

## BOCA RATON PSYCHIATRIC GROUP, P.A.

### PLEASE PRINT

DATE \_\_\_\_\_

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Male ☐ Female ☐ Other

AGE \_\_\_\_\_

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

PATIENT'S LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ APT \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ REFERRED BY \_\_\_\_\_

EMPLOYER \_\_\_\_\_ EMPLOYER ADDRESS \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ CELL# \_\_\_\_\_ EMAIL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ DRIVER LICENSE # \_\_\_\_\_

PHARMACY NAME/ADDRESS \_\_\_\_\_

PHARMACY PHONE # \_\_\_\_\_

SECONDARY ADDRESS:

\_\_\_\_\_  
\_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

### FINANCIAL RESPONSIBILITY

GUARANTOR'S LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ M \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_ DRIVER LIC # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

IS THIS CASE RELATED TO ANY LITIGATION? ☐ YES ☐ NO

DOES A LAWYER REPRESENT YOU? ☐ YES ☐ NO

### INSURANCE INFORMATION

NAME OF INSURANCE COMPANY \_\_\_\_\_

**PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)**

**PLEASE INCLUDE A COPY OF YOUR ID**

A PHYSICIAN/CLINICIAN – PATIENT TREATMENT RELATIONSHIP WILL BE ESTABLISHED IF MUTUALLY AGREED TO UPON COMPLETION OF THE INITIAL CONSULTATION PROCESS. WE DO NOT ACCEPT ASSIGNMENT FOR MEDICARE IN THIS OFFICE. WE DO REQUIRE PAYMENT AT THE TIME SERVICE ARE RENDERED.

### **AUTHORIZATION**

I AUTHORIZE BOCA RATON PSYCHIATRIC GROUP, P.A.(BRPG) TO RELEASE ANY MEDICAL OR PSYCHIATRIC INFORMATION (INCLUDING PSYCHOTHERAPY AND SUBSTANCE ABUSE RECORDS) TO THE HEALTH CARE ADMINISTRATION, MY INSURANCE COMPANY, MEDICARE AND THEIR AGENTS AS NEEDED TO AUTHORIZE THESE BENEFITS OR THE BENEFITS PAYABLE FOR THESE SERVICES. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND INSURANCE BENEFITS BE MADE ON MY BEHALF TO BOCA RATON PSYCHIATRIC GROUP, P.A. FOR SERVICES FURNISHED BY ITS AGENTS OR PROVIDERS. I ALSO AGREE THAT ANY AND ALL BALANCES WILL BE PAID BY ME, AND THAT PHOTOCOPIES OF THIS FORM WILL BE VALID. I REQUEST THAT THIS INFORMATION ALSO APPLIES TO ALL OTHER INSURANCE COMPANIES.

THERE IS AN ADMINISTRATIVE FEE FOR PAYMENTS MADE BY METHODS OTHER THAN CASH OR CHECK. CHARGES LESS THAN \$100.00= \$3.00. CHARGES \$100.00 OR MORE = \$6.00.

GOOD FAITH ESTIMATE – FOR PATIENTS WHO PAY PRIVATELY, OUR PSYCHIATRIC FEE PER EVALUATION AND/OR CONSULTATION IS \$495.00 FOR THE 1<sup>ST</sup> HOUR & \$750 FOR 1.5 HOURS. THE TYPICAL FOLLOW-UP VISIT IS \$277 BUT MAY RANGE AS HIGH AS 602.00. PSYCHOTHERAPISTS BILL AT A LOWER RATE. YOU MAY REQUEST A WRITTEN GOOD FAITH ESTIMATE FOR EXPECTED SERVICES.

