

# Harmony United Psychiatric Care

## HARMONY UNITED 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/Asian African American/Hawaiian/White/Decline \_\_\_\_\_  
Alaska Native \_\_\_\_\_ Black Pacific Islander Hispanic 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) \_\_\_\_\_

15544 W. Colonial Drive, Winter Garden, FL 34787

Phone: (800) 457-4573 | Fax: (800) 443-6422 | www.hupcfl.com

# 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 Diastolic: \_\_\_\_\_, Pulse: \_\_\_\_\_, Height (In Inches): \_\_\_\_\_, Weight (in lbs): \_\_\_\_\_

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# 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

<i>Please list below the health history of your <u>blood</u> (genetic) first degree relatives</i>				
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:				
<b>I was Adopted</b> <input type="checkbox"/>				

## 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

# 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, **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, **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]**

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Print Name of Client/Patient or Parent / Legal Representative

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



# Harmony United Psychiatric Care

## Preference to Communicate by Unencrypted Text Message and Email

This is a required form that must be completed for service

I, \_\_\_\_\_ hereby state my preference for Harmony United Psychiatric Care to communicate with me by email and standard SMS text messaging regarding various aspects of my medical care, which may include, but not be limited to, **appointments, billing, patient surveys, other administrative communications, and information about Service Providers.**

*There is some level of risk that information in a regular text message or email could be intercepted and read by someone else.*

Consequently, having been informed of this risk, Harmony United Psychiatric Care requests my preference regarding communications with me by text message and email. I have checked the appropriate box(es) below and provided the needed information.

I also understand that I may change my preferences at any time by completing a new form.

**Yes** – Please communicate with me by email. My email address is:

*I will let you know as soon as possible if my email address changes.*

**No** – Please do not communicate with me by regular (unencrypted) email

**Yes** – Please communicate with me by text message. My cell phone number is:

*I will let you know as soon as possible if my cell phone number changes.*

**No** – Please do not communicate with me by regular (unencrypted) text message.

\_\_\_\_\_  
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 services 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 with word “STOP” in response to any text message sent by Well iQ. I understand that the message and data rates may apply, and that I will receive a maximum of 1 message per visit to share my experiences 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.

# Harmony United Psychiatric Care

## 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 LLC**, 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/Parent/Legal Representative agrees to reimburse Harmony the fees of any third-party debt collector and all costs and expenses, including reasonable attorney's fees, Harmony incurs in such collection efforts. All delinquent accounts shall bear interest at the current FL legal rate of **12.0%**.

### 2. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes as the Client/Patient or Parent/Legal Representative of Client/Patient, to direct payment to **Harmony United Healthcare LLC** of any insurance benefits otherwise payable to or on behalf of the Client/Patient **for 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 if the** cost of the services are not covered by the health service plans. 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?

Yes     No

# Harmony United Psychiatric Care

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.

I hereby expressly consent to allow Harmony, its affiliates, or agents (business associates and/or third-party agencies) to contact me (including, but not limited to through the use of contact information and/or telephone numbers that I have provided to Harmony or its affiliates, via telephone, text message, cellular device, electronic mail or fax, either through the use of a pre-recorded message, artificial voice, or auto/predictive dialing equipment. I agree that I can revoke my consent to receipt such communications by providing a written statement of revocation to the business office of Harmony at the office address above. In the case of a text message, I can use the opt-out option in the text message. I agreed that oral communications for revocations are not acceptable.

**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): \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Cell  Yes  No

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

## CREDIT / DEBIT CARD PAYMENT AUTHORIZATION

I \_\_\_\_\_ [TYPE NAME] authorize Harmony United Healthcare LLC to automatically charge my credit / debit card for any balance due on the Due Date. I may withdraw this authorization at any time when my account balance has been paid in full or is Current, or I have arranged with Harmony United Healthcare LLC for another method of payment.

Any payment transaction that is not approved when submitted by Harmony United Healthcare LLC by the Due Date for that payment will be considered delinquent and I will be immediately responsible to make that payment through another means (e.g. cash, another card, check).

**Please Provide:**

**I agree that if this card is no longer valid, I will immediately inform Harmony United Psychiatric Care of a new card or another source of payment.**

Name on Card \_\_\_\_\_

Bank \_\_\_\_\_

Visa \_\_\_ Master Card \_\_\_ Amex \_\_\_ Discover \_\_\_ Others \_\_\_\_\_

Card Number \_\_\_\_\_

CVV \_\_\_\_\_ Expiration Date \_\_\_\_\_

\_\_\_\_\_  
*TYPE NAME to authorize your Approval of Card Transactions*

\_\_\_\_\_  
*Date*

If you have further questions regarding your credit/debit transactions, please call the billing department at **800-285-9288**.

# Harmony United Psychiatric Care

## **HIPAA – Notice of Privacy Practices Effective 10-01-2022**

**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. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER AT 352-792-0797 OR PRIVACY@HUPCFL.COM.**

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.
  - a) 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.
  - b) 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 assist 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.
  - c) We may mail to your home or other location designated by you any items that assist the Practice in carrying out Health Care Operations.
  - d) 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. Our email system is HIPAA compliant. We may send protected health information via email using secure password protected email communications. If you email us your protected health information, you understand that your email system may not be HIPAA compliant, therefore we would recommend sharing your protected health information only via password protected email communications that you receive from our practice. Otherwise, if you need to send us protected health information, we encourage you to use our secure electronic patient portal, if available, or call us. See Paragraph H below.

