Phone (941) 921-2792 | Fax (941) 925-2438

Behavioral Health Centers of Sarasota
5602 Marquesas Circle
Unit 212
Sarasota, FL 34233

ADULT REGISTRATION

PATIENT INFORMATION			
Date			Social Security #
Full Name			
Birth Date (MM/DD/YYYY)		Age	Sex
Address			
City	State	Zip	Referred By
Billing Address (if different)			
City	State	Zip	Email
Home Phone	Work Phone		Cell Phone
Primary Physician			
Occupation		Place of Employment	

PRESENTING PROBLEMS

List your problems or other needs we may assist you with.

Please check any of the following problems that pertain to you:

☐ Aggressive Thoughts	☐ Homicidal Thoughts	☐ Poor Memory
☐ Alcohol Use	☐ Hopelessness	☐ Purging
☐ Anxiety	☐ Hypersexuality	☐ Racing Thoughts
☐ Appetite Changes	☐ Inability to Sleep	☐ Restlessness
☐ Bingeing	☐ Inattention	☐ Seeing Visions
☐ Confusion	☐ Involuntary Movement	☐ Self Injury
☐ Daytime Napping	☐ Irritability	☐ Sexual Problems
☐ Depression	☐ Low Interest in Activities	☐ Sleep Changes
☐ Dizziness	☐ Learning Problems	☐ Stomachaches
☐ Drug Use	☐ Loneliness	☐ Stress
☐ Eating Problems	☐ Mood Swings	☐ Suicide Thoughts
☐ Excessive Sleep	☐ Nervousness	☐ Tiredness
☐ Food Restriction	☐ Nightmares	☐ Unhappiness
☐ Guilt	☐ Obsessive Thoughts	☐ Vivid Dreams
☐ Headaches	☐ Panic Attacks	☐ Weight Gain
☐ Hearing Voices	☐ Paranoia	☐ Weight Loss

PSYCHIATRIC HISTORY

Have you ever received psychological help or counseling of any kind before? ____ Yes (describe below) ____ No
Describe:

Are you currently being treated for a psychiatric illness? ____ Yes (describe below) ____ No
Describe:

Please list all psychiatric or therapeutic treatment on either an outpatient or inpatient basis. Use the back of this page if necessary.

DATE	HOSPITAL/CLINICIAN	SUICIDE ATTEMPT	REASON
		Y / N	
		Y / N	
		Y / N	
		Y / N	

FAMILY HISTORY

Do you have any relatives with known or suspected psychiatric illness or emotional difficulties? Please specify who has been affected on lines below.

☐ Hyperactivity _____	☐ Drug Abuse _____	☐ Anxiety _____
☐ Learning Problems _____	☐ Alcoholism _____	☐ Suicide _____
☐ Intellectual Disability _____	☐ Criminal Behavior _____	☐ Psychosis _____
☐ Autism _____	☐ Depression _____	☐ Other Psychiatric Illness _____

Has anyone related to you committed suicide or attempted suicide? Y / N

MEDICAL AND SURGICAL HISTORY

Please list all surgical or medical treatment given to you on either an outpatient or inpatient basis. Use the back of this page if necessary.

DATE	HOSPITAL/DOCTOR	REASON

Are you currently being treated for a physical defect or illness? ____ Yes (describe below) ____ No
Describe:

Do you have/had any of the following:

☐ Overweight	☐ High Cholesterol	☐ Blood Sugar Problem
☐ High Blood Pressure	☐ Thyroid Problem	

Present Height	Present Weight	# Pregnancies: # Live Births:

List all medications you are currently taking. Use the back of this page if necessary.

Medication	Dose	Prescribing Physician	Results/Side Effects

List all past psychiatric medications. Use the back of this page if necessary.

Medication	Dose	Prescribing Physician	Results/Side Effects

Any allergies to medications or foods? ____ Yes (describe below) ____ No
Describe:

DRUG AND ALCOHOL HISTORY

List below all forms of alcohol, drugs, and prescription drugs which you have ever used or abused. Use the back of this page if necessary.

