GULF COAST BEHAVIORAL HEALTH
1938 Soule Road, Clearwater, FL 33759
(727) 726-7442 (727) 288-1111 Fax

CLIENT DATA

Name: _____ Date of birth: _____ Email: _____

Address: _____

City: _____ St: _____ Zip:_____ Phone #:_____

Mobile #: _____ Marital Status: _____ Soc Sec #: _____

Employer/School: _____ Employment/Student Status: _____

Spouse/Partner: _____ Employer: _____

ER Contact Name: _____ ER Contact Phone: _____

Primary Care Physician: _____ PCP Phone: _____

PCP Fax: _____ Pharmacy Name and Phone Number: _____

Physicians that client is currently receiving medical/psychiatric care from:

Physician Name:	Phone Number / Fax Number:	Reason:

Allergies: _____

Briefly describe the reason(s) for seeking assistance: _____

_____

List current support systems (friends, family, clubs): _____

List interest and/or hobbies: _____

Health History: (Please check all that apply)

_____ Past Psychiatric/Psychological treatment

_____ Past drug and or alcohol treatment/use

_____ Past change in sleeping/eating patterns

_____ Past legal problems

_____ Past trauma/abuse

_____ Past medical problems

_____ Past suicidal thoughts/attempts

_____ Present Psychiatric Treatment

_____ Present drug/alcohol treatment/use

_____ Present change in sleeping/eating patterns

_____ Present legal problems

_____ Present trauma abuse

_____ Present medical problems

Please explain any items checked above: _____

_____

_____

Medications that client is currently taking (prescribed or over the counter):

Medication	Dosage	Frequency	How long	Prescribing Physician

Form C1004,
NCD Rev. 07.2014

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PARENT/GUARDIAN DATA (For clients under 18 please complete, if over 18 sign bottom and continue to next page)

Custodial Parent(s) or Guardian: _____ Email : _____

Address: _____

City: _____ _____ St: _____ Zip:_____ Phone #:_____

Father: _____ Living or Deceased DOB: _____ Education Level: _____

Address: _____

City: _____ _____ St: _____ Zip:_____ Phone #:_____

Mobile #: _____ Soc Sec #: _____ Employer:_____

Briefly describe relationship between child/adolescent and father: _____

_____

Mother: _____ Living or Deceased DOB: _____ Education Level: _____

Address: _____

City: _____ _____ St: _____ Zip:_____ Phone #:_____

Mobile #: _____ Soc Sec #: _____ Employer:_____

Briefly describe relationship between child/adolescent and mother: _____

_____

If the child/adolescent was not raised by both biological parents, please explain (include step-parents, foster or adoptive history:

_____

_____

_____

SCHOOL DATA

Name of School: _____

Type of Program: _____ Grade: _____ Academics : Poor Average Above average

Indicate behavioral problems in school, include consequences: _____

_____

_____

By signing below, I hereby acknowledge that I have read and received a copy of GCBH Client Contract, Informed Consent, Notice of Privacy Practice and Client Rights.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Witness

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CLIENT INFORMED CONSENT

Please read each item and sign below acknowledging that you have read and understand the client informed consent.

I have chosen to receive psychiatric/therapeutic services from Gulf Coast Behavioral Health. My choice has been voluntary and I understand that I may terminate treatment at any time.

I understand that there is no assurance that I will feel better, because medication management and therapy is a cooperative effort between the provider and me. I will work with my provider in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that all records are confidential will be held and/or released in accordance with state laws regarding confidentially of such records and information.

I understand that state and local laws require that my provider report all cases of abuse or neglect of minors or the elderly.

I understand that state and local laws require that my provider report all cases in which there exists a danger to self and/or others. I understand that there may be other circumstances in which the law requires my provider to disclose confidential information.

I understand that my provider may disclose any and all records pertaining to my treatment to insurance companies, insurance representatives, primary care physicians, or pediatricians if such disclosure is necessary for claims processing, case management, coordination of treatment and/or utilization review purposes.

I understand that I can revoke this consent at any time, except to the extent that treatment has already been rendered or that action was taken in reliance on this consent and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefits plan.

I have read and understand the basic rights of individuals (outlined below) who undergo treatment.

These rights include:

1. The right to be informed of the various steps involved in receiving services.
2. The right to confidentially under federal and state laws in relation to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make informed decisions whether to accept or refuse treatment.
5. The right to contact and consult with counsel and select practitioners of my choice and at my own expense.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Witness

Form C1003, CIC
Rev. 07.2014

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CLIENT CONTRACT

Please read and sign below acknowledging that you have read, understand, and agree to the terms in this contract.

