Psychiatry Clinic Intake Questionnaire

(Please print clearly and complete all pages)

Name:						T	oday's Date	
Last		First		Middle				
Home Address	s:					The state of the s		
m 1 1 1 1	No	Street		Apt#	City		State	Zip
Telephone No	•		_Cell No: _			_ Work No: _		
SS No:			Sex: M F	Date of Bir	rth://	/ Mari	tal Status:	S M D W Sep
Email:			Allerg	ies:				
Social Status:	Disabled En	nployed F	Retired S	Stay at Home	e Mom Stu	ıdent Unen	nploved	
		. ,	1				.p.oyeu	
Highest Level	of Education:	Elem Mic	ddle Hig	h (Grad Y N	l) College	(Grad Y N)	Graduate	School(Y N)
n) (n)								
Place of Educa								
For student's	Name			Address		City	4	
Place of Emplo	yment:							
*	Name			Address		City	/	
Who referred y	you to this offic	e?						
		Name					ephone #	
Who is your Pr	rimary Care Phy	/sician?				***************************************		
P . 1	1 () 1	Name					ephone#	
For what prob	lem(s) do you s	eek help? _						
What led you	to seek help nov	w?					2.00	
					• //-			
What makes th	e problem wor	se?						
							West Control of the Control of Co	***************************************
What makes th	e problem bett	er?						•
What goal(s) d	o you hope psy	chiatric tre	atment wi	ll help you t	o achieve?			
6(-)	- 7 1 1 1				o demeve	**************************************		
What form of to	reatment do yo	u expect (n	sychother	any medica	tion other)	?		
	on think this wi					•		•

	Parent(s)/Legal Guardian/Responsible Party							
Relationship to Patient: Self	Spouse Parent Other							
Name:		_ Relationship to Patient:						
Address:								
City:	State: Zip:	Phone: ()						
Employer	Work Phone ()	SSN#						
	Billing/Insurance Infor	rmation						
Policy Holder		Relationship to Patient						
SSN#:	Name of Employer:	Work Phone: ()						
Address of Employer:	City	State:Zip						
Insurance Company	Grp #	ID#						
Ins Co Address:		Ins Phone:						
DO YOU HAVE SECOND	ARY INSURANCE? Yes No IF Y	'ES, COMPLETE THE FOLLOWING						
Name of Insured	DOB							
Relationship to Patient	SSN#:							
Name of Employer:	Work #: ()							
Address of Employer:	City	State:Zip						
Insurance Company	Grp #	ID#						
Ins #:								

835 Oakley Seaver Drive Clemont, FL 34711-1968

NameDate	Name	Date
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Mark an X in the box that best describes:

Mark an X in the box that best describes:				
Sleep	None	Mild	Moderate	Extreme
sleeping too much				
difficulty falling asleep				
difficulty staying asleep				
waking earlier than desired				
Interests	None	Mild	34-3	R-4
loss of interest in pleasurable activities	Поне	MIN	Moderate	Extreme
changes in sexual interest				
Self-esteem/Guilt	None	Mild	Moderate	Extreme
excessive guilt				
feeling worthless				
regretting some behaviors				
Energy	None	Mild	Moderate	Extreme
decreased energy				
increased energy				
unable to sit still				
moving so slowly that others have noticed				
Memory, Concentration, Perceptions	None	Mild	Moderate	Extreme
difficulties with concentration				
worry about social or performance situations				
seeing things that others may not see				
hearing things that others may not hear				
Appetite	None	Mild	Moderate	Extreme
increased appetite			11400001620	Datient
decreased appetite				_
restricting what you eat to lose more weight				-
overeating/making yourself vomit				1
Mood	None	Mild	Moderate	Fortune
mood swings	None	DITA	iviouerate	Extreme
feeling sad or depressed				-
feeling nothing or feeling numb		- No. Commission of the Commis		
anger				-
temper outbursts				
irritability				
inability to stop worrying				
anxiety or fear				
and the state of t				
Other	None	Mild	Moderate	Extreme
avoiding places, people, or situations				
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Name	Date
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Mark an X in the box that best describes:

