Harmony United Psychiatric Care

HARMONY UNITIED PSYCHIATRIC CARE NEW CLIENT INFORMATION

If Client is a minor or adult who is unable to consent then the consents, acknowledgements, and financial agreement must be initialed/signed by the parent or legal representative.

Client Information

Last Name: ________________________________ **First Name:** __________________________ **Middle Initial:** ________________

Gender: M F Other: ______________ **D.O.B.** : _______/______/ _______ **S.S.N.** ________-______-__________

Marital Status: M S Other: ____________ **Sexual Orientation:** Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other:___________

Race: American Indian/ Alaska Native | Asian | African American/ Black | Hawaiian/ Pacific Islander | White/ Hispanic | Decline _____ Other: _________________

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Other: _______________ Decline: _________

FL Address: ____**City:** _________________ **Zip:**_________

Cell (Required): ______________________ **Cell Phone Service Provider (Required):** ____________________

Home Phone: _______________________

Alt. Address: ________________________________ **City:** _______________________ **ST:**_________ **Zip:**___________

Email :____

Emergency Contact Information

1. Name: ___________________________________ **Relationship:** _______________ **Cell/Home Phone:** ___________________________

2. Name: ___________________________________ **Relationship:** _______________ **Cell/Home Phone:**___________________________

Pharmacy

Pharmacy Name: _________________________________ **Phone:** ________________

Address: ____ **City:** _________________ **ST:**____ **Zip:**___________________

Insurance Information

Primary Policy: _______________________**Policy#** _______________________________ Subscriber: ______________________________

D.O.B. :___/_____/____ Employer of Policy Holder:______________________________ Relationship to Client: _____________________

Secondary Insurance Policy (if applicable) : ____

Policy Number: ____

Subscriber: __________________________ Relationship to Client: _______________

Employer of this Policy Holder: ____

Primary Care Physician: ____

Phone:_______________________________________ Fax: ____

Address: ____________________________________ City:____________________ ST: _____ Zip: _________

How did you hear about us?

☐ Physician (name) __________________________ ☐ Insurance (name) __________________________

☐ Friend ☐ Facebook ☐ Google ☐ Other Social media sites _____________________

☐ Physician Directory? (Name) ___________________ ☐ Print? (newspaper, magazine) ____________________

Harmony United Psychiatric Care

New Patient Questionnaire

DRUG ALLERGIES:	Penicillin	Sulfa	Macrolides	Cephalosporin	Tetracyclines	NSAIDS
OTHERS (Specify):						

CHIEF COMPLAINT

PSYCHIATRIC HISTORY

Condition	Check what applies to you	Condition	Check what applies to you
Major Depressive Disorder		Schizophrenia	
Generalized Anxiety Disorder		Schizoaffective Disorder	
Panic Disorder		Autism	
Bipolar Disorder		Social Anxiety	
PTSD		Alcohol Dependence	
ADHD		Other:	

Previously Psychiatric Medications: ______________________________

Previous Psychiatric Behavior: Aggression ☐ **Intentional Self Injury** ☐ **Sexual Aggression** ☐

Psychiatric Inpatient Unit Admissions? Y ☐ **N** ☐ **If Yes, how many total Admissions?** ______________

Date of Last Admission: ______________________

Have you in the past or are currently receiving outpatient mental health treatment? Y ☐ **N** ☐

If Yes, specify your care provider:______________________________

Any Actual Suicide Attempts? (Not just thoughts) Y☐ **N** ☐ **If Yes, how many?** ______________

If Yes, when was your last suicide attempt? Date: ______________________

Method? (Describe) ______________________________

Substance Abuse (Inpatient/Outpatient) Treatment: ______________________________

Harmony United Psychiatric Care

MEDICAL HISTORY

Condition	Check what applies to you	Condition	Check what applies to you
Diabetes		Hypertension	
Renal Disease (Kidney Disease)		High Cholesterol	
COPD, Bronchitis, Emphysema or Asthma		Hypothyroidism (low thyroid)	
Coronary Artery Disease/ Heart attack		Depression or Anxiety	
CHF (Heart Failure)		GERD or peptic ulcers	
Pacemaker/ Defibrillator		Cirrhosis or Hepatitis	
A-Fib or Mechanical Valve(type):		Rheumatoid Arthritis	
PVD, PAD, or DVT		Gout or Osteoarthritis	
Stable chest pain (using Nitro)		Erectile Dysfunction or BPH	
Stroke or TIA		Sleep Apnea	
Seizure, Parkinson Disease, Epilepsy		Cataracts or Glaucoma	
Dementia or Alzheimer Disease		Cancer:	
History of STD's		Other:	
Other:		Other:	

Medications, Vitamins and Herbal Supplements

Medication Name	Strength (Mg)	Number of pills taken & frequency	Medication Name	Strength (Mg)	Number of pills taken & frequency

*If you have additional medications, please provide a separate list of your current medications along with this document.

