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) _____

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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: _____

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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): _____

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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: _____

ALCOHOL

Never Used Alcohol ☐

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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

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 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 Florida 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 maximum rate allowed under Florida law of 18.0%.

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. The undersigned understands that he or she is financially responsible for charges not covered by the assignment.

3. HEALTH CARE SERVICE (INSURANCE) PLAN OBLIGATION

Harmony maintains a list of health service (Insurance) plans with which it has contracted. A list of such plans is available on **r**equest and online. Harmony has no contract, expressed or implied, with any plan that does not appear on the list. The client/Patient or Parent/Legal Representative of the Client/Patient is solely responsible for verifying the benefits coverage under his/her health care service (insurance) plan. 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 is not covered by the health service (Insurance) 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 the 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?

Harmony United Psychiatric Care

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.

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 receive such communication 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 agree 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): _____

Address: _____
Telephone Number: _____

Cell ☐Yes ☐No

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

Address: _____
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

HIPAA – Notice of Privacy Practices Effective 01-01-2024

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 888-383-4693 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 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.
    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 complaint, 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.
    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 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.

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

Harmony United Psychiatric Care
HIPAA Privacy Officer
15544 W. Colonial Drive
Winter Garden, FL 34787
Phone: (888) 383-4693
Email: 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 website at 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. 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

SIGNING THIS AGREEMENT, YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL, WAVING ANY AND ALL CLASS ACTION RIGHTS, AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT

This is a required form that must be completed for service

ARBITRATION AGREEMENT FOR CLAIMS ARISING OUT OF OR RELATED TO MEDICAL CARE AND TREATMENT

1. AGREEMENT TO ARBITRATE ALL CLAIMS. The patient agrees that any and all controversy, including without limitation, claims for medical malpractice, personal injury, slip and fall, HIPAA violations, FDUTPA or violations of similar state or federal laws, loss of consortium, or wrongful death, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by the undersigned provider of medical services, including any partners, agents, or employees of the provider of medical services, shall be submitted to binding arbitration.

2. AGREEMENT TO ARBITRATE CLAIMS REGARDING PAST CARE & TREATMENT.
The patient further agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the past diagnosis, treatment, or care of the patient by the undersigned provider of medical services or the provider's partners, agents or employees, shall be submitted to binding arbitration.

3. WAIVER OF RIGHT TO JURY TRIAL. BOTH PARTIES TO THIS AGREEMENT, BYENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVEANY AND ALL SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, ANDINSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

4. CLASS ACTION WAIVER. AS PERMITTED BY APPLICABLE LAW, BOTH PARTIES WAIVETHE RIGHT TO LITIGATE IN COURT OR AN ARBITRATION PROCEEDING ANY AND ALL DISPUTES AS A CLASS ACTION, EITHER AS A MEMBER OF A CLASS OR AS REPRESENTATIVE, OR TO ACT AS A PRIVATE ATTORNEY GENERAL.

5. ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS. All claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement binds all parties whose claims may arise out of or relate to treatment services provided by Harmony United Florida, LLC, including the patient, the patient's estate, any spouse or heirs of the patient, and any children of the patient, whether born or unborn, at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. By signing this Agreement, the parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

6. ARBITRATION PROCEDURES. The parties agree and recognize that the substantive provisions of Florida Statutes, Chapter 766, governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects, except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Florida Statutes,766.106 or 766.207, et seq. (which remain available if elected by the parties), the parties and/or claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Within thirty(30) days after a party to this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy under this Agreement, the parties to the dispute or controversy shall each appoint an independent arbitrator who is a member of the American Health Lawyers Association and give notice of such appointment to the other. Within a reasonable time after such notices have been given, the two arbitrators so selected shall select a neutral arbitrator, who shall be an administrative law judge furnished by the Florida Division of Administrative Hearings and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice

of selection of the neutral arbitrator. The parties agree that the arbitration proceedings are private, not public, and the privacy of the parties and of the arbitration proceedings shall be preserved.

