HARMONY UNITED PSYCHIATRIC CARE

New Patient Information

Client Information

Client Name : ______________________________ D.O.B : ____________________

Address : ____

City : ____________________ State : ________________ Zip : ____________________

Home Phone : ____________________ Cell (Required): __________________

SSN : ____________________ Sex: [ ] Male [ ] Female [ ] Other: ____________________

Marital Status : ____________________ Email : ______________________________

Insurance Information

Primary : ____________________ **Policy #** ______________________________

Subscriber : ____________________ Relationship to Client: ______________________________

D.O.B : ____________________

Employer of Policy Holder: ____

Secondary : ____________________ **Policy #** ______________________________

Subscriber : ____________________ Relationship to Client: ______________________________

Employer of Policy Holder: ____

301 Skyline Drive, Suite 4, Lady Lake, FL 32159.
Phone: (352) 431-3940 | **Fax:** (352) 431-3173 | **www.hupcfl.com**

Primary Care Physician Information

Primary Care Physician : ____

Phone : ____________________ Fax: ____________________

Address : ____

City : ____________________ State: ____________________ Zip: ___________________

Reference Information

How did you hear about us?

___ Physician ___Newspaper ___Magazine ___ Facebook

___ Friend ___ Google ________________________________ ____Other (Online Search)

___ Other: Specify: ____ (Offline)

Emergency Contact Information

Emergency Contact:

Name: ____________________________________ Phone/Cell: ____________________________________

Acknowledgement of Receipt of Office Policies

I am stating that 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 and accept that these policies are subjected to change from time to time. It is my responsibility to obtain 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 the up to date office policies in the future.

Initial:

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.

I understand and accept the acknowledgement of receipt of notice of Privacy practices.

Initial:

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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 mention N/A on form.**

1.

______________________________	______________________________
Print Full Name	**Relationship**
______________________________	______________________________
Phone / Cell Number	**Email**

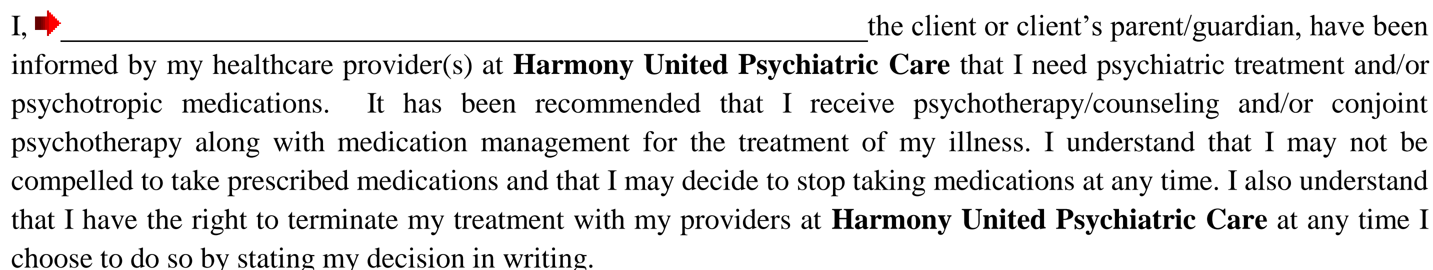
2.

______________________________	______________________________
Print Full Name	**Relationship**
______________________________	______________________________
Phone / Cell Number	**Email**

I understand and consent to the release of Information (for Emergency Purposes)to the above stated individuals.

Initial:

Consent for Treatment / Medication



I, ➡ ______________________________ the client or client's parent/guardian, 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 the healthcare provider(s) 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, etc...) is basis for termination of care due to noncompliance. I also understand that although healthcare provider(s) at **Harmony United Psychiatric Care** believe this treatment will be of benefit to me, but there is no guarantee as to the results that may be expected.

On this basis, I authorize 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.

Initial:

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.

I understand and consent for insurance filing.

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Acknowledgement

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

➡ ____ ____

Signature of the Client or Parent/Guardian Date

➡ ____ ____

Print Name