Harmony United Psychiatric Care

Client Information

ClientName:_______________________________________ **D.O.B**: __________________

Address: ____ City/Zip:_____________________

Home Phone: ____________________________________Cell Phone: ______________________________

SSN:_____________________ Sex: Male___ Female_____ Other:___ (specify: _________________)

Marital Status:________________, E-mail:____

Primary Insurance: _________________________________ **Policy #**____________________

Subscriber:____________________ Relationship to **Client**:_____________ D.O.B:__________

Employer of Policy Holder:____

Secondary Insurance(if applicable)**:**____________________________________ Policy # _______________

Subscriber: ____Policy # _________________

Employer of Policy Holder:____

Primary Care Physician:____Phone:_____________________

Address: ____

City:________________________________ State:________________ Zip:_____________

How did you hear about us?

____ Physician _____ Newspaper _______ Magazine ________ Facebook

____ A Friend _____ Google _______ Other Online Searches

_____ Other: Specify: ____

Emergency Contact:

Name: _______________________________________ Phone/Cell: _________________________________

Harmony United Psychiatric Care

Acknowledgement of Receipt of Office Policies

By signing below, I am stating I have received and read a copy of the Office Policies and am aware of the charges that will be incurred for appointments that are missed or for appointments that are cancelled less than 48 hours before the scheduled appointment. I understand that failure to comply with the office policies may result in termination of care. I understand that these policies may change, and addendums will be distributed as the company feels it necessary.

____

Signature of Client or Parent/Guardian **Date**

____

Print Name/Relationship with the Client (If applicable)

Acknowledgement of Receipt/Location of Notice of Privacy Practices

I acknowledge that I have read a copy of Provider's Notice of Privacy Practices and/or am aware of the availability of notice in the offices of Harmony United Psychiatric Care.

____ ____________________

Signature of Client or Parent/Guardian **Dat**

104 E Dixie Avenue, Leesburg, FL 34748 Phone: (352) 431-3940 Fax: (352) 431-3173
www.hupcfl.com

Harmony United Psychiatric Care

Release of Information (for Emergency Purposes)

I also give consent to Harmony United Psychiatric Care to release information on an Emergency basis only to the following people. (Please print the full legal name and relationship to you.)**If not applicable, please note N/A on form.**

1. ______________________________ ______________________________

Print Full Name **Relationship**

______________________________ ______________________________

Phone/Cell Number **Email**

2.______________________________ ______________________________

Print Full Name **Relationship**

______________________________ ______________________________

Phone/Cell Number **Email**

______________________________________ ____________________

Signature ofClientor Parent/Guardian **Date**

____

Print Name

______________________________________ ____________________

Signature of the Witness **Date**

____

Print Name

Harmony United Psychiatric Care

Consent for Treatment/Medication

I, ____the client or client's parent/guardian, have been informed by **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 **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 the doctor/ARNP/PA of my medical and psychiatric background. I understand that refusal to abide by prescribed treatment (eg: not taking or overtaking prescribed medications, missing or rescheduling appointments repeatedly...) is basis for termination of care due to noncompliance. I also understand that although **Harmony United Psychiatric Care** believes this treatment will be of benefit to me, there is no guarantee as to the results that may be expected.

On this basis, I authorize **Harmony United Psychiatric Care** to render the necessary psychiatric services as deemed advisable, and I have been notified of any possible side effects of any medications I have been prescribed.

____ ____________________

Signature of Clientor Parent/Guardian **Date**

____ ____________________

Signature of the Witness **Date**

Harmony United Psychiatric Care

Consent for Insurance Filing

Insurance Release: I authorize the release of any information my physician may feel necessary to process my insurance claims, and I authorize payment of benefits directly to my provider of services, and 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.

____ _____________________

Signature of Clientor Parent/Guardian **Date**

____ _____________________

Signature of the Witness **Date**

(Rest of the page left blank intentionally)

Harmony United Psychiatric Care

RELEASE FOR MEDICAL RECORDS/CLIENT INFORMATION

I, ____ 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 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's 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 ____

Harmony United Psychiatric Care

RELEASE FOR MEDICAL RECORDS/CLIENT INFORMATION

NOTE: When substance abuse or dependence 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 sufficient for this purpose.

This authorization shall remain in effect until:

_______Further notice of closing of case

_______Specific 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 HIPPA privacy rule.

(Rest of the page left blank intentionally)

Harmony United Psychiatric Care

RELEASE FOR MEDICAL RECORDS/SIGNATURE PAGE

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 Clientor Parent/Guardian **Date**

____

Print Name

______________________________ ______________

Signature of Witness **Date**

____

Print Name