7. ARBITRATIONEXPENSES. Each party shall bear the cost of her/its own attorneys' fees, the costs of presenting her/its case, and her/its arbitrator. Any cost associated with the neutral arbitrator shall be shared equally by the parties, to the extent not provided by the State Department of Administrative Hearings. Other costs of the arbitration (e.g. of, securing allocation for the arbitration, court reporter, etc.) shall be shared by the parties.

8. APPLICABLE LAW. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes, Section 682.01 etseq. In conducting the arbitration under Florida Statutes, Section 682.01 et seq., all substantive provisions of Florida law governing medical malpractice claims and damages related there to, including but not limited to Florida's Wrongful Death Act, the standard of care for medical providers, the applicable statute of limitations and the application of collateral sources and setoffs shall be applied. Except as otherwise provided by law, interest shall only accrue after an award by the arbitration panel. Post-decision interest shall be computed in a manner consistent with other civil claims. The provisions of Fla. Stat. § 768.81 regarding comparative fault shall apply.

9. EFFECT OF REFUSAL TO PROCEED WITH ARBITRATION. In the event that any party to this Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this Agreement to arbitration may only be avoided by a valid court order indicating that the dispute is beyond the scope of this Agreement or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party's absence at the arbitration hearing.

10. SEVERABILITY. If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

11. ACKNOWLEDGEMENTS BY PATIENT. The patient, by signing this Agreement, also acknowledges that he or she has been informed that:

    a. NO DURESS. The Agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;

    b. AGREEMENT BASED UPON OWN FREE WILL. The decision whether or not to sign this Agreement is solely a matter for the patient's determination without any influence by the medical provider;

    c. BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL. Binding arbitration means that the parties give up their right to go to court to assert or defend a claim covered by this Agreement. The resolution of claims covered by this Agreement will be determined by a neutral panel of arbitrators and not a judge or jury. Each party is entitled to a fair hearing, but the arbitration procedures are simpler and more limited than the rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final, and there will generally be no right to appeal an adverse decision. However, any party may, within 15 days from a decision of an arbitration panel, file a written request for reconsideration. Any such request for reconsideration shall be based upon (i) a claim that the panel failed to properly apply the law or applicable rules of evidence or (ii)that the procedures specified in this Agreement or Fla. Stat. §§ 682.01, et seq. were not followed. A claim that the panel was incorrect as to the facts or gave undue weight to certain evidence will not be a basis for a request for reconsideration; and

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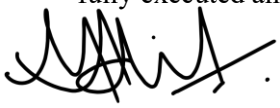
d. SIGNATURE OF AGREEMENT. This Agreement shall be effective upon the patient's and/or the patient's representative's signature below. Upon such signature, this Agreement shall be deemed to be fully executed and binding upon all parties.



By:_____
Authorized Member of Harmony United Florida, LLC,
on behalf of Harmony United Florida LLC, and as an
agent of its employees, partners, agents, and independent contractors.

Patient/Client:

_____ _____
Print Name Date

_____
Patient/Client Signature

Parent or Guardian [if patient is a minor] or Legal Representative:

_____ _____
Print Name Date

_____
Parent or Guardian or Legal Representative

Harmony United Psychiatric Care

Office Policies Effective 01-01-2026

This is a required form that must be completed for service

Missed Appointment:
There is a charge for missed appointments or cancellations that occur less than 24 hours (or one business day) before the set appointment time. Please know that we value you as a client of our practice, and we have set aside a specific appointment time just for you. While we understand that situations occur that 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 New Patient Paperwork must be completed at least 24 hours before your appointment; otherwise, it may be rescheduled. All our providers strive to make their appointments on time; therefore, we request you arrive on time. 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. You may be marked as a no-show if you are more than 10 minutes late for your appointment.

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

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

No Walk-In Visits: Due to the high volume of clients and the inconvenience this may cause other clients who are already scheduled, we cannot accommodate clients who 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 clients 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 at least once every 30 days. If you are prescribed any other schedule III-V medications (including benzodiazepines and hypnotics), you must be seen by a provider at least once every 90 days.

Urine Drug Screen: As part of your psychiatric evaluation and ongoing care, you may be required to get a Urine Drug Screen test at a laboratory as per your provider's request and our clinic policy.