TYPE (Circle)	AMOUNT	FIRST USE	LAST USE
Alcohol			
Marijuana			
Cocaine			
Methamphetamine			
LSD/Ecstasy			
Opiates/Heroin/IV Drugs			
Other (Describe)			
Caffeine (coffee, soda, etc.)			
Nicotine (cigarettes, etc.)	____ packs/day		

Have you ever received treatment for drug and/or alcohol abuse problems? ____ Yes (describe below) ____ No
Describe:

MARITAL HISTORY

Marital Status: ___ Single ___ Separated ___ Living Together ___ Married ___ Divorced ___ Other

List all marriages below.

NAME OF SPOUSE	FROM	TO	NUMBER OF YEARS

LIVING SITUATION

Please list people in the home.

NAME	AGE	SEX/GENDER	RELATIONSHIP

EDUCATION HISTORY

EDUCATION LEVEL	# YEARS	COMPLETED?	GRADUATED?
HIGH SCHOOL			
TRADE SCHOOL			
JUNIOR COLLEGE			
COLLEGE			

If you dropped out before completing education, please explain:

How well did you do with your studies? Please explain:

EMPLOYMENT HISTORY

Please list all employment from over the last five (5) years.

COMPANY/POSITION	FROM	TO	REASON FOR LEAVING

MILITARY HISTORY

BRANCH OF SERVICE	FROM	TO	TYPE OF DISCHARGE

Behavioral Health Centers of Sarasota
6075 Rand Blvd., Suite 1, Sarasota, FL 34238
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PROVIDERS

Dear Patients and Families,

We thank you for choosing BHCS and look forward to working with you. We strive to provide the very best care and, in order to do so, we would like to take this opportunity to acquaint you with our office policies. Please take a few minutes to read over the following information. **In addition, we suggest that you review your health insurance policy and familiarize yourself with the coverage it provides.**

APPOINTMENTS

We ask that you try to schedule your appointments as soon as possible, hopefully after each visit, as routine follow-up time slots are typically booked for several weeks into the future at any given point.

If you are unable to keep your appointment, please notify our office at least one working day (24 hours) in advance to avoid being billed for the time. **A missed appointment will be billed as a rate determined by your physician and also charged to your account.** We will make an attempt to contact you to confirm each appointment one or two days ahead of time. This call is a courtesy, and our failure to reach you will not relieve you of your responsibility for any missed appointment charges.

PRESCRIPTIONS

If you are on medication, please request any needed renewal prescriptions at the time of your appointment. In general, you will be provided with enough refills to last until your next expected appointment. If you do require refills between appointments, **please notify your pharmacy and have them call our office during regular office hours.**
9 am to 12 pm & 1 pm to 4:30 pm, Monday through Thursday - 9 am to 12 pm & 1 pm to 4 pm, Friday.

Prescriptions for controlled substances cannot be called in and will require a electronic prescription. Please notify our office of a need for a prescription THREE BUSINESS DAYS in advance.

LETTERS AND FORM COMPLETION

We require a minimum of 48 hours for all letters and form completion. Any information that you would like forwarded to another provider, school, attorney, employer, etc., requires a signed release of information. In some cases, we may require you to schedule an appointment for the completion of these forms. Please contact our office to inquire whether a scheduled appointment will be necessary.

FINANCIAL POLICY

IF YOU DO NOT HAVE INSURANCE: If you do not have insurance, there will be a one-time, up-front payment of **$100.00** when scheduling your initial appointment. This payment will go towards your first appointment fee. If you cancel your appointment with 24 hours or more notice, your payment will be reimbursed in full. If you cancel with less than 24 hours notice or do not show up for your appointment, then payment is forfeited.

We ask that all self-pay patients pay in full at the time of service. If you cannot pay in full, we must receive payment before scheduling your next appointment.

IF YOU HAVE INSURANCE: In order to better serve your needs, our office accepts several insurance plans. Every plan is different. It is up to the insured to know the exact requirements of their own insurance plan. In order for us to file insurance claims on your behalf, you must present proper proof of insurance at the time of your appointment at our office. However, when appropriate, if your insurance company has not responded within 60 days, full and prompt payment will be expected from you. **NO INSURANCE WILL BE FILED WITHOUT A COPY OF THE INSURANCE CARD.**

Fees due at the time of service include: Co-pays, deductibles, non-covered services, or patients that are not covered by insurance.

