HARMONY UNITED PSYCHIATRIC CARE

NEW CLIENT (PATIENT) INFORMATION

Client Information

Last Name : _____

First Name : _____

Date of Birth : _____

Sex: Male Female Other: _____

Marital Status : _____

Race: _____

Ethnicity: _____

Social Security Number: _____

Street Address: _____

City: _____ State:_____ Zip:_____

Cell (Required) : _____ Home Phone : _____

Email :_____

Emergency Contact Information

Name: _____ Relationship: _____

Cell Phone: _____

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Phone: (352) 431-3940 | **Fax:** (352) 431-3173 | **www.hupcfl.com**

Reference Information

How did you hear about us?

Physician Referral _____

Insurance Referral _____

Friend / Personal Referral _____

Google _____

Facebook _____

Other Social media sites _____

Physician directories _____

Print Media (newspaper, magazine) _____

Insurance Information

Primary : _____ **Policy #** _____

Subscriber : _____ Relationship to Client: _____

Date of Birth :_____

Employer of Policy Holder:_____

Secondary Insurance Policy: _____

Policy Number: _____

Subscriber : _____ Relationship to Client: _____

Employer of Policy Holder: _____

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Primary Care Physician Information

Primary Care Physician: _____

Phone:_____ Fax: _____

Address: _____

City:_____ State: _____ Zip: _____

Pharmacy Information

Pharmacy Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Medication List (medications you are currently taking):

Name of Medication	Dosage	Frequency
(Zoloft, Lisinopril)	(50mg or 10ml)	(once a day, twice a day, etc.)

_____

_____

_____

_____

_____

_____

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Acknowledgement of Receipt of Office Policies

I have received a copy of and read the Office Policies and I am aware of the service charges that I will incur for appointments that are missed or appointments that are cancelled less than 24 hours before a scheduled appointment OR less than 48 hours (or 2 business days) prior to a scheduled Neuropsychological Testing appointment.

I understand that failure to comply with these policies may result in termination of my care. I understand and accept that these policies are subject to change from time to time. It is my responsibility to obtain the most up to date office policies and/or to make myself aware of the current policies in the lobby area of offices of Harmony United Psychiatric Care.

I understand and accept the Office Policies. Furthermore, I also accept that I will make myself aware of updates to office policies in the future.

Initial: _____

Acknowledgement of Receipt/Location of Notice of Privacy Practices

I acknowledge that I have read the Provider's Notice of Privacy Practices and I have been made aware of the availability of notice in the offices of Harmony United Psychiatric Care.

I understand and accept the acknowledgement of receipt of notice of Provider's Notice of Privacy Practices.

Initial: _____

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Release of Information for Emergency Purposes

I give my consent to Harmony United Psychiatric Care to release information on an emergency basis only to the following people.

If you do not agree to this Release of Information for Emergency Purposes, please initial here: _____

Please print the full legal name and relationship to you.

1. _____ _____
   Print Full Name Relationship

   _____ _____
   Cell Phone Number Email

2. _____ _____
   Print Full Name Relationship

   _____ _____
   Cell Phone Number Email

I understand and consent to this Release of Information for Emergency Purposes to the above stated individuals.

Initials: _____

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Consent for Treatment/Medication

I, _____the Client/Patient have been informed by my healthcare Provider(s) at **Harmony United Psychiatric Care** that I need psychiatric treatment and/or psychotropic medications. It has been recommended that I receive psychotherapy/counseling and/or conjoint psychotherapy along with medication management for the treatment of my illness. I understand that I may not be compelled to take prescribed medications and that I may decide to stop taking medications at any time. I also understand that I have the right to terminate my treatment with my providers at **Harmony United Psychiatric Care** at any time I choose to do so by stating my decision in writing.

I understand that it is my responsibility to inform my healthcare provider(s) of my medical and psychiatric background. I understand that refusal to abide by prescribed treatment (e.g.: not taking or overtaking prescribed medications, missing or rescheduling appointments repeatedly, etc.) is a basis for termination of care due to noncompliance. I also understand that although the healthcare provider(s) at **Harmony United Psychiatric Care** believe this treatment will be of benefit to me, there is no guarantee as to the results that may be expected.

