Psychology Associates of Florida, LLC.

7450 Griffin Road

Suite 250

Davie, FL 33314

Demographic Information & Insurance Form

Patient Name_____

Date of Birth_____

Patient address_____

_____

Cell Phone _____

Home Phone_____

Social Security Number _____

Sex_____ Age_____ Marital Status_____

Email_____

Referred by_____

Emergency Contact

Name_____

Phone_____

Relationship_____

Insurance information

Insurance Company_____

Member ID_____

Group #_____

Relationship to Policy Holder_____

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PATIENT CONSENT FORM

CHARGES FOR SERVICES RENEDERED

All charges for office services are due at the time of my visit to Psychology Associates of Florida, LLC. OR ITS DESIGNEES (the "PRACTICE"). I authorize the practice to bill my insurance company. If an insurance claim is filed by the Practice, I request that payment of all benefits be made on my behalf to the Practice. It is my responsibility to pay my co-payments at each visit.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges for services rendered on my behalf, including those not paid or reimbursed by my insurance company. I am aware of the fact that my insurance carrier may deny payment for the services rendered. Therefore, if payment is denied, I agree to be personally liable and fully responsible for such payment and any collection agency fees.

SHARING/DISCLOSING HEALTH INFORMATION

I authorize the Practice to share, disclose, or otherwise release psychological information about me to my insurance company or any other authorized entity involved in my care in accordance with the provisions of HIPAA (i.e., related to treatment, payment, or overall care operations). I further authorize the Practice to gain access to medical records with the information relevant to my treatment form any and all healthcare providers, including but not limited to hospitals, laboratories, physicians, mental health care providers, and others.

TREATMENT

I further authorize and consent to the Practice's providers and their assistants and other Practice professional staff providing outpatient treatment, diagnostic procedures and/or psychotherapeutic treatment supplies, services, equipment and other items related to my care to me, as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, as well as alternative treatment modalities, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the treatment period.

CANCELLATION

I agree that I will provide at least twenty-four (24) hours' notice to the Practice when cancelling an appointment and understand that failure to provide such notice may result in a cancellation fee.

Read and acknowledged by:

Signature: _____ Date: _____

OR Parent/Guardian of Minor Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMT OF RECEPIT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Psychology Associates of Florida, LLC. or its Designees (the "Practice"). Our Notice of Privacy Practices provides information about how we may use and disclose your protected psychological/mental health information. We encourage you to read it in full.

If you have any questions about our Notice of Privacy Practices, please contact our compliance officer at:

Compliance Officer:

Psychology Associates of Florida, LLC.

7450 Griffin Road Suite 250

Davie, FL 33314

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting the Compliance Officer at the above address. I read and acknowledged all previously mentioned items and acknowledge receipt of the Notice of Privacy Practices of Psychology Associates of Florida, LLC., or it's Designees:

Signature: _____ Date: _____

OR Parent/Guardian of Minor Signature: _____ Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individuals acknowledgment, describe the good faith efforts made to obtain the individuals acknowledgement, and the reasons why the acknowledgment was not obtained:

Signature of provider representative: _____ Date: _____

An acknowledgement was not obtained because:

__ Patient refused to sign.

__ Patient was unable to sign or initial because: _____
_____

__Other reasons:_____

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CANCELLATION/MISSED APPOINTMENT POLICY

Patient Name: _____
Date:_____

Your appointment time has been set aside for you. This time is unavailable to other patients. Therefore, we require at least 24 hours advance notice if you need to cancel your appointment. For all missed appointments with less than 24-hour notice, you will be charged a **$65.00 cancellation fee.**

Appointment reminder calls are a courtesy. Should you not receive a reminder telephone call, it is still your responsibility to remember your appointment.

I _____have read and understand the cancellation/missed appointment policy.

_____

Patient Signature

If patient is a minor, please provide parent or guardian information.