For your convenience, we accept cash, check, MasterCard, Visa, American Express, and Discover.

FINANCIAL RESPONSIBILITY

The person who brings a child for care is ultimately responsible for the child's bill. The physicians will not get involved in a court decision or child support disputes.

In general, insurance companies should pay within 30 to 60 days after receipt of a claim. If your insurance company has not paid by 60 days after your visit, please check with your company as to the status of your claim.

Your insurance benefits are a contract between you and your insurance company. We cannot accept responsibility for collecting your insurance or for negotiating a settlement on a disputed claim, but we will assist you whenever possible.

If you are a member of a health plan for which we are participating providers, we will honor any restrictions on charges or fees, and these will be adjusted accordingly.

WE RESERVE THE RIGHT TO SEND AN ACCOUNT TO COLLECTION IF NOT PAID IN FULL. IF BHCS REFERS YOUR ACCOUNT OVER TO A COLLECTON AGENCY, YOU WILL BE RESPONSIBLE FOR YOUR BALANCE PLUS COLLECTION AGENCY FEES.

FEES FOR THE DOCTORS

Initial Evaluation	$375
Extended Medicine Check with Psychotherapy	$225
Medicine Check	$175
Missed Appointment	TBD by doctor

FEES FOR THE THERAPIST

Initial Evaluation	$150
Therapy Follow up	$135

Our office will do whatever we can to assist you. If you have any questions or problems, please do not hesitate to contact our office.

All patients must complete the patient information form and sign this policy agreement in order to be seen in this office.

I have read and agreed to the above office policies.

Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF MEDICAL INFORMATION

I authorize Behavioral Health Centers of Sarasota to release any medical information which may be requested to process claims for payment of medical services through an insurance carrier, prepaid medical plan, or government agency.

I request that payment be made to Behavioral Health Centers of Sarasota for any bills for service rendered to me by my doctor.

I understand that I am financially responsible to my doctor for any balance not covered by this authorization. I understand that insurance filing is done as a courtesy for the patient and my doctor takes no responsibility for denial or delay of payment.

Responsible Party's Signature _____ Printed Name of Signee _____

Patient Name _____ Date _____

Behavioral Health Centers of Sarasota has adopted a policy, in order to comply with HIPAA Privacy Regulations, requiring physicians and staff to obtain authorization from the patient in order to leave detailed messages for that patient. This policy is meant to protect the patient's privacy. If there is not a signed consent on file, physicians and staff will leave only a name and telephone number on an answering machine, voicemail, or with a live person answering the phone.

With my consent, Behavioral Health Centers of Sarasota may use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). Please refer to Behavioral Health Centers of Sarasota Notice of Privacy Practices for a more complete description of uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Behavioral Health Centers of Sarasota reserves the right to revise its Notice of Privacy Practices at any time.

INFORMED CONSENT FOR TREATMENT

I give my consent for services for myself or my child/legal dependent with Behavioral Health Centers of Sarasota and associated members of the professional staff to include evaluation, psychotherapy, medication management, testing (if indicated), and involvement in the treatment planning process. I may at any time decline specific recommendations.

We reserve the right to discharge any patient from this practice at any time for failure to comply with treatment recommendations or office policy responsibilities.

Responsible Party's Signature _____ Printed Name of Signee _____

Patient Name _____ Date _____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.

I, ___DO/___DO NOT, authorize Behavioral Health Centers of Sarasota to release information related to my evaluation and treatment to:

Primary Care Physician			Phone	
Street	City		State	Zip

Responsible Party's Signature _____ Printed Name of Signee _____

Patient Name _____ Date _____

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5602 Marquesas Circle
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HIPAA ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document updated November 14, 2014.

Signature of Patient/ Patient's Representative _____ Printed Name of Signee _____

Relationship to Patient _____ Date _____

AUTHORIZATION TO VERBALLY OBTAIN/RELEASE/EXCHANGE PHI

I hereby authorize Behavioral Health Centers of Sarasota to verbally release, receive from, or exchange with the names below. Please circle any or all that apply.

Name	Type of Information		
	Scheduling	Billing	Treatment
	Scheduling	Billing	Treatment
	Scheduling	Billing	Treatment

This authorization has no expiration date, but I understand that I may revoke this authorization at any time by providing a written statement to our office.

