00 for appointment, or missed broken without a 24 hours notice.** Failure to keep the scheduled appointment or failure to cancel an appointment more than twenty-four (24) hours in advance will result in charge of the normal fee for the expected service. Monday appointments must be cancelled by 10AM on Friday to avoid this charge. **You are personally responsible for cancellation charges.** _____(Initial here)

**COLLETION FEES AND COSTS:** There will be a fee of $25.00 for any returned checks and thereafter payment must be made with credit card or cash. In addition, in the event we must institute collection and/or court proceedings to collect unpaid fees, you agree to pay, in addition to the outstanding fee, our costs and the value of any attorneys services incurred in the collection of those fees or any part thereof. Our settlement for a smaller amount than we initially demand shall not constitute a waiver of our right to recover full fees and costs.
_____ (Initial here)

**FORENSIC REPORTS, LETTER, RECORDS MANAGEMENT FEES:** I agree to pay Goal Psychiatric Associates, all charges for attorneys related to divorce, custody, visitation, involuntary commitment social security benefits, disability benefits, and workman's compensation issues involving the patient in any way. I agree to pay for charges related to record retrieval, copying costs, and statement of opinion when I authorize release of my records to any outside party. In the event of default I promise to pay such collection costs and attorney fees as may be required to effect collection of the indebtedness. Fees for reports or letters for disability insurance, employer, school, etc. will be based on the time required by the doctor for preparation. If the doctor must be involved in litigation because of professional services provided to you please note that the forensic fee will be different from the regular in-office fee. A retainer must be paid in advanced based on an estimate of the minimum time that will be required for the services. Out-of-office services will be charged on a portal basis. The forensic fee will be applied to all services connected to the litigation, including but not limited to telephone conferences, depositions and court appearances.

**WE DO NOT ACCEPT MEDICAID AT THIS TIME!** If you have Medicaid, please come to the window and speak with our staff.

**FINANCIAL RESPONSIBILITIY**: I understand that I am fully responsible for all services that may not be covered by my insurance. I agree to pay for all charges if not paid by the insurance. It is your responsibility to know, or find out, whether or not we are providers for your specific network. _____ (Initial here)

**NON-INSURED PATIENTS (including patients whose insurance we do not accept):** Non-insured patients are expected to pay in full the day services are rendered unless specific arrangements are made in advance by writing.

**NON-COVERED SERVICES & PRESCRIPTIONS:** We provide medical care according to what our doctors believe is in the best interest of our patients. The doctor prescribes medication based on his/her knowledge and experience. Some recommended services and medications might not be covered by your insurance. We do not allow insurance companies to dictate the prescribing or treatment pattern. This means that while sometimes we may feel comfortable prescribing less costly generic medication (which may be on your insurance company's formulary list), we must insist on non-formulary or band name medication. The doctor makes this decision at the time the prescription is written. _____ (Initial here)

**PHOTOCOPIES**: I hereby authorize photocopies and electronic copies of this form to be as valid as the original.

**STATEMENT OF UNDERSTANDING:** Please ask before signing below or obtaining treatment if you have any questions about our office policies. Your signature below, or your receipt of services after having had an opportunity to read these policies and terms, constitutes your agreement to our office policies.

**I have read this contract and agree to its terms**

_____ _____
Signature of patient/guardian/guarantor Date

_____ _____
Print Name Relationship to Patient

## E-mail Policy

E-mail offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember: there are important differences. E-mail is not the same as calling our office; there is no person on the other end of the call-just a computer. You can't tell for certain when your message will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us using e-mail.
E-mail is never, ever, appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Department for emergencies.

E-mail is great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail also include prescription refill requests, referral and appointment scheduling requests and billing/ insurance questions.

E-mail should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

E-mail is not confidential. It is like sending a through the mail. The staff may be asked to read your emails to help with handling the matter. Also, you should also know that is sending e-mails from work, your employer has a legal right to read your email if he or she chooses. In addition, e-mail may become a part of the medical record when we use it, a copy may be printed and put in your chart.

E-mail is not a substitute for seeing me> If you think that you might need to be seen, please call and book an appointment.

Finally, either one of us can revoke permission to use the e-mail system at any time.

**I DO / DO NOT** (CIRCLE ONE) Want to communicate with my doctor electronically.
I have read the above information and understand the limitations of security on information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside the state in which my doctor is licensed.

E-mail Address: _____

## Consent for Purposes of Treatment and Healthcare Operations (HIPPA)

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. GOAL PSYCHIATRIC ASSOCIATES, LLC is not required to agree to the restrictions that I may request. However, if GOAL PSYCHIATRIC ASSOCIATES agrees to a restriction that I request the restriction is binging on GOAL PSYCHIATRIC ASSOCIATES.

I understand I have right to review GOAL PSYCHIATRIC ASSOCIATES. Notice of Privacy Practices prior to signing this document, in accordance with HIPPA. The GOAL PSYCHIATRIC ASSOCIATES. Notice of Privacy Practice has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in performance of health care operations of GOAL PSYCHIATRIC ASSOCIATES. This notice of privacy practices also describes my rights and the duties with respect to my health care information.

My "protected health information" means health information, including my demographic information, collected from me or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information may identify me.

The following are waivers to confidentiality. Unless otherwise specified in writing, you agree to the following limited waives and release of confidential information:

1. To the professional who referred you to our office. You agree that we may contact the individual or agency who referred you and may convey the following information: (a) the fact that you have been seen and evaluated; (b) treatment initiated and anticipated length of treatment; (c) your prognosis; (d) fitness for employment and participation in employment; and (e) updates as needed.

2. For medication consultation. You agree that we may consult with your other healthcare providers. You authorize the release of information from your healthcare provider to me and vice versa to facilitate such consultation.

3. For consultation with other medical professionals. From time to time, we may discuss with other medical professionals regarding a clinical issue. The medical professionals are bound by laws and confidentiality. You authorize the release of information we believe reasonably necessary to such a consultation. Generally, identifying data will not be released to the consulting clinician.

4. To hospitals or agencies accepting the patient for medical or mental health care.

5. To your insurer or its agent, or to any collections company, court or other entity, to the extent we believe necessary to obtain reimbursement or payment.

I have read and had any questions satisfactorily answered:

## Notice of information Practice and Privacy Statement

**How We Collect Information About You**: Goal Psychiatric Associates and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

**What We Do Not Do With Your Information**: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), Contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPPA consent form.

**How We Do Use Your Information**: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between Goal Psychiatric Associates and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, medications and insurance.

If you apply or attempt to apply too receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

**Limited Right to Used Non-Identifying Personal Information From Biographies, Letters, Notes and Other Sources**: Any stories, letters, biographies, correspondence, or thank you note sent to us become the exclusive property of GPA. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for promotional purposes that are directly related to our mission.

You may specifically request that NO information be used. We respect your right to privacy and assure you no identifying information or photos that you send to us will never be publicly used without your direct or indirect consent.

_____ _____

Patient/Guardian Signature Date