Name: _____
Relationship:_____

Parent/Guardian Signature _____

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Telemedicine Consent Form Florida

I understand that telemedicine is the use of electronic technology for communication for the purpose of providing healthcare services wherever the doctor and the patient are located. I understand that the institution is based in Florida and likewise uses telemedicine to conduct a consultation with their patients. I understand that with the use of telemedicine, the interaction shall be done through real-time audio-video communication. I understand that the laws that protect privacy and confidentiality, as well as the confidentiality of medical information through the Health Insurance Portability and Accountability Act (HIPPA) also apply to telemedicine. I understand that I will be responsible for any payments or coinsurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment; I have the right to access my information and to inspect my medical information that was transmitted through telemedicine; I have the right to privacy where it shall be necessary to seek my consent in order to disclose my information unless those that are permitted by law to disclose without the need of my consent. I understand any lawsuit airing out of this agreement or service shall be brought to the courts of the state of Florida, to the exclusion of other states.

With the pronouncements above:

I authorize the Institution to provide me their diagnosis, observations, recommendations regarding my condition through telemedicine. Whenever necessary, I authorize the Institution to consult with other physicians or specialists whom they believe to have full knowledge and skills that can address my case. I have read and understood the information provided above, my rights, and obligations regarding telemedicine. I have had the opportunity to ask questions and all of which were answered to my satisfaction. Therefore, I hereby give my consent to the use of telemedicine for medical care.

☐ Please mark this checkbox if a parent/guardian shall sign this consent on behalf of the patient.

Patient Name _____

Parent/ Guardian Name (If Patient is a Minor)_____

Patient Phone Number _____

Patient Email _____

Patient/Parent/Guardian Signature _____

Date_____

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Coordination of Care Between Health Care Providers and Release of Information

Communication between behavioral health (BH) care providers and your primary care physician (PCP), and other behavioral health providers and/or facilities, is important to ensure you receive comprehensive and quality health care. This form will allow your behavioral health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress and medication, if necessary.

Patient Rights

• You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
• If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
• You will not be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
• You have a right to a copy of this signed authorization.
• If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. This consent expires in six months from the date of my signature below unless otherwise stated herein

Date of authorization: _____

Patients Name:_____
Patients Date of Birth:_____

I, _____ hereby request and authorize Psychology Associates of Florida, LLC or its designees (The "Practice") to release the following records to:
Name_____
Address_____
_____
Phone_____
Fax_____

Please specify which items are being requested (indicate all that apply): ___Psychological Evaluation/Testing ___Progress Notes ___Psychosocial History ___Consultations ___Discharge Summary ___Treatment Plan(s) ___Other:_____

The purpose of this disclosure is to:_____

Read and acknowledged by:
Signature: _____ Date: _____ Or
Parent/Guardian of Minor Signature: _____ Date: _____

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PAYMENT INFORMATION AND POLICY FORM:

PATIENT NAME: _____

CARD HOLDER NAME: _____

CARD NUMBER: _____

EXP_____CVV_____ZIP_____

CARD HOLDER'S PHONE NUMBER_____

AMOUNT $ _____

I authorize Psychology Associates of Florida, LLC. to initiate charges to the credit card indicated above for the total amount of services and/or goods rendered as reflected on the invoice(s) provided by the office. I also authorize charges for any additional related services that I may incur. Charges to my account may vary. Our policy is that a credit card will always be available on file in case of any late cancellations or missed appointments as stated on the Cancellation/Missed Appointment Policy form. If you wish to update your payment method, please contact the office. I understand that I may cancel this authorization upon written notice to Psychology Associates of Florida, LLC. allowing thirty (30) days' time for action on my cancellation notice. The use of the above credit card as payment for services and/or goods provided by Psychology Associates of Florida, LLC. is approved by my signature below. I understand a confirmation receipt will be emailed to me for my record.

CARD HOLDER SIGNATURE:_____

DATE: _____

Email Address: _____

HIGHLY CONFIDENTIAL

OFFICE USE ONLY:

DATE(S) OF SERVICE: _____

PROCESSED DATE: _____