**I UNDERSTAND I WILL NOT RECEIVE A CONFIRMATION CALL FROM BRPG, PA REMINDING ME OF MY SCHEDULED VISIT. I UNDERSTAND THAT IF I FAIL TO KEEP A SCHEDULED APPOINTMENT OR CANCEL WITHOUT 1 FULL BUSINESS DAYS TO KEEP A SCHEDULED APPOINTMENT OR CANCEL WITHOUT 1 FULL BUSINESS DAY (24 HOURS) NOTICE, I WILL BE RESPONSIBLE FOR THE FULL NORMAL FEE OF BRPG.**

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY THE INSURANCE CARRIER. **I UNDERSTAND I WILL NOT RECEIVE A CONFIRMATION CALL REMINDING ME OF MY VISIT.** I UNDERSTAND THAT IF THE CHARGES FOR SERVICES RENDERED BY BOCA RATON PSYCHIATRIC GROUP, P.A. ARE NOT PAID WITHIN 60 DAYS OF THE DATES OF SERVICE, I AM OBLIGATED TO REIMBURSE BRPG THE FEES CHARGED BY ANY COLLECTION AGENCY, WHICH WILL BE ADDED TO THE ACCOUNT AT THE TIME ITS PLACED WITH THE AGENCY FOR COLLECTION. THIS MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 30% OF THE DEBT PLUS ALL REASONABLE COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEY FEES INCURRED IN SUCH COLLECTION EFFORTS. FURTHERMORE, I UNDERSTAND I WILL BE CHARGED INTEREST ON A MONTHLY BASIS AT A RATE OF 18% ANNUALLY, UNTIL SUCH DEBT IS PAID IN FULL.

WE DO NOT CHARGE FOR PHONE CALLS REGARDING A QUICK QUESTION OR SIMPLE ISSUE, BUT CALLS LASTING OVER 3-5 MINUTES MAY INCUR A CHARGE SIMILAR TO AN OFFICE VISIT CHARGE.

I HAVE INFORMED BOCA RATON PSYCHIATRIC GROUP, P.A. AND ITS AGENTS OF MY INSURANCE COVERAGE OR LACK THEREOF. I UNDERSTAND THAT IF MY INSURANCE STATUS CHANGES (INCLUDING MEDICARE), IT IS MY RESPONSIBILITY TO INFORM BOCA RATON PSYCHIATRIC GROUP, P.A. AND THERE WILL BE NO REFUND, NULLIFICATION, OR REIMBURSEMENT OF THE FULL, NORMAL FEE PAID OR OWED TO BOCA RATON PSYCHIATRIC GROUP, PA. FOR SERVICES PROVIDED UP TO THE DATE OF NOTIFICATION.

I AM AWARE THAT ALL PSYCHIATRIC MEDICATIONS HAVE SOME ABILITY TO IMPAIR COORDINATION OR ALERTNESS AND I NEED TO CONSIDER THIS BEFORE I DRIVE OR OPERATE MACHINERY, THIS IS ESPECIALLY TRUE WHEN STARTING A NEW MEDICATION OR INCREASING A DOSE.

### **MUST FILL AREAS BELOW**

SIGNED: \_\_\_\_\_  
(IF GUARDIAN OR LEGAL REPRESENTATIVE, ALSO PRINT NAME)

PATIENT'S NAME: \_\_\_\_\_

DATED: \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

REASON FOR VISIT TODAY? \_\_\_\_\_

### **MEDICAL HISTORY**

ALLERGIES OR DRUG REACTIONS: \_\_\_\_\_

MEDICATIONS (PLEASE LIST ALL MEDICATIONS INCLUDING ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS & SUPPLEMENTS TAKEN IN THE PAST 3 MONTHS):

NOW? \_\_\_\_\_

IN THE PAST THREE MONTHS? \_\_\_\_\_

DOU YOU CONSUME GRAPEFRUIT/GRAPEFRUIT JUICE Y\_\_\_ / N\_\_\_ (INTEREACTS WITH MEDS)

### **HABITS:**

	CURRENT USE	PAST USE
TOBACCO	_____	_____
ALCOHOL	_____	_____
“RECREATIONAL DRUGS”	_____	_____
CAFFEINE	_____	_____

### **ILLNESS: (PAST AND PRESENT)**

CARDIAC? Y\_\_\_ N\_\_\_ THYROID? Y\_\_\_ N\_\_\_ GLAUCOMA? Y\_\_\_ N\_\_\_  
SEIZURES? Y\_\_\_ N\_\_\_ DIABETES? Y\_\_\_ N\_\_\_ CHOLESTEROL PROBLEMS? Y\_\_\_ N\_\_\_  
SURGERIES? \_\_\_\_\_  
ACCIDENTS/HEAD INJURIES? \_\_\_\_\_  
OTHER MEDICAL PROBLEMS? \_\_\_\_\_