Risk Assessment	Currently	In last 6 mos	More than 6 months ago	Never
Recurrent thoughts about death				
Believing that others would be "better off" if you were dead				
Feeling hopeless about your life and future				
A family member or close friend completing suicide				
Self-harming behaviors without intent to die				
Recurrent thoughts about killing yourself				
Thinking out a plan to kill yourself				
Active preparation to kill yourself				
Attempting to kill yourself				
Recurrent thoughts about killing others				
Thinking out a plan to kill someone else				
Active preparation to kill someone else				30 St.
Attempting to kill someone else				
Voices telling you to hurt or kill yourself or others				
Being more physically or verbally aggressive than you intended to be (with spouse/partner/child)				
A physical altercation in which you caused injury				
Throwing or breaking things when angry				
Arrest for physical violence				

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Nama	Date	

Mark an X in the box that best describes any current symptoms:

Review of symptom	s	
Dry mouth	Tics/Twitches	
Constipation	Trembling/shaking	
Sweating	Excessive snoring	
Fatigue	Taking medication to sleep	
Nightmares	Fainting or dizzy spells	
Constant pain	Unexplained weight loss	
Nausea	Unexplained weight gain	
Diarrhea	Changes in hearing or vision	
Blackouts	Numbness in extremities	
Headaches	Sexual concerns	
Other		

Mark an X in the box of the family member who has had the following:

Family History	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Attention deficit disorder (ADD/ADHD)		-			
Bipolar or Manic/Depressive illness					
Alcohol or Drug Abuse					
Mental retardation		-			
Depression					
Anxiety (panic disorder, excessive worry)					
Learning disability					
Schizophrenia or psychosis					***************************************
Other					

Mark an X by all that apply:

Life Experiences		
Abusive relationship	Miscarriage	Unhappy childhood
Experienced physical abuse	Abortion	Poor academic progress
Experienced emotional abuse	Crime Victim	Few Friends
Experienced sexual abuse	War	Family Problems
Witnessed physical abuse	Poverty	
Witnessed emotional abuse	Natural Disaster	
Witnessed sexual abuse	Death of a parent	
Rape	Death of someone close	

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Date

Name

Mark an X by all that apply:		
Psychological Health History		
saw a physician for a mental health concern		
was prescribed medication for a mental health condit	tion	
saw a therapist or counselor		
received substance abuse counseling or treatment		
saw a psychiatrist for a mental health condition		
ever hospitalized for a mental health condition		
ever diagnosed with an eating disorder		
Occupational History		
frequently quit jobs/don't stay at a job long		
usually get fired from a job		
financial difficulties		
unemployed		
Academic History		
attended more than one college		
on academic probation or suspension		
suspended or expelled from school		
needed to take classes over (or repeat a grade)		
skipped a grade		
learning disability/ADHD (previously diagnosed)		
Current GPA:	Major/minor:	

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Date

Name		Date		manus:
Mark an X by all that apply:		N March 40 Control of the		
Substance Use	Commontle	In last 6 mos	Manathan Carana	
tobacco	Currently	IH last o mos	More than 6 mos ago	Never
marijuana		-		
IV drugs				
cocaine				
heroin				
1 1 1 1 1 1 1 1 1 1				
ecstasy selling or trading prescription				
medicine given to you				
prescription medication for				
recreational use				
overuse of a prescription medication				
taking prescription				
medication for reasons other				
than it was prescribed				
Do you drink alcohol?	Y N			
how many days of the mo				
how many drinks do you				
do you drink to get drunk				
has your alcohol use incre	eased in the past month?			
have you had problems at				
have you blacked out in t		American de la company de la c		
do you drive after drinkin		cluding Alcoholics A	nonymous)?	
•	-	use (i.e. DVII public is	ntoxication)?	
Do you drink caffeinate			itoxication):	
how many drinks in an av	· ·			
T	1			
I understand the questionn I certify that the information	aire information I ha	ave provided is im	portant in assessing the he	ealth care I may need
coming and the unvillation	on on this tour is ut	acturate to	the oest of my knowledge	î•
Patient Signature			Date	
Psychiatrist Signature Page 6 of 6, Psychiatry Clinic In	ntoka Quartionnoiro	(A M	Date	
age o or o, rsychiatry Clinic li	make Questionnaire,			

PSYCHIATRIC HISTORY CHECKLIST

Please answer each question, circling Y (yes) or N (no) as indicated.

