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

New Adult Patient Information

Personal: Date: ____ / ____ / _______

Last Name: _______________________ First Name: ___________________ Middle Initial: ______

SSN: _______ - _______ - __________ Date of Birth: ____ / ____ / _______ Age: ______

Street Address: ____

City: ______________________________ --___ State: ______ Zip: ___________

Home Phone: (   ) _____ - ________ Cell Phone: (   ) _____ - ________

Would you like automated appointment reminders sent as a text? Please mark preference.
[ ] Yes [ ] No

May we contact you via email: [ ] Yes [ ] No Email: ___________________________________

Race: ________________ Gender: _______________ Religion: ___________________________

Marital Status: _______________________ Employment Status: ___________________________

Employer: ___________________________ Position/Title: ________________________________

Highest Level of Education: ________________________________

This form was completed by: [ ] Self [ ] Parent/Guardian [ ] Other: _______________

How did you hear about Baytree Behavioral Health?: ___________________________________

Military Service (If applicable, please bring in copy of DD-214):

Branch: ___________ Years on active duty: _____ to _____ Years as Reservist: _____ to _____

Highest Rank: _______________ Discharge Status: ________________

Emergency Contact Information:

Name: _____________________________________ Relation: ___________________________

Home/Work Phone: (   ) _____ - ________   Cell Phone: (   ) _____ - ________

Clinical Information:

Reason for visit:

____

____

____

____

Previous Treatments:

Hospital/Clinic	Dates	Reason	Outcome

Past Psychiatric Medications:

Medication	Dose	Name of Prescriber	Response

Current Psychiatric Medications:

Medication	Dose	Name of Prescriber	Response

Please bring in a copy of all current medications

Medication Allergies: ____

Substance Use:
Nicotine: [ ] Yes [ ] No If Yes: _______ packs/cans per day

Years of Use: ____ Associated Health Problems: ___________________________________

Alcohol: [ ] Yes [ ] No If Yes: _______ drinks per sitting _______ times per week

Years of Use: ____ Associated Health Problems: ___________________________________

Drugs: [ ] Yes [ ] No If Yes, what substance(s): _______________________________

Years of Use: ____ Associated Health Problems: ___________________________________

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
- Contact the National Suicidal Hotline (800) 273-8255, Press 1 if you are a veteran.
- Go to the nearest Emergency Room.
- Dial 988 for suicide/crisis lifeline

3. Appointments:
A clinical therapy appointment can be expected to be 45 to 60 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:
Often there are patients on a waiting list to see their provider. Subsequently, there is a $50 charge for each scheduled hour 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.

7. Telehealth:

Baytree Behavioral Health adheres to the guidelines established by HIPAA for the safe and secure administration of therapeutic services through telehealth. All video conferencing applications used by Baytree Behavioral Health are HIPAA compliant and provide end-to-end encrypted transmission for a secure provider-to-client connection. Protocols are scrupulously followed to ensure that the privacy and confidentiality of each patient is maintained.

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) (Date)

_______________________________________ _______________________________________
(Patient Representative) (Witness)

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) (Date)

Patient Financial Policy

No-shows or cancellations with less than 24 hour notice are subject to a $50 minimum fee for the appointment and up to $50 charged per scheduled hour of service.

[ ] I accept

____ _________________________
(Patient Signature) (Date)

CONSENT: Charges to credit/debit card on file

Baytree Behavioral Health requires a valid credit card on file for all patients with insurance, co-pays, deductibles, and self-pay patients. This is due to a high incidence of unreported deductibles and the fact that insurance may not cover certain services such as marriage counseling, family counseling and sessions lasting longer than 60 minutes.

By paying via credit/debit card, you acknowledge and agree that this credit card information will be kept on file to be charged for all services that are deemed to be the legal patient's responsibility. These amounts typically include co-pays, co-insurance, and deductibles that have not yet been met or were quoted incorrectly by the insurance company.

Co-pays or any anticipated expenses will be charged to the card on file at the time of the appointment. If the appointment is outside of typical office hours the card will be charged on the next available business day.

In the event that your insurance company notifies us of additional changes, we will notify you of the amount due and, unless other arrangements are made, we will charge the balance due the following business day.

By signing my name below, I authorize Baytree Behavioral Health to keep my credit card on file and to charge my credit card an amount not to exceed $250.00 (if applicable) without my verbal consent. Receipts will be supplied upon request. I have the right to request my credit card be removed via written or verbal request.

THIS AUTHORIZATION EXPIRES 6 MONTHS FROM THE DATE OF OUR FINAL APPOINTMENT.

[ ] I accept

____ _________________________

(Patient Signature) (Date)