With this understanding, I authorize my healthcare provider(s) at **Harmony United Psychiatric Care** to render the necessary psychiatric services as deemed advisable, including but not limited to psychiatric medication management, psychotherapy/counseling, neuropsychological testing, etc. I also consent to take psychotropic medications prescribed to me and I will discuss the side effects of the medications prescribed to me with the healthcare provider.

I understand and consent for Treatment/Medication.

Initials: _____

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Consent for Telehealth

Telehealth technology is currently being utilized to provide health care services nationally and in Florida. Telehealth technology can enable real-time communication between patients and health care providers using live video conferencing; and, can securely store-and-forward clinical data to offsite locations for evaluation by health care providers.

The United States Department of Health and Human Services notes that Telehealth is not a type of health care service but is rather a means or method used to deliver health care services.

As with in-office visits, I understand that I am expected to abide by the treatment prescribed by my providers at **Harmony United Psychiatric Care**. I understand that my refusal to abide by the prescribed treatment (e.g.: not taking or overtaking prescribed medications, missing or rescheduling telehealth appointments repeatedly, etc.) delivered through Telehealth technology is a basis for termination of my care due to noncompliance. I also understand that although the healthcare providers at **Harmony United Psychiatric Care** believe this treatment will be of benefit to me, there is no guarantee as to the results that may be expected.

With these understandings, I authorize my healthcare provider(s) at **Harmony United Psychiatric Care** to render the necessary psychiatric services through Telehealth technology, including but not limited to psychiatric medication management, psychotherapy/ counseling, etc. Further, I agree that this Consent does not supersede or replace my Consent for Treatment for in-office services.

I, _____the Client/Patient, consent to have my treatment delivered through Telehealth technology**. If I elect to not sign this Consent, I will not be eligible to receive my treatment via Telehealth technology.**

Sign: _____ Date:_____

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Consent for Insurance Filing

Insurance Release: I authorize (1) the release of any information my Provider may feel necessary to process my insurance claims, (2) I authorize payment of benefits directly to my Provider of services, (3) I fully understand that I am responsible for any portion of my bill not covered by my insurance company including but not limited to co-payments, deductibles, etc.

I understand and consent for insurance filing.

Initials: _____

Consent to Receive Marketing Information From Harmony United Psychiatric Care

I consent to receive information (including unsolicited marketing information) from Harmony United Psychiatric Care about new products or services, or general medical information.

I consent to receive information via my (please check):

Email: _____

Text to my Cell Phone: _____

Direct Mail: _____

I understand I may opt-out of this Consent at any time by notifying Harmony United Psychiatric Care.

Initial: _____

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Consent to Receive Communications

From Harmony United Psychiatric Care

I consent to receive communications from Harmony United Psychiatric Care regarding my upcoming appointments.

I consent to receive information via my (please check):

Email: _____

Text to my Cell Phone _____

Phone call: _____

Initial here: _____

Acknowledgement

I acknowledge that I have read, fully understand, and accept the above documents.

_____ _____

Signature of the Client / Patient Date

_____

Print Name

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New Patient Questionnaire

All Answers Are Confidential!

PLEASE COMPLETE THE PHQ-9 FORM AT THE END OF THIS PACKAGE.

What is the reason for your visit to the clinic? [Chief Complaint(s)]

_____

_____

_____

_____

Have you ever had any Psychiatric admissions to an inpatient unit? Yes / No

If yes, then, how many total admissions? (e.g.: 1, 2, 5, or more than 5): _____

Last Admission (e.g. in Nov 2015, Jan 2010 or just 2015 or 2010):

_____

Past suicide attempts? Yes / No

If yes, then, How many suicide attempts (actual harm to self not just thoughts) _____

Last suicide attempt and method of suicide attempt (e.g. Nov 2015, overdose on medication):

_____

Have you in the past or are currently seeing a psychiatrist or therapist? Yes _____ No _____
(e.g. "Was seeing a psychiatrist 'Dr. Clark' for 3 years, last saw 1 year ago, was seeing a therapist Mr. John Doe, or I am currently seeing a psychiatrist 'Dr. Johnson' for 5 years")

_____

_____

Current or past treatment for substance abuse? Inpatient or Outpatient detox/ rehab:

_____

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Your Medical Problems: (Medical Diagnoses)

_____

_____

_____

_____

_____

Your Psychiatric Problems: (Mental Health Diagnoses)

_____

_____

_____

_____

_____

Allergies to Medication(s) or Non-Medication (food, pollen, etc.):

_____

_____

_____

How was your growth and development as compared to your peers as a child?