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- e) We may set up a secure electronic patient portal for you to use to access and view date of your appointments with us, results of diagnostic tests, vital signs taken during your visits with us, prescriptions ordered for you, and communications with us. We have made every effort to provide a secure patient portal; however, security may be compromised due to events beyond our control. If we discover the security of our patient portal has been compromised, we will notify you if the security breach involves your records maintained on our patient portal.
- f) We may provide services to you via secure electronic two-way audio and video communications (telehealth platform). We have made every effort to provide a secure telehealth platform; however, security may be compromised due to events beyond our control. If we discover the security of our telehealth platform has been compromised, we will notify you if the security breach involves you.
- 4) We may send information to you including appointment reminders, care coordination to help manage your health, referrals to specialists, or general information about the practice via US mail, email, text message, cell phone, home phone, or other methods of communications. We make every effort to send information securely; however, security may be compromised due to events beyond our control. If we discover security has been compromised, we will notify you if the security breach involves your protected health information.
- 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

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# Harmony United Psychiatric Care

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 Notice of Privacy Practices 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.

## 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. We recommend you only share protected health information via password protected email communications that you receive from our practice. Otherwise, if you need to send us protected health information, we encourage you to use our secure electronic patient portal, if available, or call us. Our practice does not encourage email communication of sensitive information if you do not, use encrypted or HIPAA compliant email service or communicate via password protected emails from our practice.

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# Harmony United Psychiatric Care

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.

**Harmony United Psychiatric Care**  
**HIPAA Privacy Officer**  
**15544 W. Colonial Drive**  
**Winter Garden, FL 34787**  
**Phone: (352) 792-0797**  
**Email: [privacy@hupcfl.com](mailto:privacy@hupcfl.com)**

I acknowledge that I have read, understand, and accept the Provider's Notice of Privacy Practices and I am aware of the availability of notice in the offices of Harmony United Psychiatric Care and on the web site at [hupcfl.com](http://hupcfl.com). HUPC reserves the right to revise and change its HIPAA Notice of Privacy Practices at any time. It is my responsibility to obtain the most up to date HIPAA Notice of Privacy Practices 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](http://hupcfl.com). If I do not agree to this HIPAA Notice of Privacy Practices 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

## Office Policies Effective 1-1-2022

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. All our providers strive to make their appointments on time, therefore; we request you arrive on time as well. If you are a new patient, please arrive 15 minutes early. If you are returning for a follow-up, please arrive 5 minutes early. If your appointment is scheduled via telemedicine, please connect 10 minutes early to allow time for troubleshooting. If you are more than 10 minutes late for your appointment you may be marked as a no-show.

**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 or getting prescriptions for other controlled medications from another provider and failed to disclose to the provider at our practice, this will be cause for termination of care.

**Stimulant/ Controlled Medication Prescription/Appointments:** If you are prescribed a stimulant or other schedule II medication you must be seen by a provider every 30 days. If you are prescribed any other schedule III-V medications (including benzodiazepines and hypnotics) you must be seen by a provider every 90 days.

**Paperwork Fee:** Forms for Disability, FMLA and other paperwork have a processing fee of \$25.00 to \$75.00 per page of the paperwork, 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.

**Social Security Number:** Our practice requires the clients/patients or parents/legal guardians to provide their social security number to our practice if they would like to receive services through their health insurances. If anyone wishes not to provide their social security number, then they must choose to receive our services as a self-pay client. Our practice keeps your information confidential and secure.

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# Harmony United Psychiatric Care

**Minor Patients:** Patients under the age of 18 must have a parent/legal guardian attend their first appointment with them. Follow-ups for medication management appointments would require a parent to be present for at least part of the appointment. Follow-ups for psychotherapy or neuropsychological/neurocognitive testing can be done without a parent/legal guardian present during the appointment with parental consent.

**Balance/Payment:** Payment is due at the time of service. It is your responsibility to keep your 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.

## **Phone Visits or Provider Callback 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, and its approval is contingent upon our provider callback policy.

**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 5minutes.

## Medication Management Self-Pay Clients:

- New Client - initial evaluation for medication management - \$325
- Established Client- Follow Up Appointments - \$225 per visit.

## Psychotherapy/Counseling Self-Pay Clients: Including: Individual and Couples/Marriage Counseling

- New Clients - Initial psychiatric evaluation for psychotherapy/counseling is \$225.
- Established Clients – Follow-Up Psychotherapy Appointments - \$175 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.

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# Harmony United Psychiatric Care

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 \$100 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 (\$150) 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. This Advance Deposit will be applied towards the Testing Fee. Any Missed Appointment fees incurred by you will be deducted from the Advanced Deposit.
- Testing Fee for the Evaluation is \$1,300. This includes cost of testing material and up to a total of 6 hours for the evaluation, test administration, test interpretation, and generating the report.
- If any additional time is required, it will be billed at \$200 per hour.

## **ONLINE NEUROCOGNITIVE TESTING**

Testing for ADHD/Dementia/TBI/Autism Spectrum Disorder, etc., can be done on-line 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 \$200.00 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 this 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 On-Line 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.

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Signature of Client/ Patient or Parent/ Legal Representative

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Date

# 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.