W	here	were you born?								
Si	nce	what year have you lived continuously in this area?								
Н	How many years of school did you complete?									
Υ	Ν	When you first started school, did you have trouble separating from your mother or discomfort at being away from home?								
Υ	Ν	In school, did you have more difficulty sitting still or paying attention than other kids, or were you ever diagnosed as being hyperactive or having attention-deficit disorder?								
Υ	N	Did you have any specific learning problems, such as with spelling, reading, math, or speech; were you labeled a slow learner; or were you placed in special classes?								
Υ	Ν	As a child, did you frequently wet your bed after age 5?								
Υ	N	Were you ever the victim of physical or sexual child abuse; violent crime; sexual assault, molestation, or harassment; natural disaster; motor vehicle or industrial accident; combat injury; discrimination or persecution based on gender, race, ethnicity, religion, sexual orientation, etc.? (If Yes, please circle which one(s).)								
Υ	Ν	Did you ever serve in the Armed Forces, active duty or reserves?								
Υ	Ν	If so, did you receive a service-connected disability rating?								
Υ	Ν	Have you ever assaulted anyone or been in jail?								
Υ	Ν	Have you ever attempted suicide or harmed yourself on purpose without intending suicide, such as to get a sense of relief or someone's attention?								
		ten do you gamble (cards, casinos, racetracks, Jai Alai, etc.)?the most you lost in one day?								
Υ	Ν	Have you ever been markedly overweight?								
Υ	Ν	Have you ever felt fat or tried to lose weight despite family or friends saying that you were not overweight?								
Υ	Ν	To lose weight, have you ever made yourself vomit or taken laxatives, diuretics (water pills), or diet pills?								
Υ	N	Have you frequently eaten large amounts of food in binges and felt guilty afterwards?								
Υ	N	If yes, did you then vomit?								
Υ	N	Have you ever had a period of confusion, for example while hospitalized or ill, during which you became confused and lost track of where you were or what day it was or could not recognize people you knew?								
Y	N	Do you often forget where you put things, have trouble finding your way home, or forget what people tell you unless you write it down?								

- Y N Have you ever before consulted a psychiatrist?
- Y N Have you ever consulted a psychologist, social worker, or any other type of therapist?
- Y N Have you ever been hospitalized for psychiatric reasons or for detoxification?
- Y N Have you ever received shock treatments (electroconvulsive therapy)?
- Y N Have you ever felt depressed almost every day for at least two weeks?
- Y N Have you ever had a period of time lasting days to weeks when you felt clearly different than your usual self: your mood was euphoric or irritable; you felt more energetic, talkative, sociable, or creative; thoughts raced through your mind; you felt little need to sleep; you bought things without considering whether you could afford them; your sex drive was increased; and you felt you could conquer the world? (If yes, please circle which one(s).)
- Y N Have you ever had compulsions (repetitive seemingly purposeful but unnecessary behaviors such as checking the doors several times before leaving home, frequent handwashing, counting things repeatedly, etc.?
- Y N Have you ever had sudden attacks of anxiety or nervousness?
- Y N Have you ever had phobias (fears of specific situations or things such as heights, enclosed places, open places, driving, flying, roaches, etc.)?
- Y N Do you become so anxious in social situations or when called upon to talk or perform that you have difficulty speaking or performing?
- Y N Have you frequently found yourself in places without knowing how you got there, found personal belongings in places you did not recall having placed them, been greeted by people who seemed to know you but you did not know them, or been unable to account for what you had been doing for some period of time? (If yes, please circle which one(s).)
- Y N While you were fully awake, have you ever heard voices talking to you or about you that did not come from anyone near you?
- Y N Have you ever seen things, such as faces, animals, or ghosts, that other people could not see?
- Y N Have you ever tasted or smelled things or felt things touching you or crawling on you when nothing was there?
- Y N When you were in public, have you often felt that people were watching you, following you, talking about you, reading your mind, putting thoughts into your mind, trying to hurt or control you in some way, or plotting against you?
- Y N Has it often happened that things you've seen appeared larger, smaller, closer, or farther away than you knew them to be?
- Y N In unfamiliar places, have you often felt that you've been there before, or have familiar places often seemed strange, different, or unfamiliar?
- Y N Have you ever injected anything into your veins?