- ☐ Normal
- ☐ Abnormal

If Abnormal, please explain:_____

_____

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Where were you born and raised? : _____

Who raised you as a child? : _____

In one word, how would you describe your childhood experience?

GOOD BAD TRAUMATIC PLEASANT UNPLEASANT DIFFICULT FAIR

PLEASE SPECIFY:_____

_____

Have you ever been abused? No / Yes

PHYSICAL _____ SEXUAL _____ EMOTIONAL _____

IF YES, PLEASE SPECIFY:

_____

_____

_____

What is your highest completed level of education: _____

Employment status:

EMPLOYED _____ UNEMPLOYED _____ DISABLED _____ RETIRED _____

If employed, please specify your profession:

_____

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Sexual Orientation:

Heterosexual _____ Homosexual _____ Bisexual _____ Other**:** _____

Marital Status:

MARRIED WIDOWED SINGLE IN A RELATIONSHIP DIVORCED SEPARATED

How many children? _____

Who do you live with OR lives with you? _____

How do you support yourself financially? _____

Who do you consider as your emotional support? _____

Are you <u>currently</u> using any illicit drugs or Alcohol? Yes / No

ALCOHOL ___COCAINE _____MARIJUANA _____HEROIN_____ OTHER_____

If yes, please specify the quantity, frequency and how long you have been using drug(s) / Alcohol.
(ex: *5-6 beers, daily, for 20 years*)

_____

_____

Have you in the ***<u>past</u>*** used any illicit drugs or abused alcohol? Yes _____ No _____

If yes, please specify:

_____

_____

Are you a Tobacco or Tobacco product user? Yes _____ No _____

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Does anyone in your immediate family (e.g.: father/mother/siblings) have a history of mental illness, suicide (attempted or completed), or substance abuse? Please Specify:

_____

_____

Any arrests or incarcerations? When and Why?

_____

_____

Currently on probation or parole? If yes, specify the duration for probation/parole.

_____

Have you served in the military? No_____ Yes _____

If yes, then number of years served: _____

Type of discharge: _____

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Financial Agreement

1. FINANCIAL AGREEMENT

The undersigned agrees as the agent of, or as Patient, that in consideration of the services to be rendered to the patient, he or she individually obligates himself or herself to pay the account of Harmony United Healthcare and Research, P.A. d/b/a Harmony United Psychiatric Care ("Harmony") in accordance with the regular rates and terms of Harmony. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the current FL legal rate of 9.0%.

2. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes as the agent of, or as Patient, direct payment to Harmony of any insurance benefits otherwise payable to or on behalf of the Patient for this treatment, including emergency services if rendered, at a rate not to exceed the Harmony's regular charges. It is agreed that payment to Harmony, pursuant to this authorization, by an insurance company shall discharge such company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he or she is financially responsible for charges not covered by the assignment.

3. HEALTH CARE SERVICE PLAN OBLIGATION

Harmony maintains a list of health service plans with which it has contracted. A list of such plans is available on request. Harmony has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he or she is individually obligated to pay the full costs of all services rendered to him or her by Harmony if he or she belongs to a plan which does not appear on the above-mentioned list.

Please read and respond to the following statements regarding advance directives (durable power of attorney for health care or living will):

Please Confirm:

☐ I have received information about my right to make decisions regarding my medical treatment, my right to formulate advance directives in the case of my subsequent incompetency, and Harmony's policies on the implementation of these rights.

Do you have an Advance Directive for healthcare or Durable Power of Attorney for Healthcare or Living Will?

☐ Yes
☐ No

Has Harmony received a copy of your Advance Directive prior to this visit?

☐ Yes
☐ No

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If Harmony has not received a copy of my Advance Directive for healthcare or Durable Power of Attorney for Healthcare or Living Will, I understand it is my responsibility to present a current copy on each visit.

THE UNDERSIGNED (THE PATIENT) CERTIFIES THAT I HAVE READ THE ABOVE PROVISIONS OF THIS AGREEMENT, RECEIVED A COPY OF THIS AGREEMENT, AND I AM DULY AUTHORIZED TO EXECUTE THE ABOVE AGREEMENT AND TO ACCEPT ITS TERMS.

