Baytree Behavioral Health — Laurie Paquette, Ph.D.

New Patient Information/Intake

Name: ____ DOB: _____/_____/________ Age: ________

Address: ____

City: ___________________________________ State: ______________ Zip Code: ________________

Phone: Home _________________________ Work _____________________________

Cell ___________________________ Email _____________________________

(please circle preferred method of contact)

Marital Status:
___Married
___Divorced
___Single
___Separated
___Widowed
___N/A (for child)

Employment:
___Employed
___Student
___Retired
___Unemployed
___Disabled
___Stay-at-home parent

Insurance Information

Primary: _______________________ Policy # _________________ Phone: ________________

Primary Cardholder: _______________________________________ Relation: ______________

Date of Birth: _______________________ SS# _________________

Secondary: _______________________ Policy # ________________ Phone:_______________

Primary Cardholder: _______________________________________ Relation: ______________

Date of Birth: _______________________ SS# _________________

Primary Care Provider:

Name: ____ Phone: __________________________

Additional (Optional) Information:

Ethnicity:
___African American
___Asian American
___Caucasian
___Hispanic
___Native American
___Other (specify: ________________)

Religion:
___Catholic
___Hindu
___Jewish
___Moslem
___Protestant
___No Preference
___Other

Military Service:
___Active
___Retired
___Discharge (Honorable/Dishonorable – circle one)
___Medical discharge
___none

Education:
___less than H.S.
___H.S. graduate
___Some college
___College graduate
___Post-graduate

Laurie Paquette, Ph.D.
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. Any time 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) (Print Name)

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