Vitals: BP Systolic:______, BP Dyastolic: _______, Pulse:_______, Height (In Inches): _________, Weight (in lbs): __________

Harmony United Psychiatric Care

PSYCHOSOCIAL HISTORY

Your Birth Order: ____

Who raised you as a child? ____

Describe Your Childhood Experience: Normal ☐ Abusive ☐ Dysfunctional ☐ Rough ☐

Have You Ever Been Abused? No ☐ Yes ☐

If Yes: Domestic Violence ☐ Emotional Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐

Highest level of Completed Education ______________________

Employment Status: Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐

If Employed, please state profession: ___________________________________

Marital Status: Married ☐ Widowed ☐ Single ☐ In a Relationship ☐ Divorced ☐ Separated ☐

Who do you live with or lives with you? ____

Housing Status: Rental Home ☐ Home Owner ☐ Other ☐ _________________________________

How do you support yourself financially? ____

SUBSTANCE ABUSE HISTORY

ILLICIT DRUG USE (Check Box if Applies)

Never Used Illicit Drugs ☐

Former Illicit Drug User ☐ Date Quit: ___________________

Currently Using Marijuana ☐ Former Marijuana User ☐

Currently Using Illegal Drugs: Cocaine ☐ Heroin ☐ Other(s)________________________________

If currently using drugs, specify for each drug use individually:

	Name	Quantity	Route of Administration	Frequency of Use
1				
2				
3				
4				
5				

TOBACCO PRODUCTS

Never Smoked ☐

Former Smoker ☐ Date Stopped: __________

Heavy Smoker > 10/day ☐

Light Smoker < 10/day> ☐

Current User of E-Cigarettes ☐

Former User of E-Cigarettes ☐ Date Stopped: _______________

Current User of Smokeless Tobacco ☐

Former User of Smokeless Tobacco ☐ Date Stopped: _________

Harmony United Psychiatric Care

ALCOHOL

Never Used Alcohol ☐
Former Alcohol User ☐ Date Stopped: _______________

Current Alcoholic Beverage		*Number of Drinks*	*Frequency of Use*
Beer	☐	______________	______________
Liquor (Type)	☐ __________	______________	______________
Wine	☐	______________	______________
Other (Type)	☐ __________	______________	______________

FAMILY HEALTH HISTORY

Please list below the health history of your blood (genetic) first degree relatives

Relative	Living (L) or Deceased (D)	Type of Mental Illness	Type of Substance Abuse	Death by Suicide
Father:				
Mother:				
Brother(s):				
Sister(s):				
Mother's Father				
Mother's Mother				
Father's Father				
Father's Mother				
Child(ren)				
Other:				
I was Adopted ☐				

LEGAL

Any Arrests? No ☐ Yes ☐ Any Incarcerations? No ☐ Yes ☐
If Yes, When, Why, Duration? ____
Currently on Probation? No ☐ Yes ☐ If Yes, For What & Duration?______________________________
Currently on Parole? No ☐ Yes ☐ If Yes, For What & Duration? ________________________________

MILITARY HISTORY

Have You Served in the Military? N ☐ Y ☐
Branch of Service: ____________________
Duration_____________ Type of Discharge___________________

Harmony United Psychiatric Care

Consent for Release of Information for Emergency Purposes

I consent to Harmony United Psychiatric Care to release information on an emergency basis only to the following people. Please print the full legal name, relationship to you, the Child or the Client and their contact info.