Insurance Coverage: The Company will make its best efforts, based on our research and experience, to verify your eligibility. Ultimately, it is your (the client's, Guardian's, or Legal Representative's) responsibility to ensure your benefits cover your services. We recommend reviewing your policy and contacting your carrier to confirm coverage before receiving our services. You will be responsible for paying in full for all services not covered by insurance.

Photo ID: Our practice requires clients or parents/legal guardians to provide their Photo ID if they would like to receive services from our practice.

Minor Clients: Clients 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.

Minors' and Split Parental Disclosure:

Medical Records: Florida Statute. § 61.13(2)(c)(7)

Harmony United Psychiatric Care

Access to records and information about a minor child, including, but not limited to, medical, dental, and school records, may not be denied to either parent. Full rights under this subparagraph apply to either parent unless a court order expressly revokes these rights, including any restrictions on these rights as provided in a domestic violence injunction. A parent having rights under this subparagraph has the same rights upon request as to form, substance, and manner of access as are available to the other parent of a child, including, without limitation, the right to in-person communication with medical, dental, and education providers.

As such, barring a court order limiting either parent's access to the child's medical records, either parent has the right to obtain information regarding a minor child.

Dispute over Medical Decisions:
Florida law does not require both parents to consent, only one. The medical provider is not required to play arbiter for both parents who may disagree. When consent is necessary for a medical action, the medical practitioner informs the consenter about the procedure and any potential risks or harm under accepted medical standards and practice. Once the medical practitioner has provided the consenter with information about the risk of harm, the medical practitioner has done their duty to receive informed consent before any medical action is practiced on the child.

New or Established Client Appointments Disclosure: By scheduling an appointment with our provider, you (the client, Guardian, or Legal Representative) confirm a consultation visit, and it is not a pre-confirmation of a prescription. The Company cannot ensure that any prescription will be issued. Prescription determinations will be made solely by the provider, based on medical necessity, after a consultation, evaluation, and fulfillment of all required criteria.

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 before any future appointments are 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 of the reproduction.
- There is no charge for medical records sent to a healthcare provider when arranging a 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, seek medical advice, or discuss any aspect of your care, these services are billable time, and its approval is contingent upon our provider callback policy.

Harmony United Psychiatric Care

Clients with Insurance: Your phone services will be billed to your insurance carrier. Please be aware that if you have a co-pay, coinsurance, or deductible with your insurance plan, it will apply to these phone visits in a similar fashion as it would to your regular office visit.

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

Medication Management Self-Pay Clients:

- New Client - Initial evaluation for medication management for MD/DO: $400
- Established Client- Follow-Up Appointments per visit for MD/DO: $275
- New Client - Initial evaluation for medication management for APRN/PA: $325
- Established Client- Follow-Up Appointments per visit for APRN/PA: $225

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

- New Clients - Initial psychiatric evaluation for psychotherapy/counseling for Psychologists/post-doctoral: $250
- Established Clients – Follow-Up Psychotherapy Appointments per session for Psychologists/Post-Doctoral: $200
- New Clients - Initial psychiatric evaluation for psychotherapy/counseling for Therapists (LMHC, LCSW, LMFT, Interns): $175
- Established Clients – Follow-up psychotherapy Appointments per session for Therapists (LMHC, LCSW, LMFT, Interns): $150

For marriage/couples counseling, the first visit with the therapist must consist of individual sessions for each client. Then, follow-up visits will include both clients seeing the therapist 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 is charged for any New or Follow-Up IN-PERSON Neuropsychological testing missed appointment or cancellation that occurs 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 Clients

- An Advance Deposit of $200 is required before scheduling your testing appointment. $100 will cover the cost of testing materials, and the remaining balance ($100) will be refunded to you upon completion of the testing.
- Any missed appointment fees charged will be deducted from the Advanced Deposit.

Self-Pay Clients:

- An Advance Deposit of $200 is required before scheduling your testing appointment. This Advance Deposit will be applied towards the Testing Fee. Any missed appointment fees you incur will be deducted from the advanced deposit.
- The Testing Fee for the Evaluation is $1,500. This includes the cost of testing material and up to 6 hours for the evaluation, test administration, test interpretation, and generating the report.
- If 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 online on a computer in the clinic office, or it can be emailed to you to be completed at home.

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.