Date : _____

Time :_____

Patient Name :_____

SSN :_____

Signature :_____

In the presence of:

Witness Signature : _____

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT, OR THE PATIENT'S LEGAL REPRESENTATIVE:

I agree to accept financial responsibility for services rendered to the Patient and to accept the terms of the Financial Agreement, assignment of insurance benefits, and health care service plan obligation provisions (SECTIONS ONE, TWO, and THREE, respectively) of the above agreement.

Responsible Party/Guarantor : _____

SSN :_____

Signature : _____

In the presence of : _____
Print Name

Witness Signature : _____

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Office Policies - Effective March 16, 2020

New Client Appointments: There is a $100 fee charged for missed appointments or cancellations that occur less than 24 hours (or 1 business day) prior to the set appointment time.*

This fee must be paid, or an acceptable payment arrangement must be made prior to scheduling another appointment. The payment arrangement will be determined on a Client by Client basis. Failure or Refusal to pay will result in termination of care.

Established Client Appointments: There is a $50 fee charged for missed appointments or cancellations less than 24 hours (or 1 business day) prior to set appointment time.*

This must be paid, or an acceptable payment arrangement must be made prior to scheduling another appointment. The payment arrangement will be determined on a client to client basis. Failure or Refusal to pay will result in termination of care.

Please note: The No-Show fee for Neuropsychological testing is different from these appointments. Please refer to NEUROPSYCHOLOGICAL TESTING missed appointment charges listed below.

Please know that we value you as a client to our practice, and we have set aside a specific appointment just for you. While we understand that situations occur which may prohibit you from making it to your scheduled appointment, please know that there is still a cost incurred by our practice even when you don't make it to your scheduled appointment. There is a loss of time for the provider you were going to see, along with the continuation of maintaining staff and building maintenance/utilities. For this reason, we have a missed/cancellation fee in place as part of our office policy directives.

No Walk-In-Visits: If you have missed or failed to schedule a return visit you will not be seen as a Walk-In patient. Due to the high volume of patients, as well as the inconvenience this may cause other patients that are already scheduled, we are unable to accommodate clients that just walk into the office. Therefore, we request that you schedule an appointment with the Provider you would like to see.

In case of an emergency please CALL 911 or go to the nearest Emergency Room available to you.

Prescription Refills: Prescription refills or requests must have a follow up appointment. You are responsible to keep track of your medications and request refills during your scheduled appointment with the Provider.

Controlled Medications: (Narcotics/Benzodiazepines/Stimulants/Hypnotics): If you are prescribed a controlled substance and you misplace the written prescription and/or the medication itself, you will not be given another prescription until you are due. It is your responsibility to keep medications in a safe place. If you take more than you are prescribed, and you do not discuss this matter with the physician/ARNP/PA, you will not be granted an early refill without an appointment. If it is found that your prescribed medication is being abused this could result in immediate termination of care. The state of Florida follows all controlled substance medications in a secure website called **E-FORCSE**. Harmony United Psychiatric Care does check

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on patients to see what controlled substances are prescribed. If it is found that you are being prescribed the same controlled medication from another provider this will be cause for termination of care.

Paperwork: Forms for Disability, FMLA and other paperwork that need to be completed by our office will have a fee of $50.00 to $250.00 depending on the complexity and time required to complete the paperwork. These services are not covered by insurance. Therefore, Florida Statutes permits imposing a fee for these types of services to be fulfilled. This fee must be paid by you prior to completion of the paperwork.

Insurance: It is your responsibility to know your insurance coverage. All services rendered that are not covered by the insurance will be your responsibility for payment in full.

Balance/Payment: Payment is due at the time of service. It is your responsibility to keep their account in good standing. If there is a balance, this should be paid in full or an acceptable payment plan must be made with the Billing Office. The payment plan will be approved on a client by client basis. Failure to keep your account in good standing can result in termination of care.

The Billing Office number is 352-504-0652.

Returned Checks: Returned checks will result in a fee of $35.00, plus the current balance due amount. This must be paid prior to any future appointments being scheduled or an approved payment arrangement must be made with the Billing Office. The payment arrangement will be decided on a client to client basis. Harmony United Psychiatric Care has the right to refuse future checks from those clients.