How many cups	, glasses, or o	cans of beverages	containing	caffeine	(coffee,	tea,	colas) (lo you	drink in a
day?		_	_				,		

MEDICAL HISTORY/REVIEW OF SYSTEMS CHECKLIST

Please circle each item you have had: Head injury Seizure/convulsion Loss of consciousness Stroke Recurrent headache Encephalitis Meningitis Dizziness Weakness Numbness or tingling Other neurological disorder (specify): Glaucoma Cataract Loss of vision Retina/macular disease Tinnitus/persistent ringing in the ears Hearing loss Itching **Psoriasis** Other persistent rash (specify): Arthritis Lupus Fibromyalgia Back problems Osteoporosis Asthma Emphysema Chronic bronchitis Pulmonary embolus Wheezing Shortness of breath Other lung disease (specify): High blood pressure Low blood pressure Fainting spells Rheumatic fever Congestive heart failure Heart murmur Mitral valve prolapse Angina/chest pain Heart attack Endocarditis (heart valve infection) Abnormal heart beat/arrhythmia Pacemaker insertion High cholesterol/triglycerides Other heart problem (specify): Esophageal spasm Peptic/duodenal ulcer Irritable bowel Persistent constipation/diarrhea Diverticulosis Diverticulitis Crohn's disease Ulcerative colitis **Pancreatitis** Hepatitis Jaundice Gallstones Persistent nausea/vomiting Abdominal pains Other stomach or intestinal problem (specify): Kidney failure Kidney stones Recurrent urinary infections Urinary blockage Incontinence Other bladder or kidney problem (specify) Diabetes Hypoglycemia Thyroid problems Infertility Bleeding tendency Anemia Porphyria Cancer (what part of your body?): Positive HIV test Herpes Syphilis Mononucleosis Lyme disease Malaria Other infectious disease: Poisoning Traumatic injury Men only: Prostate problems Vasectomy Women only: # of pregnancies # of Caesarean sections # of abortions_ Stillbirths Miscarriages D&C Hysterectomy **Tubal ligation** Ovary removed Breast surgery

Appendix

Hemorrhoids

Other (specify):

Gallbladder

Abdominal

None:

Tonsils Adenoids

Hernia

Heart

Surgery:

Allergies to medications:

Please circle each of the following that you ever took, even once:

Antipsychotics/neuroleptics/major tranquilizers/anti-Parkinsonians

Thorazine/chlorpromazine Trilafon/perphenazine

Compazine/prochlorperazine

Haldol/haloperidol

Navane/thiothixene Moban/molindone Risperdal/risperidone

Seroquel/quetiapine Artane/trihexyphenidyl Mellaril/thioridazine Stelazine/trifluoperazine

Torecan/Norzine/thiethylperazine

Orap/Pimozide

Taractan/chlorprothixene

Loxitane/loxapine Clozaril/Clozapine Geodon/ziprasidone Cogentin/benztropine Serentil/mesoridazine Prolixin/fluphenazine

Antidepressants/mood elevators

Elavil/Endep/amitriptyline Tofranil/imipramine Triavil/Etrafon

Surmontil/trimipramine Ludiomil/maprotiline Prozac/Sarafem/fluoxetine

Luvox/fluvoxamine Effexor/venlafaxine Nardil/phenelzine

Eldepryl/deprenyl/selegiline

Pamelor/Aventyl/nortriptyline Norpramin/desipramine

Limbitrol

Anafranil/clomipramine Desyrel/trazodone Zoloft/sertraline Celexa/citalopram

Wellbutrin/Zyban/bupropion Parnate/tranylcypromine

Moclobemide

Sinequan/Adapin/doxepin Vivactil/protriptyline

Symbyax

Asendin/amoxapine Serzone/nefazodone Paxil/Pexeva/paroxetine Lexapro/escitalopram Remeron/mirtazapine Marplan/isocarboxazid

Cymbalta/duloxetine

Mood stabilizers and anticonvulsants

Lithium/Eskalith/Lithobid

Tegretol/Epitol/Equetro/carbamazepine

Neurontin/gabapentin

Depakote/Depakene/valproic acid

Topamax/topiramate

Lamictal/lamotrigine Trileptal/oxcarbazepine

Anxiolytics/minor tranquilizers/sleeping pills

Valium/diazepam Paxipam/halazepam Ativan/lorazepam Dalmane/flurazepam Halcion/triazolam Ambien/zolpidem Rozerem/ramelteon

Librium/chlordiazepoxide Centrax/prazepam Xanax/alprazolam Restoril/temazepam ProSom/estazolam Sonata/zaleplon BuSpar/buspirone

