

EMERGENCY CONTACT INFORMATION

Name: _____ Home phone: _____

Relationship: _____ Work phone: _____

Living with: _____ History by: ____ Patient or Other _____

EMPLOYMENT INFORMATION

____ Unemployed ____ Student Employed as: _____

Employer: _____ Supervisor: _____

Position: _____ Phone: _____

CLINICAL INFORMATION

Chief Complaint (brief description of current problem):

Previous Treatment:

Hospital/Clinic	Dates	Reason	Outcome
Intake			

Previous Diagnosis:

Diagnosis	Date	Doctor/Therapist

GENERAL SYMPTOMS

Current Symptoms	Minimal	Mild	Moderate	Severe	Extreme
Brooding					
Decreased activity					
Depressed mood					
Decision difficulty					
Loss of effectiveness					
Feelings of guilt					
Hopelessness					
Inadequacy					
Feeling incompetent					
Too much sleep					
Irritable					
Lack of interest					
Low energy					
Low self-esteem					
Overeating					
Poor appetite					
Poor concentration					
Self-critical					
Social withdrawal					

SOCIAL SYMPTOMS

Symptoms	Minimal	Mild	Moderate	Severe	Extreme
Argument w/ spouse					
Argument w/ family					
Stormy relationships					
Authority conflicts					
Fear of rejection					
Sexual problem					
Initiating rel. problem					
Maintain rel. problem					
Decreased social life					
Distancing					
Dependent on others					
Can't express feelings					
Social inhibition					
Lack of assertiveness					
Few relationships					
Few friends					
Probs w/ the law					
Prob w/ parents					
Fighting					
Social withdrawal					
Verbal aggression					

WORK SYMPTOMS

Symptoms	Minimal	Mild	Moderate	Severe	Extreme
Absenteeism					
Authority problem					
Worker conflict					
Supervisor conflict					
Career confusion					
Demotion					
Tardiness					
Job hopping					
Poor concentration					
Lack of interest					
Ltd motivation					
Indecisiveness					
Workaholic					
Overwhelmed					
Failure to advance					
Quit because of Sx					
Inability to work					
Need much structure					
Poor assertiveness					
Social withdrawal					
Lateness in work					
Procrastination					
Substance abuse					

SUBSTANCE ABUSE

Nicotine: ___ Yes ___ No Amount _____

Type _____ Duration _____ Related Health Problems _____

Alcohol: ___ Yes ___ No Frequency ___ Rare ___ Occasional

Last Use: _____ ___ Moderate ___ Frequent

Dates of Sobriety: _____ ___ Excessive

Pattern: ___ Episodic ___ Binge ___ Regular ___ Daily ___ Weekends

PREVIOUS PSYCHOTROPIC MEDICATIONS

Medication	Dose	Begin	Response

CURRENT PSYCHOTROPIC MEDICATIONS

Medication	Dose	Begin	Response

Medication Allergies: _____

Baytree Behavioral Health
Orientation to Clinical Services

Following is an outline of items and issues which will be discussed in our first clinical meeting. These issues are discussed early in the therapeutic process to facilitate a clear understanding of the many factors which influence the clinical work we do together. They are established to ensure the highest quality of care. Anytime you have questions regarding these policies and procedures, please feel free to discuss them in therapy. All of our administrative practices are in compliance with the Health Insurance Portability and Privacy Act (HIPPA).

1. CONFIDENTIALITY: Some exceptions to maintaining confidentiality include:

- Insurance processing (limited information necessary to process claim)
- Discussions with other clinical professionals in private anonymous consultation
- In the case of child abuse
- Suicidal or homicidal plan, action, or intent
- Disclosure of violent crimes or of threat or intent to harm others
- Other individuals, only with your written consent

2. EMERGENCIES:

- Contact the clinic during normal business hours
- The clinic or answering service will contact your therapist. After-hours emergency phone sessions will be charged private pay in increments of 15 minutes. Price depends on the provider.
- Go to the nearest Emergency Room

3. APPOINTMENTS:

A clinical therapy appointment can be expected to be 45 minutes in length and I make every attempt to start the appointment on time. From time to time, clinical needs may dictate adjustments, but every effort will be made to avoid delays.