OFFICE HOURS: Our phones are answered Monday – Thursday 9:00 am - 12:00pm, 1:00 pm – 6:00 pm, Friday 9:00 am - 3:00pm. Our office is closed Saturday & Sunday**.**

APPOINTMENTS: If you are unable to keep your scheduled appointment we require a 24-hour notice. In the event you do not give a 24-hour notice you will be billed a fee. **All fees must be paid before future appointments can be scheduled**. See schedule of fees on page 2.

EMERGENCY CONTACT NUMBERS: The emergency phone numbers provided on the office voicemail are for after-hours emergencies only. These numbers should not be used during business hours or for appointment requests or prescription refill request. **Clients who choose to contact a provider after hours for a non-emergency will be billed for a phone consultation. Phone consultations are not paid by insurance companies.**

PRESCRIPTION REFILLS: Prescription refill request are approved during office hours only. All refill requests must come directly from your pharmacy via fax or phone or from yourself and require 3 business days for processing. If you are out of medication due to a missed appointment you will need to pay your missed appointment fee and schedule an appointment in order to receive a refill. All prescription requests for controlled substances require a written prescription for each refill and require 5 business days for processing. All medication samples and prescriptions must be picked up during office hours by the client or their legal guardian. This office does not mail out medication samples or prescriptions.
INSURANCE & CLIENT RESPONSIBILITY: It is the client's responsibility to notify us with any insurance changes and to obtain any required authorizations. Our office will submit claims to the insurance company we have on file. Per our contractual agreement with insurance companies we must collect all co-payments and/or deductibles due from the client. Co-payment and/or deductibles are due at the time of service unless other arrangements have been made in advance. **Should the insurance company not cover the service, the balance may become payable by you. Any balance due from the client that is not paid within 90 days will be referred to a collection agency. The client is responsible for reasonable attorney fees or collection agency fees equal to 35% to 50% of the total outstanding balance.**

RELEASE OF RECORDS: All clients or their parent/legal guardian must sign a release authorizing the release of any information. No information will be released without a properly executed consent. Record request may take up to 30 days to process and pre-payment is required.

FEES NOT COVERED BY INSURANCE: Fees for the items listed below are not covered by insurance companies and are the clients's responsibility. Fees for these items must be paid at the time the service is rendered and prior to the next scheduled appointment.

- Fees for medical records sent to attorneys or other agencies
- Fees for no shows or cancellations less than 24 hours before the appointment
- Fees for returned checks
- Fees for disability forms, FMLA forms, or letter preparation

REASONS FOR TERMINATION: The reasons outlined below are common reasons for termination from our office. This list is not comprehensive and the treating provider has final authority on terminating treatment.

- Continuously canceling or not showing for scheduled appointments
- Not following the recommended treatment plan
- **If the client is not seen within 6 months, unless otherwise instructed by your provider, your file will be closed (voluntarily terminated) and no prescriptions will be authorized for refills until you are seen.**

CONFIDENTIALITY: In accordance with moral, ethical, and legal guidelines regarding your right to confidentiality, cleint's personal information is carefully guarded. However, there are some exceptions which must be noted:

- If a client poses a threat to his or her own safety or the safety of others, we are required to notify concerned parties and the authorities.
- If a client reports actual or suspected abuse of any individual, our office must notify the proper authorities.
- In client groups of two or more, including the lobby and check-out, confidentiality is urged but not guaranteed.

AUTHORIZATION & SIGNATURE ON FILE: By signing this form, I authorize Gulf Coast Behavioal Health to release all necessary information to insurance companies to process claims or obtain authorization for treatment. I authorize payments be made to A&M Psychiatric Services from insurance companies, government agencies, or any other agency providing benefits for services rendered. I authorize that a copy of the signature below may substitute as the original.

I have read, understood and agree to follow all terms and conditions of this contract.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Witness

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Rev. 07.14

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FEE SCHEDULE:

The fees outlined below are effective October 1, 2012 and may be changed at anytime.

This is not a comprehensive list of all fees in this office; please inquire about current fees prior to authorizing any service that is not covered by your insurance company. Please initial EACH item.

____ • $25 Return Check fee for checks of $49.99 or less
____ • $35 Return Check fee for checks greater than $50 but less than $299.99
____ • $45 minimum or 3% of the face value Return Check fee for checks over $300
____ • $40 No show or late cancellation fee
____ • $75 No show or late cancellation fee for initial evaluations
____ • $25 Letter preparation fee
____ • $1 per page fee (first 25 pages / $0.25 for each additional page) for Records (waived if sent directly to another provider, hospital, or insurance company)
____ • $50 Disability and/or FMLA Form preparation (1-2 pages)
____ • $75 Disability and/or FMLA Form preparation (3+ pages)
____ • $20 per five minutes phone consultation fee, billed in 5 minute increments

I have read, understood and agree to the above fees.

_____ _____
Client Signature Date

_____
Parent/Guardian Signature

_____
Witness