Tranxene/clorazepate Serax/oxazepam Klonopin/clonazepam Doral/quazepam

Lunesta/eszopiclone

Other psychoactive substances

Alcohol LSD Mescaline Peyote

Amphetamines/speed/diet pills Ritalin/Concerta/Metadate/Methylin/methylphenidate Cocaine/crack

Tobacco Quaaludes Barbiturates

Aricept/donepezil

Namenda/memantine

Marijuana/grass/pot/weed/hash/reefer

Psilocybin/mushrooms Adderall/Adderall XR

Cylert/pemoline Glue/other volatile inhalants

Other downers Exelon/rivastigmine Ecstasy/MDMA DMT STP PCP

Strattera/atomoxetine Focalin/dexmethylphenidate Provigil/modafinil Heroin/other opiates

Reminyl/galantamine

ON THE BACK OF THIS PAGE, PLEASE list the name(s) and relationship to you of any blood relatives who have suffered from or been treated for mental/emotional/psychological problems, including

depression, nervousness, suicide or suicide attempts, alcoholism, drug abuse, schizophrenia, phobias, etc., or from neurological or unusual diseases.

Name	Date	
LIGHT	Date	

BECK DEPRESSION SCALE

<u>INSTRUCTIONS</u>: Below are groups of statements. Please read the entire group of statements in each category. Then pick out the one statement in that group which best describes the way you feel this week, including today. Circle the number beside the statement you have chosen.

- A. O. I do not feel sad.
 - 1. I feel sad.
 - 2. I am sad all the time and I can't snap out of it.
 - 3. I am so sad or unhappy that I can't stand it.
- B. 0. I am not particularly discouraged about the future.
 - 1. I feel discouraged about the future.
 - 2. I feel I have nothing to look forward to.
 - 3. I feel that the future is hopeless and that things cannot improve.
- C. O. I do not feel like a failure.
 - 1. I feel I have failed more than the average person.
 - 2. As I look back on my life all I can see are alot of failures.
 - 3. I feel I am a complete failure as a person.
- I get as much satisfaction out of things as I used to.
 - 1. I don't enjoy things the way I used to.
 - 2. I don't get real satisfaction out of anything anymore.
 - 3. I am dissatisfied or bored with everything.
- E. O. I don't feel particularly guilty.
 - 1. I feel guilty a good part of the time.
 - 2. I feel quite guilty most of the time.
 - 3. I feel guilty all of the time.

- F. O. I don't feel I am being punished.
 - 1. I feel I may be punished.
 - 2. I expect to be punished.
 - 3. I feel I am being punished.
- G. O. I don't feel disappointed in myself.
 - 1. I am disappointed in myself.
 - 2. I am disgusted with myself.
 - 3. I hate myself.
- H. O. I don't feel I am any worse than anybody else.
 - 1. I am critical of myself for my weaknesses or mistakes.
 - 2. I blame myself all the time for my faults.
 - 3. I blame myself for everything bad that happens.
- I. O. I don't have any thoughts of killing myself.
 - 1. I have thoughts of killing myself, but I would not carry them out.
 - 2. I would like to kill myself.
 - 3. I would kill myself if I had the chance.
- J. O. I don't cry more than usual.
 - 1. I cry more now than I used to.
 - 2. I cry all the time now.
 - 3. I used to be able to cry but now I can't cry even though I want to.

- K. O. I am no more irritated now than I ever am.
 - 1. I got annoyed or irritated more easily than I used to.
 - 2. I feel irritated all the time.
 - 3. I don't get irritated at all by the things that used to irritate me.
- L 0. I have not lost interest in others.
 - 1. I am less interested in other people than I used to be.
 - 2. I have lost of my interest in other people.
 - 3. I have lost all of my interest in other people.
- M. O. I make decisions about as well as I ever could.
 - 1. I put off making decisions more than I used to.
 - 2. I have greater difficulty making decisions than before.
 - I can't make decisions at all any more.
- N. O. I don't feel I look any worse than I used to.
 - 1. I am worried that I am looking old or unattractive.
 - 2. I feel that there are permanent changes in my appearance that make me look unattractive.
 - 3. I believe that I look ugly.
- O. O. I can work as well as before.
 - It takes extra effort to get started at doing something.
 - 2. I have to push myself very hard to do anything.
 - I can't do any work at all.
- P. O. I can sleep as well as usual.
 - 1. I don't sleep as well as I used to.
 - 2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
 - 3. I wake up several hours earlier than I used to and cannot not get back to sleep.