1. ____
Print Full Name Relationship Cell/Home Phone

2. ____
Print Full Name Relationship Cell/Home Phone

____
Print Name of Client/Patient or Parent / Legal Representative

____ ______________
Signature of Client/Patient or Parent/ Legal Representative Date Effective

15544 W. Colonial Drive, Winter Garden, FL 34787
Phone: (352) 431-3940 | **Fax:** (352) 431-3173 | **www.hupcfl.com**

Harmony United Psychiatric Care

Consent for Treatment/Medication

This is a required form that must be completed for service

I, ____am the Client/Patient or Parent/Legal Representative of Client/Patient. I understand that the healthcare Provider(s) at Harmony United Psychiatric Care will discuss my, my child's or my Client's condition and treatment options with me. If I, my Child or my Client require psychiatric treatment and/or psychotropic medications, the Provider(s) will recommend that I, my Child or my Client receive psychotherapy/counseling and/or conjoint psychotherapy along with medication management for the treatment of my, my Child's or my Client's illness. I understand that I, my Child or my Client may not be compelled to take prescribed medications and that I, my child or my Client may decide to stop taking medications at any time. I also understand that I, my child or my Client has the right to terminate treatment with Provider(s) 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, my Child's or my Client's healthcare provider(s) of my, my Child's or my Client's 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 my, my Child's or my Client's healthcare provider(s) at Harmony United Psychiatric Care believe this treatment will be of benefit to me, my Child or my Client, there is no guarantee as to the results that I, my child or my Client may expect.

With this understanding, I authorize my, my Child's or my Client's 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, my Child or my Client also consents to take psychotropic medications prescribed to me, my Child or my Client if necessary, for the treatment of my, my Child's or my Client's mental health condition. The Provider(s) will discuss the risks, benefits and alternatives with me when the medication is prescribed to me, my Child or my Client. I understand and consent for Treatment/Medication.

Consent for Utilizing Surescripts

I also give my consent to retrieve and use my, my Child's or my Client's medication history from Surescripts.

____ ______________________________

Signature of Client/ Patient or Parent/ Legal Representative Date

____

Print Name

Harmony United Psychiatric Care

Consent for Telehealth

This is a required form that must be completed for Telehealth service

Telehealth technology is currently being utilized by Harmony United Psychiatric Care to provide health care services throughout Florida. Telehealth technology enables real-time communication between clients/patients and health care providers using live video conferencing.

As of the effective date below, **I authorize** Harmony United Psychiatric Care to perform health care services via Telehealth, including but not limited to psychiatric medication management, psychotherapy/ counseling, and other services. [**Check here]** ☐

OR

As of the effective date below, **I withdraw my authorization** for Harmony United Psychiatric Care to conduct health care services via Telehealth, including but not limited to psychiatric medication management, psychotherapy/counseling, and other services**. [Check here]** ☐

____
Print Name of Client/Patient or Parent / Legal Representative

____ ________________
Signature of Client/Patient or Parent/ Legal Representative Date Effective

Harmony United Psychiatric Care

Consent for Well iQ Patient Experience Survey

At Harmony United Psychiatric Care, it's important for us to understand your experience so that we can provide you the best patient care possible. By agreeing to this consent, you will receive a text message from our service partner, Well iQ, after each appointment with a link to provide feedback about your experience with Harmony United Psychiatric Care. A quick, interactive survey will let you rate the care and service you received during your patient journey. At the end of each survey, you can enter to win a $25 prize drawing for an Amazon gift card.*

* * * * * * * * * * * * * * * * * *

I hereby give my consent to receive texts from Well iQ for the purposes stated above. I may choose to stop participating at any time by texting the word "STOP" in response to any text message sent by Well iQ. I understand that message and data rates may apply, and that I will receive a maximum of 1 message per visit to share my experience and feedback.

☐ Approve Consent

☐ Decline Consent

____________________________________ ____________________

Signature of Client/ Patient or Parent/ Legal Representative — Date

____

Print Name

*Medicare and other government insurance plans do not qualify for the drawing.

Consent Given to Receive Marketing Information

From Harmony United Psychiatric Care

I consent to receive unsolicited informational and/or marketing materials from Harmony United Psychiatric Care which may include but not limited to information about products, services, general medical information and announcements.

☐ I consent to receive this information via email, text messages to cell phone/home phone and direct mail.

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

_______________________________________ _________________________

Signature of Client/ Patient or Parent/ Legal Representative — Date

____

Print Name

Harmony United Psychiatric Care

Decline to Receive Marketing Information

From Harmony United Psychiatric Care

I decline to receive unsolicited informational and/or marketing materials from Harmony United Psychiatric Care which may include but not limited to information about products, services, general medical information, and announcements.

☐ I have decided to Opt-Out of receiving unsolicited informational and/or marketing materials.