Signature of Patient/ Patient's Representative _____ Printed Name of Signee _____

Relationship to Patient _____ Date _____

BEHAVIORAL HEALTH CENTERS OF SARASOTA
Gleydys Salgado Cardoso, M.D.
Carol Monroe PMHNP-BC, Guerline Antoine PMHNP-BC
Daniel Huk- LMHC- Mary Cantillo LMHC

TELEHEALTH INFORMED CONSENT

As a patient receiving mental health services through telehealth methods, I understand that such service is provided by technology (including but not limited to video, phone, text, and email) and in part or in whole does not involve direct, face to face communication. TECHNOLOGY/EQUIPMENT: If a remote video platform is utilized, then I understand that I will need an installed and working webcam and speakers or headphones. I understand that I will receive an e-mail or text with a link to open the remote video program, via iPhone or other cellular phone or other internet enabled device may not work and may not be appropriate.

The quality of the communication depends upon the sophistication and reliability of the telehealth medium used based upon my own internet connection, my provider's internet connection, the program itself, or the program's internet cloud based system. I understand that there could be some miscommunication or lack of communication as a result of technological limitations or unreliability inherent within my or my provider's internet service and platform utilized which are not under the control of myself or my provider.

In the event of disruption of the telehealth service or in the event of an emergency, or for other routine or administrative reasons, it may be necessary to communicate by other means such as direct telephone communication. The following phone numbers will be set up as a backup in the event the telehealth platform cannot be utilized from the start of the scheduled session or at any time after the session begins:

Providers at Behavioral Health Centers of Sarasota

Patient:_____

CONFIDENTIALITY: I understand that other BHCS staff be may present during the session to initiate the connection or if there is a problem only to assure reliable operation of the telehealth system. Such staff will maintain confidentiality of any information under contractual arrangements and/or Federal law and/or State law.

While telehealth services allow for greater convenience in service delivery, there are risks in transmitting information over the internet that include, but are not limited to: breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties which may not be under the control of either my mental health services provider or myself.

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ENVIRONMENT: It is my responsibility to maintain privacy and a controlled quiet environment on my end of the telehealth communication which means that there should be not any disruption such as from children, animals, family members, other individuals, or other environmental disruptions (e.g., telephone calls or ringtones, etc.).

DOCUMENTATION: I understand that the documentation my provider writes in relation to any telehealth session will be created and stored in the same EHR system as any note created from a face to-face appointment/session. Such documentation falls under the same legal, professional, and contractual guidelines as any document stored as the result of a face-to-face appointment/session. No different than any documentation in my record, I understand that I have access to information resulting from the telehealth service to the extent required by State and Federal law.

RIGHT TO WITHDRAW CONSENT: I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time so long as it is provided in writing in accordance with State and/or Federal law without affecting my right to future care or treatment. As long as this consent is in force, telehealth services may be provided to me without the need to sign another consent form.

RECORDING: If my provider provides the telehealth service in the State of Florida, then according to Florida law and under penalty of Florida law, I understand that there will be NO recording of any video or audio information from the telehealth session by myself or my provider or any other participant in my telehealth session(s) without the mutual signed consent of myself and my provider (and any other participant as applicable).

COMPLIANCE WITH LAW: I understand that telehealth services provided to me must comply with State and Federal (HIPAA) law and I acknowledge that I am aware of such laws. I understand that the reporting requirements (e.g., to law enforcement or a state agency) which may be mandatory under State law are no different than if the service was provided face-to-face as per the Consent Form I originally signed for service.

INSURANCE: I understand that telehealth services may or may not be a covered benefit under my insurance plan; if they are covered, any plan co-pay and deductible will apply. The same No-Show and Cancellation policies previously signed and agreed to at the start of treatment remain in effect.

I have read or had this form read and/or had this form explained to me.
I am choosing voluntarily to participate in a telehealth consultation. This document does not replace other agreements, contracts, or documentation of informed consent.

_____ _____
Patient Name Patient or Legal Guardian (if applicable)

_____ _____ _____
Signature of Patient, Parent or Legal Guardian Date Patient Date of Birth

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