Baytree Behavioral Health — Juda DeCara, LMHC

New Patient Information

PERSONAL **Date ___/___/_____**

Name: Last _____ First _____ Middle Initial ___ Title _____

SSN _____-____-_____ Date of Birth _____/_____/_____ Age _____

Marital Status:
__divorced
__living cooperatively
__married
__N/A (for child)
__never married
__separated
__single
__widowed

Employment:
__disabled
__employed
__employed/student
__retired
__student
__unemployed

ADDRESS

Street Address: _____

City: _____

State: _____

Postal Code: _____

Residence:
__private household
__group home
__residential
__correctional
__shelter
__with family

If patient is a minor: __mother
__father
__guardian

Address: _____

_____

Please list all of your phone numbers and CIRCLE the preferred contact number.

Phone: Home _____ E-mail _____@_____

Work _____ (contact at work OK?? Yes No initial ____)

Cell _____ Do we need to dial the area code? Y or N

May we send you email reminders of your appointments? Y or N

This form completed by ___ self ___ parent ___ guardian ___ other_____

INSURANCE INFORMATION

Primary: _____ Policy #: _____ Phone: _____
Primary Cardholder: _____ Relation: _____
Date of Birth: _____ SS#: _____
Secondary: _____ Policy #: _____ Phone: _____
Primary Cardholder: _____ Relation: _____
Date of Birth: _____ SS#: _____

REFERRAL INFORMATION

Referral Source:
__ clergy/church
__ court
__ EAP
__ family
__ ER
__ nursing home
__ outpt mental health
__ outpt therapist
__ police
__ primary care provider
__ residential treatment
__ school
__ self
__ spouse
__ substance abuse center
__ supervisor
__ work
__ other_____

Primary Care Provider:

Name: _____

Phone: _____

Other therapist:

Name: _____

Phone: _____

Where did you hear about Baytree Behavioral Health? _____

ADDITIONAL (OPTIONAL) INFORMATION

Race:
__ African American
__ Asian American
__ Caucasian
__ Hispanic
__ Native American

Religion:
__ Catholic
__ Hindu
__ Jewish
__ Moslem
__ Protestant
__ No preference
__ Otherwise

Military Service:
__ active
__ retired
__ honorable discharge
__dishonorable discharge
__ medical discharge

Education level:
__ less than H.S.
__ some H.S.
__ H.S. graduate
__ some college
__ 4 yr. college grad
__ post-graduate

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: _____

_____

Juda DeCara, LMHC
1370 Bedford Drive, Suite 106, Melbourne, FL 32940
Phone: (321) 253-8887 Fax: (321) 253-8878

No-Show and Late Cancellation Policy:

Working with you and/or your child to help achieve your therapy goals is very important to me. It is understandable that there may be scheduling conflicts that arise during treatment. Baytree Behavioral Health's administrative staff will work hard to try to accommodate any scheduling conflicts that may arise. The more advanced notice you can provide, the more accommodating we can be to try to find an alternative time that will meet your needs. Due to the high demand for psychological services, any no-shows or cancellations with **less than 24-hour** notice will be assessed a fee. We appreciate your cooperation with this matter and look forward to providing you and your family with mental health services.

Effective immediately, all appointments that result in a no-show or late cancellation will be charged a **$50 fee**. Due to the high demand for afternoon appointments, those scheduled for 2:30 p.m. or later will be charged a **$100 fee**. This charge will be your responsibility and cannot be billed to your insurance company.

I acknowledge that I have read and understand the no-show/cancellation policy as defined above.

_____
Printed Name of Client/Guardian

_____ _____
Signature of Client/Guardian ***Date***

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. 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 or second insurance will be the patient's responsibility.

5. 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)

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.

_____ or _____
Patient Signature Parent/Legal Guardian

_____ _____
Witness Date

****

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

_____ or _____
Patient Signature Parent/Legal Guardian

_____ _____
Witness Date