Medical Records: Medical Records will be released with a completed HIPAA (Health Insurance Portability and Accountability Act) compliant medical record release form. There will be a fee charged for paper or electronic copies of medical records provided directly to the patient or to governmental or non-governmental entities. Fees will be charged as below:

- Records requested by someone other than the patient (Non-Governmental): Records will be charged $1.00 per page; Sales Tax and Actual Postage will be charged additionally.
- Records requested by the patient or governmental entities: Records will be charged $1.00 per page for the first 25 pages. For each page in excess of 25 pages, there will be a charge of $0.25 per page. The cost of reproducing non-written records such as X-Rays will be charged at the actual cost to make the reproduction.
- There is no charge for medical records that are being sent to a healthcare provider when arranging transition of care or related to communications between healthcare providers.

Phone Visits or Provider Call Back Services:

Telephone communication with our office staff regarding any aspect of your care (insurance, billing, medication refills, questions related to side effects of medications, prior authorization requests, medical records, any other paperwork request, etc.) is free of charge. In most cases when our office staff needs to communicate with your healthcare provider in our practice to get answers to your questions we typically do not charge for these services.

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However, if you are an established client of our practice and you (or your family members) would like to request to speak with the provider over the phone directly to discuss your mental health condition, discuss your medications, to seek medical advice, or discussion about any aspect of your care, then these phone services are billable provider time.

For Clients with Insurance: You phone services will be billed to your insurance carrier. Please be aware that if you have any co-pay, coinsurance, or deductible with your insurance plan then it will be applicable to these phone visits in a similar fashion as they would to your regular office visit.

For Self -Pay Clients: There will be a charge for every returned call by provider, billed at a rate of $25.00 (twenty-five) for 5 mins. These calls will be billed in increments of 5 minutes.

Clients without insurance coverage must pay a "self-pay" fee at the time of service. Also, a $100 deposit will be collected before your first visit is scheduled that can be refunded at the end of your treatments if your balance is paid.

The fee schedule for self-pay clients is as follows:

Medication Management:

• New Client - initial psychiatric evaluation for medication management - $300

• Established Client- Follow Up Appointments - $150 per visit.

Psychotherapy/Counseling: Including: Individual and Couples/Marriage Counseling

• New Clients - Initial psychiatric evaluation for psychotherapy/counseling is $200.

• Established Clients – Follow-Up Psychotherapy Appointments - $150 per session.

• For Marriage/Couples counseling - the first visit with the therapist must be individual sessions for each client and then follow up visits will include both clients seeing the therapist as a couple during the same session.

NEUROPSYCHOLOGICAL TESTING:
Testing for ADHD/Dementia/TBI/Autism Spectrum Disorder, etc.

The Evaluation will be conducted in two to three parts. The Initial Appointment will take up to three (3) hours. The follow-up appointment will be for two (2) hours for test interpretation and any additional follow-up visit will be scheduled if recommended by the Provider.

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Missed Appointment Policy: There is a $150 fee charged for any New or Follow-Up testing missed appointment or cancellations that occur less than 48 hours (or 2 business days) prior to the set appointment time. The Missed Appointment Fee must be paid, or an acceptable payment arrangement must be made prior to scheduling another appointment. The payment arrangement will be determined on a client by client basis. Failure or refusal to pay the fee will result in termination of care.

Insured Patients

• An Advance Deposit of $200 is required before scheduling your testing appointment, from which $50 will be used to cover the cost of testing materials.

• Any Missed Appointment fees incurred by you will be deducted from the Advanced Deposit.

• Any remaining balance of the Advance Deposit will be refunded to you upon completion of the testing.

Neurocognitive Testing

• The Initial Neurocognitive Test is scheduled in the Clinic office or the test can be sent to you to complete On-line. The charge is $150.00 for one hour (in Clinic testing) and the cost is the same for on-line testing. The cost of testing is not covered by insurance.

The testing result interpretation will be part of your next scheduled follow-up visit, which is billed to your insurance.

Self-Pay Patients

• The Initial Appointment Fee is $150.00.

• The Testing Fee for the Evaluation is $900, which includes up to 6 hours of time for the evaluation, generating the report, and cost of testing materials

However, if additional time is required then it will be billed at $150 per additional hour.

• An Advance Deposit of $300 is required before scheduling your testing appointment. Testing Fees will be applied to the Advance Deposit.

• Any Missed Appointment fees incurred by you will be deducted from the Advanced Deposit.

