WELCOME TO OUR OFFICE

Today's Date ______________________

GREATER ORLANDO PSYCHIATRIC ASSOCIATES, P.A.
1417 N Semoran Blvd. Ste 203
Orlando, FL 32807
(407) 206-1106

PATIENT INFORMATION

Name:	Social Security Number:	Birth Date:	Marital Status : Single ☐ Married ☐ Widowed ☐ Divorced ☐

Street Address:	Apt Number:	City:	State:	Zip Code:

Home Phone:	Work Phone:	Cellular Phone:

Occupation/Student FT/PT	Are you above 18 Years of Age? Yes ☐ No ☐	If you are not 18 years of age, A parent or Guardian must sign these forms for consent to treat and financial responsibility.

GUARANTOR INFORMATION *(Required if patient is under18 years of age)*

Name:	Social Security Number:	Birth Date:	Day Time Phone:

Street Address: (If different from Child)	Apt Number:	City:	State:	Zip Code:

INSURANCE INFORMATION

Do You Have Medical Insurance? Yes ☐ No ☐	Type Of Insurance: HMO ☐ Medicare ☐ Medicaid ☐ PPO ☐ Worker's Comp. ☐ Other________________

Primary Insurance Company:	Policy Number:	Group Number:	Authorization Number:

Insurance Company Claims Address:	Insurance Phone Number:	Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other________

Name of Policy Holder:	Date of Birth:	Social Security #	Address if different from patient:

Is the policy through an employer? Yes ☐ No ☐	Name of Employer:	Business Address:

Secondary Insurance? Yes ☐ No ☐	Secondary Insurance Company:	Policy Number:	Group Number:

Secondary Claims Address:	Secondary Phone Number:	Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other________

CLINICAL INFORMATION

Known Allergies:	Primary Care Physician:	Physician Phone Number

Emergency Contact	Relationship to Patient:	Phone:

What is your chief complaint?

I declare all above information is true and authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage.

Patient or Guarantor Signature____ Date__________________________

Physician's Assignment and Release

INFORMED CONSENT FOR TREATMENT: I, the patient/guarantor, agree and consent to participate in behavioral health care services offered by Greater Orlando Psychiatric Associates, P.A. I understand that I am consenting and agreeing only to those services that the above named group's providers are qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of the license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and or/legally authorized to initiate and consent to treatment on behalf of this individual.

RELEASE OF INFORMATION: The undersigned hereby authorizes any Physician/Nurse Practioner/Therapist who have attended the patient to furnish any potentially liable insurance companies or their representatives with any and all information concerning hospitalization, treatment, interpretation and/or examination that may be contained in their medical records.

ASSIGNMENT OF INSURANCE BENEFITS: As undersigned, I hereby authorize direct payment to any involved Healthcare Providers of the benefits otherwise payable to the patient or guarantor. I also assign any and all rights to insurance coverage relative to this treatment, but not to exceed the regular charges for consultation, treatment, interpretation and/or examination.

FINANCIAL RESPONSIBILITY: As undersigned, I understand that I am responsible for any service rendered by a Physician/Therapist, regardless of whether this service is covered by an insurance policy. I understand that payment is due at the time of service unless other arrangements have been made in advance. The accepted methods of payment are Cash, Check (processed electronically), Visa, Mastercard, and Discover. If my insurance companies requires pre-certification, I understand that I am responsible for obtaining the initial authorization.

Returned checks will be charged a $35.00 fee. Missed appointments or appointments not canceled with a minimum of twenty-four hours notice will be assessed a fee of $25.00.

CONFIRMATION OF APPOINMENTS: At Greater Orlando Psychiatric Associates, P.A., one of our top priorities is to maintain our patients' confidentiality. As we call to confirm your future appointments, please indicate below which telephone number you would prefer us to use.

Telephone number to confirm appointments: (________) _________ - _______________

____________________________	X______________________________	X_________________
Patient Name (Please Print)	Patient/Guarantor Signature	Date

____	X____________________________
Guarantor Name and relationship (If applicable)	Witness

PRIMARY CARE PHYSICIAN
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This form will allow your Behavioral Health Provider to share protected health information with your Primary Care Physician. This information will not be released without your signed authorization. This protected health information may include diagnosis, treatment plan, progress, lab reports, and medication if necessary. <u>You are not required to complete this authorization form.</u>

I hereby authorize:

GREATER ORLANDO PSYCHIATRIC ASSOCIATES, P.A.
1417 N. SEMORAN BLVD SUITE 203
ORLANDO, FL 32807
PHONE: (407) 206-1106 FAX: (407) 206-1112

To release confidential protected health information, including personal, psychological, psychiatric, substance abuse, AIDS-related information, medical records, and opinions resulting from my contact with them for the purpose of providing coordination and continuity of care, to:

____
Primary Care Physician

____
Address

____
City/State/Zip

____
Phone Fax

I understand that this consent is revocable upon written notice to the facility, except to the extent that action has already been taken by the facility pursuant to this authorization. This consent shall remain in force for twelve months.

________________________________ ______/____/________
Patient Name (Please Print) Patient Date of Birth

________________________________ ______/____/________
Signature - Patient, Custodial Parent, Date Signed
Custodial Guardian, or Power of Attorney

________________________________ ______/____/________
Witness Date Signed

PATIENT QUESTIONNAIRE

Name: ______ Age: ______ Marital status: ______
Occupation: ______ Place of employment ______
If a student, Grade level: ______ School: ______
Lives with: ______
Who referred you to us? ______

Please check all that apply:

☐ depressed mood	☐ suicidal thoughts	☐ obsessions	☐ alcohol abuse	☐ bedwetting
☐ anxiety	☐ homicidal thoughts	☐ rituals	☐ drug abuse	☐ soiling
☐ lack of interest	☐ self destructive acts	☐ hallucinations	☐ seizures	☐ learning problems
☐ decreased sleep	☐ poor concentration	☐ delusions	☐ blackouts	☐ delayed development
☐ increased sleep	☐ mood swings	☐ trauma	☐ DTs	☐ mental retardation
☐ decreased appetite	☐ muscle tension	☐ flashbacks	☐ hyperactivity	☐ other:______________
☐ increased appetite	☐ panic attacks	☐ nightmares	☐ impulsivity	☐ other:______________
☐ guilt	☐ headaches	☐ dissociation	☐ inattention	☐ other:______________
☐ social withdrawal	☐ stomach aches	☐ gambling	☐ distractibility	☐ other:______________
☐ hopelessness	☐ muscle aches	☐ lying	☐ explosive temper	☐ other:______________
☐ helplessness	☐ back pain	☐ phobias	☐ poor frustration	☐ other:______________

Duration of condition: ______
Triggers/stressors: ______

List all current medications and dosages with name of prescribing physician: ______

Allergies: ______
Medical illnesses: ______

Are you on medical leave? N/Y by whom/when? ______
Are you in counseling? N/Y If yes, name of counselor: ______
List all psychiatric hospitalizations and dates: ______

History of physical abuse N/Y (by whom/when?) ______

History of domestic violence N/Y (by whom/when?) ______

History of drug/alcohol or cigarette use? N/Y describe: ______

Do you currently use alcohol, drugs, or cigarettes? N/Y describe: ______

History of legal problems N/Y (details, when?) ______

Are you on probation N/Y If yes, name of Probation Officer ______

Where were you born?______________________________ Raised in?________________________________
How many brothers?____________ Sisters?____________ Birth Order?____________________________________
Parents Divorced? If yes, how old were you then?

Signature (Patient/Parent/Legal Guardian) ______ Printed Name ______ Date ______