**FEMALES ONLY:** ARE YOU PREGNANT? Y\_\_\_ N\_\_\_ PLANNING TO GET PREGNANT? Y\_\_\_ N\_\_\_

NUMBER OF PREGNANCIES \_\_\_\_\_ MISCARRIAGES \_\_\_\_\_ ABORTIONS \_\_\_\_\_

### **PSYCHIATRIC HISTORY**

PREVIOUS PSYCHIATRISTS/THERAPISTS: WHEN? \_\_\_\_\_

MEDICATIONS PRESCRIBED IN THE PAST? \_\_\_\_\_

PSYCHIATRIC HOSPITALIZATIONS: WHEN? \_\_\_\_\_ WHY? \_\_\_\_\_

WHEN? \_\_\_\_\_ WHY? \_\_\_\_\_

### **FAMILY HISTORY**

PSYCHIATRIC PROBLEMS (IN YOUR FAMILY): \_\_\_\_\_

SUICIDE ATTEMPTS IN YOUR FAMILY? \_\_\_\_\_

SEIZURES \_\_\_\_\_ THYROID DISEASE \_\_\_\_\_

DRUG PROBLEMS? \_\_\_\_\_ ALCOHOL ABUSE PROBLEMS? \_\_\_\_\_

NAME: \_\_\_\_\_

CURRENT SYMPTOM CHECKLIST

(PLEASE X THOSE THAT APPLY CURRENTLY)



- \_\_\_ Sadness/Depressed mood
- \_\_\_ Appetite change
- \_\_\_ Loss of energy
- \_\_\_ Difficulty concentrating
- \_\_\_ Loss of interest/pleasure in activities
- \_\_\_ Guilt
- \_\_\_ Worthlessness
- \_\_\_ Hopelessness
- \_\_\_ Work Issues
- \_\_\_ Trouble falling asleep
- \_\_\_ Waking during the night
- \_\_\_ Early morning awakening (too early)
- \_\_\_ Declining school grades or work performance
- \_\_\_ Elevated mood
- \_\_\_ Suicidal thoughts
- \_\_\_ Passive thoughts
- \_\_\_ Do you possess a gun: Yes / No / Choose not to answer
- \_\_\_ Suicidal Intent
- \_\_\_ Suicidal plan
  
- \_\_\_ Anxiety
- \_\_\_ Excessive worry
- \_\_\_ Excessive Energy
- \_\_\_ Hypersexuality
- \_\_\_ Panic attacks
- \_\_\_ Fears/Phobias
- \_\_\_ Obsessions
- \_\_\_ Compulsions
- \_\_\_ Worry
- \_\_\_ Rituals/things needed to be "just so"
- \_\_\_ Flashbacks
  
- \_\_\_ Thoughts of hurting others
- \_\_\_ Decreased need for sleep
- \_\_\_ Speeded up thoughts
- \_\_\_ Grandiosity
- \_\_\_ Excessive speech/Pressured speech
- \_\_\_ Flight of Ideas
- \_\_\_ Excessive activity
- \_\_\_ Irritability

NAME: \_\_\_\_\_

(PLEASE X THOSE THAT APPLY CURRENTLY)



- \_\_\_ Feeling others are against you
- \_\_\_ Belief that thoughts are being controlled
- \_\_\_ Hallucinations
- \_\_\_ False Beliefs

- \_\_\_ Overactivity
- \_\_\_ Short attention span
- \_\_\_ Distractibility
- \_\_\_ Impulsivity
- \_\_\_ Lying
- \_\_\_ Stealing
- \_\_\_ Oppositional or defiant
- \_\_\_ Temper problems

- \_\_\_ Legal problems
- \_\_\_ Aggression/Violence
- \_\_\_ Misuse of prescription drugs
- \_\_\_ Skipping school

- \_\_\_ Fear of becoming fat
- \_\_\_ Binge eating
- \_\_\_ Vomiting or using laxatives to lose weight

- \_\_\_ Problems with family relationships
- \_\_\_ Problems with money
- \_\_\_ Low Sex Drive
- \_\_\_ Memory problems