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HIPAA Privacy Policy

Protecting the privacy and the confidentiality of patient's personal information is important to the providers and staff at Harmony United Psychiatric Care. We strive to provide our patients with excellent care and service. Every member of our staff must abide by our commitment to privacy in the handling of personal information. Our Privacy Policy applies to the personal health information of all patients that is in our possession and control.

What is Personal Health Information or PHI? Personal Health Information means information that identifies an individual relating to his or her physical or health (including medical history), the providing of mental health care to the individual, and payments or eligibility for health care.

Accountability: We take our commitment to securing patient privacy very seriously. Each healthcare provider and employee associated with the practice is responsible for the personal information under his or her control. Our employees are informed about the importance of privacy.

Identifying purposes: We ask and collect information to establish a relationship to serve your mental health needs. We obtain most of your information about you directly from you or from your referring physician whom you have authorized to disclose information. We limit the information we collect to what we need for the purposes of our practice to treat your mental health needs. We will obtain your consent if we wish to use your information for other purposes.

You have the right to determine how your personal health information is used and disclosed. For most healthcare purposes, your consent is implied as a result of your consent to treatment. However, in all circumstances express consent must be written. Your written consent will be forwarded to the Privacy Officer who will document the request in the patient's medical records and notify the appropriate health care providers and their supporting staff.

Personal Health Information permits certain collections, uses, and disclosures of your PHI, despite the consent directive; healthcare providers may override the consent directive in certain circumstances such as emergencies and the consent directive may result in delays in receiving health care.

A. Permitted Disclosures of PHI. We may disclose your PHI for the following reasons:

1. Treatment. We may disclose your PHI to a physician or other health care provider providing treatment to you. For example, we may disclose medical/mental health information about you to physicians, nurses, technicians, or personnel who are involved with the administration of your care.
2. Payment. We may disclose your PHI to bill and collect payment for the services we provide to you. For example, we may send a bill to you or to a third-party payer for the rendering of services by us. The bill may contain information that identifies you, your diagnosis and procedures and supplies used. We may need to disclose this information to insurance companies to establish insurance eligibility benefits for you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

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3. Health Care Operations. We may disclose your PHI in connection with our health care operations. Health care operations include quality assessment activities, reviewing the competence or qualifications of health care professionals, evaluating provider performance, and other business operations. For example, we may use your PHI to evaluate the performance of the health care services you received. We may also provide your PHI to accountants, attorneys, consultants and others to make sure we comply with the laws that govern us.

4. Emergency Treatment. We may disclose your PHI if you require emergency treatment or are unable to communicate with us.
5. Family and Friends. We may disclose your PHI to a family member, friend, or any other person who you identify as being involved with your care or payment for care, unless you object.
6. Required by Law. We may disclose your PHI for law enforcement purposes and as required by state or federal law. For example, the law may require us to report instances of abuse, neglect or domestic violence; to report certain injuries such as gunshot wounds; or to disclose PHI to assist law enforcement in locating a suspect, fugitive, material witness or missing person. We will inform you or your representative if we disclose your PHI because we believe you are a victim of abuse, neglect or domestic violence, unless we determine that informing you or your representative would place you at risk. In addition, we must provide PHI to comply with an order in a legal or administrative proceeding. Finally, we may be required to provide PHI in response to a subpoena discovery request or other lawful process, but only if efforts have been made, by us or the requesting party, to contact you about the request or to obtain an order to protect the requested PHI.
7. Serious Threat to Health or Safety. We may disclose your PHI if we believe it is necessary to avoid a serious threat to the health and safety of you or the public.
8. Public Health. We may disclose your PHI to public health or other authorities charged with preventing or controlling disease, injury, disability, or charged with collecting public health data.
9. Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These activities include audits; civil, administrative, or criminal investigations or proceedings; inspections; licensure or disciplinary actions; or other activities necessary for oversight of the health care system, government programs and compliance with civil rights laws.
10. Research. We may disclose your PHI for certain research purposes, but only if we have protections and protocols in place to ensure the privacy of your PHI.
11. Workers' Compensation. We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs.
12. Specialized Government Activities. If you are active military or a veteran, we may disclose your PHI as required by military command authorities. We may also be required to disclose PHI to authorized federal officials for the conduct of intelligence or other national security activities.
13. Organ Donation. If you are an organ donor or have not indicated that you do not wish to be a donor, we may disclose your PHI to organ procurement organizations to facilitate organ, eye or tissue donation and transplantation.