- Q. 0. I don't get more tired than usual.
 - 1. I get tired more easily than usual.
 - 2. I get tired from doing almost anything.
 - 3. I am too tired to do anything.
- R. 0. My appetite is no worse than usual.
 - 1. My appetite is not as good as it used to be.
 - 2. My appetite is much worse now.
 - 3. I have no appetite at all any more.
- S. 0. I haven't lost much weight, if any lately.
 - 1. I have lost more than 5 pounds.
 - 2. I have lost more than 10 pounds.
 - 3. I have lost more than 15 pounds.
 I am purposely trying to lose weight by eating less:

Yes	No
-----	----

- T. 0. I am no more worried about my health than usual.
 - 1. I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
 - 2. I am very worried about physical problems and it's hard to think of much else.
 - I am so worried about my physical problems, I cannot think about anything else.
- U. 0. I have not noticed any recent change in my interest in sex.
 - 1. I am less interested in sex than I used to be.
 - 2. I am much less interested in sex now.
 - 3. I have lost interest in sex completely.

EXPRESS AND INFORMED CONSENT FOR TREATMENT

PATIENT NAME:						
I the undersigned, apatient,guardian advocate, healthcare surrogate/proxy, hereby authorize the professional staff of this facility to administer mental health assessment and treatment.						
I understand that I am responsible for fees for services rendered.						
I understand that more information will be provided to me before my informed consent will be requested for the administration of psychotropic medications.						
I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.						
understand that my records are confidential, but there are some exceptions. Serenity Health Center agrees not release any information about you, other than Serenity Health Center staff on a need to know basis without getting your permission in writing. Florida and Federal law protects such information. Violations of these regulations may be reported as a crime. However, there are times when the law also says that information must be shared. These include cases where there is physical and sexual abuse or neglect of children, elders, or isabled persons; there is expression of intent to harm self or others; there is a threat or commission of a crime on Serenity Health Center's premises or to staff; a court order is issued equiring Serenity Health Center to release information; we learn of a contagious disease which may harm others; and or the State requires that we report client data for follow-up today.						
herebyGIVEDO NOT GIVE Serenity Health Center permission to contact me.						
We may want to contact you to remind you of an appointment or to find out how you are doing upon completion of your treatment.)You can call me at () during these times:						
Signature of Patient: Date:						
Signature of Parent or Guardian: Date:						
signature of Witness Date:						

Patient Rights And Responsibilities

While receiving services from Serenity Health Center you have the right to....

- 1. An environment that preserves the dignity and contributes to a positive self-image.
- 2. Be served in the least restrictive treatment alternative available with your treatment needs.
- 3. Have all identifying and treatment information held in a confidential manner.
- 4. Know that information disclosed concerning abuse, neglect or exploitation of a child, disabled adult, or the elderly MUST be reported to the Department of Health and Rehabilitation for possible investigation (under Florida State Law).
- 5. Be involved in the development and review the clinical records compiled as a result of treatment.
- 6. Refuse care, treatment or services at any time.
- 7. Treatment free from mental, physical sexual and verbal abuse, neglect and exploitation, or any form of corporal punishment.
- 8. To be informed (and when appropriate, family members) about the outcomes of care, including unanticipated outcomes.
- 9. Exercise citizenship privileges.

As a patient of Serenity Health Center you have the responsibility to ...

- 1. Provide accurate and complete information.
- 2. Schedule appointments and make any calls during normal office hours 9 am-4 pm Mon-Wed.

 If you call after normal business hours please leave a message and we will return your call. If you are in crisis or have an emergency immediately call 911.
- 3. Meet financial commitments by: A) Paying the fees for services rendered.
 - B) Being financially responsible for missed appointments.
- 4. Ask questions when you do not understand your care or do not know what is expected of you.
- 5. Show respect and consideration. You may be held legally responsible for any verbal or physical abuse towards Serenity Health Center's staff.
- 6. Follow rules and regulations set forth by staff.

Witness Signature

- 7. Attend medication appointments to obtain prescription refills.
- 8. Accept the consequences for outcomes if you do not follow treatment recommendations.

By signing this form, I am verifying that I have read and rec	eived a copy of my Rights and Responsibilities form	Π
Patient Signature:	Date	
Parent or Guardian Signature:	Date	_
:		
	Data	



Medication Profile

Please list any medications that are currently being prescribed to you.