____ ________________________
Signature of Client/ Patient or Parent/ Legal Representative — Date

____
Print Name

Financial Agreement

This is a required form that must be completed for service

1. FINANCIAL AGREEMENT

The undersigned agrees as the Client/Patient or, Parent/Legal Representative acting on behalf of the Client/Patient, that in consideration of the services to be rendered to the Client/Patient, the Client/Patient or, Parent/Legal Representative 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 Client/Patient 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 Client/Patient or Parent/Legal Representative of Client/Patient, to direct payment to Harmony of any insurance benefits otherwise payable to or on behalf of the Client/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 and online. Harmony has no contract express or implied with any plan that does not appear on the list. The undersigned agrees that they are individually obligated to pay the full costs of all services rendered to him or her by Harmony they belong 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):

I the Client/Patient or Parent/Legal Representative of Client/Patient, understand that I have the right to make decisions regarding my/my Child's/my client's medical treatment and I the client/patient have the right to formulate advance directives in the case of my subsequent incompetency.

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

☐ Yes ☐ No

Has Harmony received a copy of your or your Client's Advance Directive prior to this visit?

☐ Yes ☐ No

If Harmony has not received a copy of the 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.

Harmony United Psychiatric Care

THE UNDERSIGNED (THE CLIENT/PATIENT OR PARENT/LEGAL REPRESENTATIVE) 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/Client (Print Name): ____

SSN (Client/Patient): ____

Parent/Legal Representative (Print Name if Applicable): ____

SSN (Parent/Legal Representative if Applicable): ____

Signature: ____

Client/Patient or Parent/Legal Representative

*Please Note! If the Client/Patient is a minor or unable to consent, then this form needs to be signed by a Parent or a Legal Representative.

Harmony United Psychiatric Care

Consent for Insurance Filing

This is a required form that must be completed for service

I authorize (1) release of any information my Provider may feel necessary to process my insurance claims and (2) payment of benefits directly to my Provider of services.

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 provide my consent for insurance filing.

____ _________________

Signature of Client/ Patient or Parent/ Legal Representative Date

Harmony United Psychiatric Care

HIPAA -Privacy Notice Effective 01-04-2021

This is a required form that must be completed for service

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting the privacy and the confidentiality of patient's personal information is important to the providers and staff at Harmony United Psychiatric Care. Every member of our team must abide by our commitment to privacy in the handling of personal information and are informed about the importance of privacy. Our Notice of Privacy Practices applies to the personal health information (PHI) of all patients that is in our possession and control.

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.

You have the right to determine how your personal health information is used and disclosed. For most healthcare purposes, your consent is implied because 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. We will obtain your consent if we wish to use your information for other purposes.

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 to any insurance company or Medicare or its administrators any information needed to process and pay your claims 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.
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. We may also provide your PHI to accountants, attorneys, consultants and others to make sure we comply with the laws that govern us.
   - We may call your cell phone, home phone, or email or text, and leave messages on voicemail or in person in reference to any items that assists Practice in carrying out its Health Care Operations, such as appointment reminders, insurance items and any calls pertaining to your clinical care, including laboratory test results, among others.
   - We may mail to your home or other location designated by you any items that assist the Practice in carrying out Health Care Operations.
   - We may e-mail you to the email address you provided us with for our records. We may email any items that assist the practice in carrying out our Health Care Operations, such as appointment reminders, telehealth links, patient statements, and informational items.

4). We may send our marketing materials to you via US mail, email, text message, cell phone, home phone, or other methods of communications.

5) Emergency Treatment. We may disclose your PHI if you require emergency treatment or are unable to communicate with us.

6) 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.

7) Required by Law. We may disclose your PHI for law enforcement purposes and as required by state or federal law. 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.

8) 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.

9) Public Health. We may disclose your PHI to public health or other authorities charged with preventing or controlling disease, injury or disability, or charged with collecting public health data.
10) Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law.
11) 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.
12) Workers' Compensation. We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs.
13) 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.
14) 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.
15) 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.
16) 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.

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.
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, or you can obtain an updated HIPAA privacy notice on our website or from our office locations.

E. Acknowledgment of Receipt of Notice.

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

Harmony United Psychiatric Care

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.

G. 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 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.

H. 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 secured so only authorized individuals can access these 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.