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14. Coroners, Medical Examiners, Funeral Directors. We may disclose your PHI to coroners or medical examiners for the purposes of identifying a deceased person or determining the cause of death, and to funeral directors as necessary to carry out their duties.
15. Disaster Relief. Unless you object, we may disclose your PHI to a governmental agency or private entity (such as FEMA or Red Cross) assisting with disaster relief efforts or National Emergency.

B. Disclosures Requiring Written Authorization.

1. Not Otherwise Permitted. In any other situation not described in Section A above, we may not disclose your PHI without your written authorization.
2. Psychotherapy Notes. We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment, or health care operations activities.
3. Marketing and Sale of PHI. We must receive your written authorization for any disclosure of PHI for marketing purposes or for any disclosure which is a sale of PHI.

C. Your Rights.

1. Right to Receive a Paper Copy of This Notice. You have the right to receive a paper copy of this Notice upon request.
2. Right to Access PHI. You have the right to inspect and copy your PHI for as long as we maintain your medical record. You must make a written request for access to the Privacy Officer at the address listed at the end of this Notice. We may charge you a reasonable fee for the processing of your request and the copying of your medical record pursuant to Chapter 456, Florida Statutes. In certain circumstances we may deny your request to access your PHI, and you may request that we reconsider our denial. Depending on the reason for the denial, another licensed health care professional chosen by us may review your request and the denial.
3. Right to Request Restrictions. You have the right to request a restriction on the use or disclosure of your PHI for the purpose of treatment, payment, or health care operations, except in the case of an emergency. You also have the right to request a restriction on the information we disclose to a family member or friend who is involved with your care or the payment of your care. However, we are not legally required to agree to such a restriction.
4. Right to Restrict Disclosure for Services Paid by You in Full. You have the right to restrict the disclosure of your PHI to a health plan if the PHI pertains to health care services for which you paid in full directly to us.
5. Right to Request Amendment. You have the right to request that we amend your PHI if you believe it is incorrect or incomplete, for as long as we maintain your medical record. We may deny your request to amend if (a) we did not create the PHI, (b) is not information that we maintain, (c) is not information that you are permitted to inspect or copy (such as psychotherapy notes), or (d) we determine that the PHI is accurate and complete.

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6. Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of PHI made by us (other than those made for treatment, payment, or health care operations purposes) during the 6 years prior to the date of your request. You must make a written request for an accounting, specifying the time period for the accounting, to the Privacy Officer at the address listed at the end of this Notice.
7. Right to Confidential Communications. You have the right to request that we communicate with you about your PHI by certain means or at certain locations. For example, you may specify that we call you only at your home phone number, and not at your work number. You must make a written request, specifying how and where we may contact you, to the Privacy Officer at the address listed at the end of this Notice.
8. Right to Notice of Breach. You have the right to be notified if we or one of our business associates become aware of a breach of your unsecured PHI.

D. Changes to this Notice.

We reserve the right to change this Notice at any time in accordance with applicable law. Prior to a substantial change to this Notice related to the uses or disclosures of your PHI, your rights or our duties, we will revise and distribute this Notice.

E. Acknowledgment of Receipt of Notice.

We will ask you to sign an acknowledgment that you received this Notice.

F. Questions and Complaints.

If you would like more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding the use, disclosure, or access to your PHI, you may submit a complaint to us by contacting the Privacy Officer at the address and phone number at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

Limiting Collection: We collect information by fair and lawful means and collect only that information which may be necessary for the purposes related to the provision of your medical care. Under no circumstances do we sell patient lists or other personal information to third parties. There are some types of disclosure of your PHI that may occur as a part of this practice fulfilling its routing obligations and practice management. This includes consultants and suppliers to the practice, on the understanding that they abide by our privacy policy, and only to the extent necessary to allow them to provide business services or support this practice.

We will retain your information only for the time it is required for the purposes we describe and once your personal information is no longer required, it will be destroyed. However due to our ongoing exposure to potential claims, some information is kept for a longer period of time.

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Safeguards: We protect your information with appropriate safeguards and security measures. The practice maintains personal information in a combination of paper and electronic files. Recent paper records concerning individual's personal information are secured and kept on site at our office.