4. CANCELLATIONS:

Many times there are patients on a waiting list to see a therapist. Subsequently, there is a \$50 charge for appointments missed or appointments not canceled within 24 hours of the appointed time. This fee cannot be charged to insurance and is the responsibility of the patient.

5. INSURANCE:

If financial conditions make it necessary to adjust service fees or co-pays, the insurance company must be notified of such an adjustment. It is unethical and constitutes insurance fraud if a co-pay is waived without the insurance company's awareness. Patients are responsible for the payment of their co-pays and deductibles at the time the service is rendered. If the insurance company refuses to pay, the patient is responsible for the cost related to the services. Baytree Behavioral Health will not bill tertiary insurance for patients. Costs not covered by primary/second insurance will be the patient's responsibility.

6. TRAINING INSTITUTE:

Periodically, we may supervise mental health professionals in training who may be involved in various aspects of the therapeutic process. Their clinical participation is critical to the development of quality clinicians. They, of course, follow the same rigorous rules regarding confidentiality and your permission is always requested.

Please read and sign:

I hereby fully understand that I enter into treatment having discussed the nature of the therapeutic relationship, the therapeutic course, and techniques to be used, to include therapeutic risks and benefits. I am aware of issues relating to confidentiality and its exceptions, patient's rights and responsibilities, the established fees, insurance company requirements, and policies related to "no shows" and cancellations. I have had the opportunity to review the Privacy Act Policies of the clinic and I am also aware that I may discuss these issues at any time.

(Patient Signature)

(Date)

Baytree Behavioral Health Notices of Privacy Practices

I have read and understand Baytree Behavioral Health HIPAA Practices and my rights and responsibilities as they pertain to my treatment record at Baytree Behavioral Health. I am also aware that upon request I may receive a hardcopy of this Privacy Notice.

Patient Signature:

Patient Representative:

Witness:

Date:

Date: _____

Patient Name: _____

I have been provided information on the following:

Patient Privacy Statement (HIPAA)

I Accept _____
(Patient Signature)

Benefits & Release: I authorize the billing of my insurance company for services provided.
(For Medicare/Tricare patients: Your plans are almost always secondary to any other commercial insurance. Failure to disclose other insurance is illegal and could result in charges not being covered by either insurance, becoming patient responsibility.)

I Accept _____
(Patient Signature)

Patient Financial Policy

Note: No-shows or cancellations with less than 24 hours notice are subject to a \$50 fee

I Accept _____
(Patient Signature)

*****For Tricare Patients Only*****

Baytree Behavioral Health

Office: 321-253-8887 / Fax: 321-253-8878

CONSENT TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

I, _____ (DOB _____), hereby authorize Baytree Behavioral Health, located at 1370 Bedford Dr., Suite 106, Melbourne, Florida 32940, _____ **to release to** _____ **to receive from** (check appropriate line)

Person/facility/agency: **45th Medical Group Patrick AFB**

Fax/Phone: **P: 321-494-7599 F: 321-494-8334**

Address if known: _____

The specific information indicated below with regard to the services provided to me for the period of treatment from _____ (all dates included) _____ for the following purposes:

- _____ For coordination of care
- _____ For treatment at this facility
- _____ For processing of my insurance claim
- _____ For peer review/third party payer
- _____ Other (specify): _____

Information to be furnished (this section must be completed)

Check/Initials

- _____ Progress reports throughout treatment
- _____ Report of psychological/psychiatric evaluation
- _____ History and Physical
- _____ Medical Discharge Summary
- _____ Psychosocial Assessment
- _____ Continuing Care Plan
- _____ Progress Notes
- _____ Neuropsychological Assessment
- _____ Lab and Radiographic results
- _____ Consultations
- _____ Legal
- _____ Other: Specify _____

I understand that the above consent is subject to revocation by me at any time except to the extent that action has been taken in reliance on this consent prior to revocation. The Federal Regulations regarding the confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR part 2) have been explained to me as applicable.

Patient Signature or _____
Parent/Legal Guardian

Witness Date

I do not want my records released to Patrick Airforce Base.

Patient Signature or _____
Parent/Legal Guardian

Witness Date