Boca Raton Psychiatry
9980 N Central Park Blvd suite 210
Boca Raton FL 33428

Delray Beach Psychiatry
4205 W Atlantic Ave Unit C
Delray Beach FL 33445

Patient Name: ____
First Last

Home Address: ____
Street Apt #

____
City State Zip

Date of Birth: ______________________Social Security #: ___________________________

Telephone (Best # to reach you):______________________Alternate # ______________________

Email:________________________________

Primary Physician: ____
Name Phone Fax

Primary Insurance

Subscriber Name (primary insurance holder):____

Relationship to primary insurance holder: __________________ **Subscriber DOB**: ______________

Insurance Company: ________________Policy#_______________**Subscriber SSN:** _______________

Secondary Insurance

Subscriber Name (primary insurance holder):_____________________________________

Relationship to primary insurance holder: ___________________**Subscriber DOB**: ______________

Insurance Company: ________________Policy#______________ Subscriber **SSN:** _______________

I hereby authorize Boca Raton or Delray Beach Psychiatry to release to my Insurance Company or its representative, any medical, psychiatric records as well as any other information needed to obtain authorization for treatments for payment or to process claims for medical benefits.
I also authorize and request my insurance company to pay directly to Boca Raton Psychiatry LLC, the amount due in my pending claim for any services that have been provided.

Medicare, Aetna, Cigna and United Healthcare, Humana & BCBS Patients

Boca Raton Psychiatry LLC is only contracted with government Medicare, Aetna, Cigna and United Healthcare, Humana and Blue Cross Blue Shield. Please check with your insurer to determine whether prior authorizations are required or if you have a copay/coinsurance or deductible to meet. Please check with your insurer to determine whether or not Boca Raton or Delray Beach Psychiatry and its providers are contracted providers. If your insurance status changes (loss of insurance/change to a different insurer) it is your responsibility to notify us within five days of policy change or you become responsible for all future bills.

Signature of Patient or Guardian: ______________________________ **Date:** ____________________

Office, Prescription and Medication Policies for Boca Raton and Delray Beach Psychiatry LLC

-Please notify us of changes in insurance, address or telephone numbers. All fees (copay/coinsurance and/or deductible) are due at the time of service.

****Your appointment is reserved just for you.**
Please call 24 hours in advance if it is necessary to change or cancel your appointment, otherwise your visit will be considered a missed appointment. The scheduled time for your appointment is your responsibility. Cancellations for illness, weather conditions and similar situations are reasonably considered. Agreement to the office policies entails responsibility for all treatment fees, missed appointment fees in addition to any collection agency fees after 45 days of treatment/service date.

****Missed appointment fee**
$60 for missed follow-up visit with Psychiatrist or Therapist.
Third missed appointment (psychiatrist and/or therapist) will result in discharge from practice.
$20 for returned check.
All collection agency fees for up to an additional 45% (forty-five percent) of the unpaid balance due.

-Boca Raton and Delray Beach Psychiatry and all practitioners including therapists and psychiatrists do not become involved with any legal matters whatsoever including criminal/civil cases, workers compensation claims, or disability suits. Any subpoena will result in a $500/hr per charge for any/all legal matters including review of records, travel, discussions with legal counsel or any time involving legal matters

MEDICARE

- We are participating government only Medicare providers. We will bill Medicare and you will be responsible for payment of the annual deductible, any copayments or coinsurance, and charges for non-covered services.

-Medicare and supplemental coverage-After Medicare is billed, we will bill your supplemental plan whether we are contracted or not with the supplemental carrier. If no payment is received from your secondary/supplemental carrier with 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

AETNA/CIGNA/UNITED HEALTHCARE/HUMANA/BCBS

-If we participate (are contracted) with a commercial plan under which you are covered, we will bill the carrier. We will bill your primary and secondary insurances for contracted plans. You will be responsible for payment of the annual deductible, copayments and/or coinsurance and any non-covered services.

Medication and Prescription Policies

-Please note that State and Federal Guidelines, as well as those mandated by our own Insurance Company contracts require an appointment with our medical providers prior to prescribing medications and/or medication refills. This policy applies to both existing and new patients.

-All intakes/first appointments do acknowledge that current medications may or may not be prescribed by any psychiatrist here at Boca Raton or Delray Beach Psychiatry after initial examination and some medications may remain with other current providers (internist/family physician) if deemed beyond FDA limits or safe/tolerable prescribing practice. There is no “guarantee” any physician here at Boca Raton or Delray Beach Psychiatry will take over any medicine.

- Your signature below acknowledges all statements have been read, accepted and will be abided by.

Signature: ___________________________ Date:_________________

PATIENT CONSENT FORM

Boca Raton Psychiatry
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Boca Raton FL 33428

Delray Beach Psychiatry
4205 W Atlantic Ave Unit C
Delray Beach FL 33445

I understand that under the Health Insurance Portability & Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________________

Signature: ____

Relationship to Patient: ______________________________

Date: __________________

Emergency Contact:

Name: ____ Relationship: __________________________

Best Contact Number: ____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

FOR OFFICE CODING ___0___ + _______ + _______ + _______

=Total Score: _______

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

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

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Height and Weight Questionnaire:

Question 1: How tall are you without shoes?

Please write (feet, inches):

Question 2: How much do you weight? Please

write in pounds:

Smoking Cessation Screening:

Question 1: Do you Smoke?

Question #2: How much do you smoke per day?

Fall Risk

Question 1: Have you fallen in the last three months	YES	NO
Question 2: Do you have two or more medical problems?	YES	NO
Question 3: Do you use crutches, a cane or walker?	YES	NO
Question 4: Do you hold onto furniture to walk or balance?	YES	NO
Question 5: Do you feel weak when walking?	YES	NO
Question 6: Do you need assistance when rising from a chair?	YES	NO

PHARMACY AND MEDICATION INFORMATION SHEET

Pharmacy Name: ____

Address/Zip Code: ____

Pharmacy Phone Number: ____