Access to personal information will be authorized only for the healthcare providers and employees associated with the practice and other agents who require access in the performance of their duties, and otherwise authorized by law. We provide information to health care providers acting on your behalf, understanding that they are also bound by law and ethics to safeguard your privacy.

Our computer systems and electronic medical records are password secured and constructed in such a way that only authorized individuals can access secure systems and databases. All our employees use HIPAA compliant email which is encrypted. However, sending emails to the office via email server that is not HIPAA Compliant is not secure against interception. Our practice does not encourage email communication of sensitive information if you do not use encrypted or HIPAA compliant email service. We request that you call the office with any requests, problems, or information. If you have any additional questions or concerns about privacy, we invite you to contact us by phone and we will address your concerns to the best of our ability.

Access to correction with limited exceptions: We will give you access to the information we retain about you within a reasonable time, upon presentation of a written request and satisfactory identification. We may charge you a fee for this service and if so, we will give you notice in advance of processing your request. If you find errors of fact in your personal health information, please notify us as soon as possible and we will make the appropriate corrections. We are not required to correct the information relating to clinical observations or opinions made in good faith. You have a right to append a short statement of disagreement to your record if we refuse to make a requested change. If we deny your request for access to your personal information, we will advise you in writing of the reason for the refusal and then you may challenge our decision.

We encourage you to contact us with any questions or concerns you might have about your privacy. We will investigate and respond to your concerns about any aspect of handling your information.

HIPAA Privacy Policy

Harmony United Psychiatric Care
301 Skyline Drive Suite 4
Lady Lake, FL 32159

Release of Medical Records / Client Information

I, _____ Date of Birth: _____ do hereby authorize

Harmony United Psychiatric Care to: Release _____ Obtain _____ the following information pertaining to myself:

___ Ongoing comprehensive treatment coordination.
(including history and physical, progress notes, all labs/Imaging, etc.)

___ Presence in treatment, including admission and discharge dates.

___ Diagnosis, brief progress notes and prognosis.

___ Psychological Assessment, Psychotherapy Notes.

___ Psychiatric evaluations and management.

___ Substance Abuse evaluation and treatment.

___ Other: _____

This information may be: Released to _____ Obtained from _____ Physician/Company/ Hospital/ Person

Name :_____

Address: _____

Phone : _____

Fax :_____

This information is being requested for the following:

___ To coordinate with other healthcare providers.

___ To provide on-going treatment.

___ To enable judges, attorneys, probation/parole officers to support treatment goals and/or to make informed legal decisions

___ To coordinate treatment efforts with my family/concerned persons.

___ To coordinate treatment and continuing care efforts with my employer.

___ To obtain insurance, employment, or government benefits.

___ For emergency purposes, ONLY.

___ Other _____

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Release of Medical Records/Client Information ***Continued***

If submitting patient records via mail to Harmony United Psychiatric Care, please send to:
301 Skyline Drive Suite 4
Lady Lake, FL 32159

If submitting electronically, send to:
FAX:(352) 431-3173 or EMAIL: info@hupcfl.com

NOTE: When substance abuse or dependency issues are relevant in Client's medical records, I understand that the Release of Medical Records/Client Information has been disclosed from records whose confidentiality is protected by Federal Law.

Federal regulations (42CFR part 2) prohibit any further disclosure without specific written consent of the person it concerns. A general authorization for the release of medical or other information is not enough for this purpose.

This authorization shall remain in effect until:

___ Further notice of closing of a case

___ Specific: Start Date: _____ to Expiration Date: _____

___ Specific Event_____

I do voluntarily for the purpose(s) specified above, have the right to revoke this authorization, in writing, at any time. However, this revocation will not be effective to the extent that action has already been taken in compliance of my consent or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used, disclosed, or obtained pursuant to the authorization may be subjected to re-disclosure by the recipient to your information and no longer protected by the HIPAA privacy rule.

By signing this form, I authorize the use and disclosure of my health information in the manner described on the **"Release of Medical Records/ Client Information"** page. I have signed this form voluntarily in order to document my wishes regarding the use and disclosure of my health records.

_____ _____
Signature of the Client Date

_____
Print Name

_____ _____
Signature of Witness Date

_____
Print Name

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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
☐	☐	☐	☐

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