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 Notice
Harmony United Psychiatric Care
15544 W. Colonial Drive
Winter Garden, FL 34787

(352) 431-3940

I acknowledge that, I have read, understand and accept 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 and on the web site at hupcfl.com. HUPC reserves the right to revise and change its HIPAA Privacy Notice at any time. It is my responsibility to obtain the most up to date HIPAA Privacy Notice and/or to make myself aware of these policies in the lobby area of offices of Harmony United Psychiatric Care, or on-line at hupcfl.com. If I do not agree to this consent or later revoke it, HUPC may decline to provide treatment to me or my Client.

____ _______________________
Signature of Client/ Patient or Parent/ Legal Representative Date

____
Print Name

Office Policies Effective 1-4-2021

This is a required form that must be completed for service

Missed Appointment:
There is a charge for a missed appointments or cancellations that occur less than 24 hours (or 1 business day) prior to the set appointment time. Please know that we value you as a client to our practice, and we have set aside a specific appointment time just for you. While we understand that situations occur which may prohibit you from making it to your scheduled appointment there is still a cost incurred by our practice even when you don't make it to your scheduled appointment. For this reason, we have a missed/cancellation fee in place as part of our office policy directives.

New Client Appointments: $100 fee **Established Client Appointments:** $50 fee

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

No Walk-In-Visits: 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.

Controlled Medications: (Narcotics/Benzodiazepines/Stimulants/Hypnotics): The state of Florida follows all controlled substance medications in a secure website called **E-FORCSE**. Harmony United Psychiatric Care does check 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 Fee: Forms for Disability, FMLA and other paperwork have a processing 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. 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.

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.

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:

- 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.

Harmony United Psychiatric Care

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.

If you 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, these services are billable time.

Clients with Insurance: Your 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.

Self -Pay Clients: Clients without insurance coverage must pay a $100 deposit before your first visit is scheduled that can be refunded at the end of your treatments if your balance is paid. 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.

Medication Management Self-Pay Clients:

- New Client - initial evaluation for medication management - $300
- Established Client- Follow Up Appointments - $150 per visit.

Psychotherapy/Counseling Self-Pay Clients: 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 - the first visit with the therapist must be individual sessions for each client and then follow up visits will include both clients seeing the as a couple during the same session.

IN-PERSON 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.

Missed Appointment Policy: A $150 fee charged for any New or Follow-Up IN-PERSON Neuropsychological testing missed appointment or cancellation that occur less than 48 hours (or 2 business days) prior to the appointment time. There is no missed appointment fee for Online-Neuropsychological Testing.

The Missed Appointment Fee must be paid, or an acceptable payment arrangement must be made prior to scheduling another appointment. 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 charged will be deducted from the Advanced Deposit.
- Any remaining balance of the Advance Deposit will be refunded to you upon completion of the testing.

Self-Pay Patients:

- 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.
- If additional time is required it will be billed at $150 per hour.
- Testing Fee for the Evaluation is $900 and includes up to 6 hours for the evaluation, generating the report, and cost of testing materials

Harmony United Psychiatric Care

ONLINE NEUROCOGNITIVE TESTING
Testing for ADHD/Dementia/TBI/Autism Spectrum Disorder, etc., can be done online on a computer in the clinic office, or it can be emailed to you to be completed at home.

The Initial Appointment will take up to one hour and it is taken on the computer. An email will be mailed to you with a link to the test or you can take the test in the Clinic if you prefer. The follow-up appointment will be one hour for test interpretation and any additional follow-up visit will be scheduled if recommended by the Provider.

- The Initial Neurocognitive Test charge is $150.00 for one hour and is scheduled in the Clinic office or the test can be sent to your email to complete On-line. The cost of testing is not covered by insurance.
- The testing result interpretation will be part of your next scheduled follow-up visit, and if you are a self-pay client, you will be responsible for the follow-up visit fee.

There is no Missed Appointment fee for Online Testing.

I acknowledge that I have read, understand and accept the office policies and I have been made aware of the availability of Office Policies in the offices of Harmony United Psychiatric Care and on the web site at hupcfl.com. HUPC reserves the right to revise and change its Office Policies at any time. It is my responsibility to obtain the most up to date Office Policies and/or to make myself aware of these policies in the lobby area of offices of Harmony United Psychiatric Care, or on-line at hupcfl.com. If I do not agree to this consent or later revoke it, HUPC may decline to provide treatment to me or my Client.

____ ________________________
Signature of Client/ Patient or Parent/ Legal Representative Date

____
Print Name

Harmony United Psychiatric Care

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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.