NAME \_\_\_\_\_

DATE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

## Checklist: Review of Systems (Please check boxes that apply)

- Constitutional**      ☐ weight loss ☐ weight gain ☐ fatigue ☐ general weakness ☐ fever
- Eye**                      ☐ visual changes ☐ eye pain ☐ double vision ☐ blurry vision  
☐ flashing lights
- Ears, nose, throat**      ☐ runny nose ☐ stuffy nose ☐ frequent nose bleeds ☐ stuffy ears  
☐ ear pain ☐ ringing in ears ☐ hearing loss
- Cardiovascular**      ☐ chest pain ☐ exercise intolerance ☐ palpitations ☐ faintness,  
☐ Lightheadedness upon standing
- Respiratory**              ☐ cough ☐ sputum ☐ wheeze ☐ shortness of breath
- Gastrointestinal**      ☐ abdominal pain ☐ difficulty swallowing ☐ nausea ☐ vomiting  
☐ bloody stools ☐ black tarry stools ☐ heartburn ☐ yellow eyes or skin  
☐ diarrhea ☐ constipation
- Genitourinary**              Urinary: ☐ incontinence ☐ pain ☐ night urination ☐ hesitancy ☐ bloody  
**Female:** ☐ menopause ☐ low sex drive ☐ vaginal-discharge  
☐ heavy menses ☐ hot flashes ☐ trouble reaching orgasm  
**Male:** ☐ low sex drive ☐ erectile dysfunction ☐ pain with sex  
☐ trouble reaching orgasm
- Musculoskeletal**      ☐ falls ☐ muscle pain ☐ stiffness ☐ joint swelling ☐ joint pain ☐ arthritis  
☐ back pain
- Skin/Breast**              ☐ itching ☐ rashes ☐ excessive dryness ☐ hair loss  
☐ breast pain or discharge
- Neurological**              ☐ limb weakness ☐ seizures ☐ fainting ☐ headache ☐ pins and needles  
☐ numbness ☐ poor balance ☐ speech problems ☐ dizziness ☐ tremor
- Endocrine**                  ☐ sweaty ☐ excessive thirst ☐ excessive amounts of urine  
☐ heat or cold intolerance,      **Female:** ☐ irregular periods
- Blood System**              ☐ anemia ☐ excessive bleeding ☐ easy bruising
- Immunologic**              ☐ recurrent infections ☐ allergic reactions ☐ swelling of lymph nodes



## TEXT REMINDER

I request that Boca Raton Psychiatric Group (BRPG) send me appointment reminder texts to the following cell phone number:\_\_\_\_\_

I understand that the text will say the name of the clinician I am seeing as well as the office phone number. The text messages are informational only and cannot be responded to.

I understand that text messages are unable to be sent in an encrypted format.

I understand that this is just an added assistance and that if for some reason I do not get the text, I am still responsible for keeping the appointment and for informing BRPG of any changes in my phone number.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print

Date\_\_\_\_\_

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## HIPAA PRIVACY PRACTICES

PLEASE LET THE FRONT OFFICE KNOW IF YOU WOULD LIKE A COPY OF OUR HIPAA PRIVACY PRACTICES.

### PLEASE PRINT AND SIGN YOUR NAME

I,\_\_\_\_\_ (print name) have been offered/read a copy of Boca Raton Psychiatric Group's Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

(Our Notice of Privacy Practices is subject to change. If you would like to check on an update in the future, please contact us.)

## **A NOTE TO OUR PATIENTS**

We would like to take the opportunity to highlight some of our routine office practices so that we can avoid misunderstandings in the future.

### **1. PRESCRIPTIONS:**

If you are on medication, we generally prescribe ample medication to last until your next appointment. If you return for appointments as recommended, you should not run out of medicine. Please remember that our office does not “call in” routine prescriptions to your pharmacy. Our policy is to provide written prescriptions. There should be enough medication on the previous prescription until the next scheduled appointment. Please note: if your physician does feel it is appropriate to call in prescriptions, we can only do so during routine office hours. As we do not have access to our patients’ charts outside office hours, we do not feel the best medical care can be provided under these circumstances. Anytime you need to have a refill on medication it is important to check if you are due for an appointment by calling our staff. You can check the status of any refills prior to the end of the working day. There will be a fee for any services extra to writing prescriptions, eg: faxing or mailing prescriptions, getting authorizations, etc.