	Name of Medication	Dosage	Prescribing Physician	Last Date Filled
-				

WHAT AND THE STREET				

Serenity Health Center NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions regarding this notice, please contact

Serenity Health Center 835 Oakley Seaver Dr.

Clermont, FL 34711 Effective date November 14, 2008

WHO WILL FOLLOW THIS NOTICE
This notice describes our practice's privacy practices and that of:

Any physician or health care professional authorized to enter information into your medical chart.

All departments and units of the practice.

- All employees, staff and other personnel.
- All these individuals, sites and locations follow the terms of this notice. In addition, these individuals, sites and locations may share medical information with each other or with third party specialists for treatment, payment, or office operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

make sure that medical information that identifies you is kept private;

give you this notice of our legal duties and privacy practices with respect to medical information about you; and

follow the terms of this notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be used. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in taking care of you in the office and elsewhere. We also may disclose medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care provided you have consented to such disclosure. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company or a third receive at our office may be billed to and payment may be collected from you, an insurance company or a third receive at our office may be billed to and payment may be collected from you. party. For example, we may need to give your health plan information about procedures you received at the office so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the

For Healthcare Operation. We may use and disclose medical information about you for medical office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective, We may also disclose information to our physicians, staff and other office personnel for review and learning purposes.

Appointment Reminders. We may also use your information to contact you as a reminder that you have an appointment for treatment or medical care in the office. You may be contacted by any of our personnel via phone, mail or email.

Treatment Alternatives. We may use your information to tell you about possible recommended treatment

options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use your information to tell you about health-related benefits or

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose information about you to an entity assisting in a disaster relief effort so that your family can be notified of your condition, status and location.

As Required By Law. We will disclose medical information about you when required to do so by federal, taste or local law.

state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. The oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official in response to a court order, a subpoena, warrant, summons or similar process. To identify or locate a suspect, fugitive, material witness or missing person, about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement, about a death we believe may be the result of criminal conduct, about criminal conduct at the office, and emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners. Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release medical information about patients of the office to funeral directors as necessary to carry out their

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we obtain about you:

Right to Inspect and Copy. You have a right to a copy of your medical information that may be used to make decisions about your care. To inspect and/or receive a copy of medical information that may be used to make decisions about you, you must submit your request in writing to Serenity Health Center. If you request a copy of the

about you, you must submit your request in writing to Serenity Health Center. If you request a copy of the information, we may charge a fee for the costs of copying and mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances.

Right to Amend. If you feel that information we have about you is incomplete or incorrect, you may ask us to amend the information. You have the right to ask for an amendment for as long as the information is kept by our office. To request an amendment, you must request in writing to your physician. In addition you must provide a reason that supports your request. We may refuse to amend your record under certain limited circumstances.

Right to an Accounting of Disclosures. You have a right to request a list of disclosures we made of medical information about you. To request this list you must submit a request in writing to Serenity Health Center and denote a

information about you. To request this list you must submit a request in writing to Serenity Health Center and denote a time period not to exceed seven years, or to predate November 14, 2008. The first request is free of charge but additional lists we may apply fees to be determined before any charges are applied, at which time you may retract your

request before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use to disclose about you for treatment, payment or healthcare operations. You also have a right to request a limit on the medical information we disclose about you to someone who is involved in you care or payment for your care, like

a family member or friend.

We are not required to agree to your request. If we do agree to comply with your request, we will do so unless the information is needed to provide you emergency treatment. You must submit a request in writing to Serenity Health Center citing (1) which information you wish to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may request that we only contact you at wok or by mail. Please submit your request in writing. We will not ask a reason for your request and we will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You have a right to receive a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You may request in writing to Serenity Health Center that a copy be mailed

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have or may obtain in the future. We will post a current copy of the notice in the office. The notice will contain on the first page, in the top left hand corner, the effective date.

In addition, each time you register we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with Serenity Health Center, 835 Oakley Seaver Drive, Clermont, Florida 34711 or with the Office of Civil Rights within the Department of Health and Human Services by visiting their website at www.hhs.gov/ocr/hipaa. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission, you may also revoke that permission at any time, in writing. If you revoke your permission, we will no longer use or disclose information about you for reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Notice of Privacy Practices Acknowledgement and Consent

The notice of Privacy Practices tells you how we may use and share your health records.

- 1. We will use and share your health records to treat you and to bill for the services we provide.
- 2. We will use and share your health records to run our practice.
- 3. We will use and share your health records as required by law.

You have the following rights with respect to your health records:

- 1. You have the right to look at and receive a copy of your records.
- 2. You have the right to receive a list of whom we have given your records to.
- 3. You have the right to ask us to correct a mistake in your heath records.
- 4. You have the right to ask that we not use or share your health records.
- 5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices

I have received a copy of Serenity Health Center's Notice of Privacy Practices.

I consent to the use and the sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.

Signature:			
(Patient	or Legal	Representative)	
Date:			ment

835 Oakley Seaver Drive Clermont, FL 34711

You Must Read And Initial Where Indicated

1.	I request that payment of authorized Medicare/Other Insurance Company benefits be made on behalf to Serenity Health Center for services rendered from physicians or associates of Serenity Health Center. () Initials
2.	I authorize Serenity Health Center to release any medical information
	concerning me to my insurance company or its agents necessary to
	determine benefits or the benefits related to the payable services. I am
	aware that I am responsible for any deductibles, co-insurances, and non-covered services. I understand this applies to all Medicare, and Commercial
	Insurance Companies. () Initials
3.	I understand that payment is due at the time services are rendered. All
	co-pays and deductibles will be collected. () Initials
4.	Serenity Health Center will file a claim to your insurance company. If your
	insurance company does not respond to the claim within 60 days from the date of filing, then the balance will become the Patient's responsibility. The
	patient will receive a statement and payment is due upon receipt. If payment
	is not received within 30 days further action will be taken. If your deductible
	has not been met, or if you do not have insurance, arrangements must be
_	made prior to seeing the M.D. () Initials
5.	Medicare Patients: We will file your secondary insurance as a courtesy. We will only bill one insurance company after Medicare. If we receive no
	response, the balance after Medicare pays is your responsibility.
	()Initials
6.	If you have an HMO, obtaining authorization is your responsibility for all visits,
	procedures, etc. If you choose to be seen without an authorization and your
	insurance denies payment, you will be responsible for the entire bill.
	() Initials
lm	portant Note: Please remember that your coverage is a contract between
	and your insurance company. WE ARE NOT PART OF THAT CONTRACT.
W	e file as a courtesy to you.
I,	(Print Name) have read and understand the above billing
	l insurance procedures.
Pet	ient Signature Date
a CA	WILL DIGITALIAN V

NO SHOW/NO CONTACT OFFICE POLICY

Appointments are scheduled to accommodate your schedule and the doctors' schedule.

- Patients must Arrive by the of their scheduled appointment.
- Patients have 15min extra to arrive after their appointment time if they are running late, and need to arrive within that time.
- If patient is running late, they are required to place a courtesy call to the office to make us aware to be able to accommodate the patient when he/she arrives.
- If patient arrives after their appointment time and no courtesy call was placed they will be charged a No Show/No Contact Fee of \$100.00.
- Appointment Reminder calls are placed as a courtesy to all patients.
- Patients/parents are requested to contact the office to confirm the appointment.
- If an appointment is not confirmed/cancelled or rescheduled within 24-48 hours the patient will be charged a No Show/No Contact Fee of \$100.00.
- Please be aware 3 NO SHOW'S will automatically result in a discharge from the practice.

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Patier	nt Nan	ne													

Date

Date

Patient Signature

Parent/Legal Guardian Signature

835 Oakley Seaver Drive Clermont, FL 34711-1968 Tel. 352-241-9282 Fax 352-241-4282

Patient Authorization Disclosure of Confidential Information

disclosure of my health information in the n	r signing this authorization form; authorize the use and nanner described below. I have signed this form arding the use and disclosure of the health information.
I authorize, check all which are appropriate to be	e used and disclosed.
Diagnosis with Medication(s) Prescribed	Laboratory Results
Outpatient Treatment / Visits	Psychiatric Treatment & Services
Evaluation Results	Other
(List any person, practice, business, school etc. with whore Name:	Tel:
Address:	Fax
Purpose:	
I Authorize Serenity Health Center, PA To Release (List person(s), practice(s), employer(s), school etc. which Name: Address:	Serenity Health Center, PA may send, give or communicate to.
Purpose:	
Patient or Guardian Signature Date	
Witness Signature Date	