### **2. CANCELLING APPOINTMENTS:**

It is important that you call to cancel existing appointments for at least a full business day in advance. A specific time is allotted for appointments. Without advance notice, we are unable to utilize this time for other patients who might need to see us. Therefore, you will be charged for the time that was held for your appointment. We would rather not charge you and would rather utilize the time for other patients. You would need to cancel a Monday appointment on the prior Friday morning in order for us to try to utilize that time.

### **3. EMERGENCIES:**

Please call between appointments if any urgent clinical matters arise. If a clinical emergency or urgent situation arises outside routine office hours, you can reach us through our answering service. However, please utilize this only for true emergencies and not for routine matters. If we are unavailable due to vacation etc., there will always be a covering psychiatrist to assist you.

### **4. PHONE CALLS FROM OUR OFFICE:**

Please pay attention to incoming calls and voicemails from our office because they usually contain important information about your health and/or appointments.

**PATIENTS: PLEASE KEEP THIS PAPER FOR YOUR INFORMATION.**

**OVER**

## PROCEDURES FOR PATIENTS RECEIVING PRESCRIPTIONS FOR MEDICATIONS

1. Your Psychiatrist is placing you on medication(s) for purposes of assisting in the relief of your current symptoms. It is expected that you will share in the responsibility for your treatment by taking your medication(s) as directed. If you have symptoms, which you think may be medication side effects, you should contact your Psychiatrist.
2. It is important that you keep all your appointments with your Psychiatrist in order for him/her to monitor your progress and make any necessary changes or adjustments.
3. Medication renewal will occur during the medication follow-up sessions with the prescribing Psychiatrist. You have an obligation to present yourself in person for medication monitoring. Medications will not be prescribed over the telephone routinely.
4. You are strongly urged to keep your regularly scheduled appointment to avoid running out of your medication prescribed by your doctor. You are encouraged to monitor your supply closely and check with your pharmacy for refills when your supply is low.
5. If you are not able to keep your scheduled appointment with your Psychiatrist due to an emergency and you are about to run out of medication, please call your Psychiatrist as soon as possible. Please note that we do not respond to faxes for refills from pharmacies. We only respond to calls directly from patients.
6. Please be aware that all requests for medications due to your absence are subject to your doctor's discretion and **may not be granted without an office visit**. The amount of medication authorized upon a telephone request may only be equal to the number of days until the rescheduled face-to-face monitoring session.
7. **Do not wait until you are out of medication to call the office.** Please allow two (2) business days for your doctor to contact the pharmacy. The office staff cannot guarantee that your doctor will be able to reach the pharmacy to order medication the same day you call.
8. If a second monitoring session is missed, no medication authorization shall occur until you attend an in person medication monitoring appointment with your Psychiatrist.

**OVER**

Notifier: Boca Raton Psychiatric Group, P.A. 7100 W Camino Real, Ste. 401, Boca Raton, FL 33433

Telephone: 561 368-8998 561-392-9170

Patient Name:

Identification Number:

## Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for Service below, you may have to pay.

Medicare does not pay for everything; even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Service below.

Item or Service:	Reason Medicare May Not Pay:	Estimated Cost
99205 Evaluation & Management Official New Patient Consult	Because Medicare May Determine That This Procedure Is Not Medically Necessary Or Documentation Does Not Meet Criteria For Billing Code.	

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Service listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**OPTIONS:** Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the Service listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the Service listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the Service listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**Additional Information:** Additional Valid Date: Please Choose One Option:

Option 1. \_\_\_\_\_ Option 2. \_\_\_\_\_ Option 3. \_\_\_\_\_ Date: \_\_\_\_\_ Initials \_\_\_\_\_

Option 1. \_\_\_\_\_ Option 2. \_\_\_\_\_ Option 3. \_\_\_\_\_ Date: \_\_\_\_\_ Initials \_\_\_\_\_

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Patient Signature or Representative:	Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11)

Form Approved OMB No. 0938-0566

## EXCHANGE / RELEASE OF INFORMATION

***I AUTHORIZE THE RELEASE OF INFORMATION***

**FAX OR MAIL REQUEST** \_\_\_\_\_  
DATE / INITIALS