Continental Psychiatric Services, PLLC
2672 1st Ave. S.
Saint Petersburg, FL 33712
Phone: (727) 800-9705
Fax: (727) 800-9806
Email: assistant.fl@continentalpsychiatry.com
Website: www.continentalpsychiatry.com

NAME: _____
DOB: _____
DATE: _____

Patient's Information Form

A copy of your identification card and medical insurance card is needed at the time of the intake appointment!

Patient's Last Name: _____ First Name: _____

Middle Name: _____ Date of Birth: _____ SS#: _____ Gender: F/ M

Address (Street #, City, Zip Code): _____

Phone Number: (H)_____ (C)_____

May we leave message? On your home phone number (YES/ NO); on your cell phone number (YES/ NO)

Emergency Contact (Name, DOB, Relationship): _____

Emergency Phone Number: _____

Marital Status: _____Name of Spouse (If applicable): _____

Others living at home (Name, DOB, Relationship to you and any relevant comments):

1. _____
2. _____
3. _____

Employer: _____ Occupation: _____

How long have you worked/ been working there: _____ Education? _____

Have you been in therapy before: YES / NO.? If yes, when: _____

Name of therapist: _____

Give brief description of issues worked on: _____

Referred by (therapist, physician, yellow pages, friend, etc.): _____

Pharmacy's name, complete address, phone number:

_____

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Authorization for Treatment

I hereby authorize Continental Psychiatric Services, PLLC and the providers affiliated to the practice, to give and/or administer psychiatric and medical treatment and any appropriate patient care services which, in their judgment becomes necessary to my care.

_____
Patient or Guardian Signature

_____
Relationship to Patient

_____
Witness (Name and Signature)

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Patient's Financial Responsibility Form (1 of 2)

I authorize payments of medical benefits to Continental Psychiatric Services, PLLC for services rendered.

Payment in full for services are due at the time services are rendered. Co-payments will be collected at the time of service. Professional fees, services fees, co-payments and deductibles are non-refundable. There will be a $20 fee for returned checks.

I understand and agree that I am financially responsible for all charges for all services rendered.
This includes any medical service or visit, and any other screenings, procedures or tests ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered.

I understand that I am responsible for any services or charges that are determined by my insurance carrier not to be medically necessary.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary insurance ID card. If the office does not have the proper information for a secondary insurance, the secondary insurance will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. **Questions about non-payment or about any invoices received from our office, should be directed to your insurance company.**

If you are unable to keep your scheduled appointment, we ask that you give adequate notice of 24 hours prior to your appointment time, so that we may open your reserved time for another patient. There will be a $50.00 charge if you don't provide the office a 24-hour notice of cancellation. If you miss two appointments without proper notice, you will be required to pay a $50.00 deposit prior to scheduling further appointments. This is a good-faith deposit to reserve your appointment time.

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Patient's Financial Responsibility Form (2 of 2)

When the appointment is kept, this $50.00 fee will be applied to your office visit fees or refunded as appropriate. If the appointment is missed without proper notice of cancellation, the deposit becomes non-refundable.

The patient understands:

- Protected health information may be disclosed or used for treatment, billing, health care operations and/or as required by law.
- Continental Psychiatric Services, PLLC has a summary Notice of Privacy Practices, and the patient can review this notice.
- The patient has the right to be informed when their PHI is believed to have been breached.
- The patient is allowed to restrict PHI disclosure to their health plan if the patient is agreeing to pay out of pocket and in full for services rendered.

The doctors and staff of Continental Psychiatric Services, PLLC appreciate your compliance with these policies and procedures. We strive to provide the best mental health available to you. We are happy to discuss any questions or concerns you have about these policies.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Continental Psychiatric Services, PLLC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient's or Guardian's Signature: _____

Continental Psychiatric Services, PLLC Witness: _____

I give permission to communicate my Private Healthcare Information (PHI) to:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

The authorization to communicate patient's PHI will be valid until expressly revoked by the patient.

Our office does not make the rules. They are determined by your specific medical insurance.

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Authorization for Coordination of Care

To complete your psychiatric evaluation, it is crucial for your clinician to review your most recent physical examination, blood work, EKG and any other pertinent medical information.

Please fill out and sign this form to authorize your clinician to exchange information regarding your medical and behavioral health condition to your primary care physician and any other behavioral health provider who may be directly involved in making decisions regarding your healthcare. This authorization will remain in effect indefinitely, as it is necessary for coordination and continuation of care purposes.

Please notify your behavioral health provider whenever you change your primary care physician.

I authorize CONTINENTAL PSYCHIATRIC SERVICES PLLC and its medical providers to exchange information, written or verbal, with each other and/or to the person(s) or organization(s) listed below for ongoing coordination of care:

1. Primary care physician (name, address, phone and fax number):

Name:_____

Address:_____

Phone No. _____ Fax No. _____

2. Other behavioral healthcare provider involved in treatment, e.g., psychiatrist or psychotherapist/ psychologist (name, address, phone, and fax number):

Name: _____ Title: _____

Address:_____

Phone No. _____ Fax No. _____

Patient's signature: _____

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____, V code: _____(security code on the back of the card)
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I authorize Continental Psychiatric Services, PLLC to charge my credit/debit card above for the amount corresponding to my deductible, coinsurance, copayments, or any other patient's financial responsibility as per my insurance carrier benefits.
I understand that my information will be saved to file for future transactions on my account.

_____
Patient's Signature:

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Acknowledgement of Receipt of HIPPA Notice of Private Practices and Practice Policy

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and therefore been advised of how health information may be used and disclosed. I also acknowledge that I reviewed and fully understand the Practice Policy and Payment Policy. I agree to abide by the terms and conditions of this Agreement and to consent to participate in psychotherapy and or psychiatric treatment at Continental Psychiatric Services, PLLC

_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative Authority

****

(**For internal use** – where signature above cannot be obtained)

Except in emergency treatment circumstances, the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that we make a good effort to obtain written acknowledgment of the patient's receipt of the Notice of Privacy Practices on the first date after April 14, 2003, we provide treatment, products or services to the patient. We must make a good faith effort to obtain written acknowledgment when reasonably practicable following an emergency treatment situation. If such acknowledgment cannot be obtained, we must document our good faith efforts to obtain the acknowledgment and why it was not obtained.

Describe good faith efforts to obtain written acknowledgment
1._____
Name: _____Date: _____
2. _____
Name: _____Date: _____

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INFORMED CONSENT FOR THE USE OF EMAIL

Patients who wish to communicate with their therapist or psychiatrist and/or administrative staff using email, are welcome to do so. However, there are several privacy concerns and potential risk factors that should be considered before transmitting confidential information by email.

General concerns include email is immediately broadcast worldwide and can be received by unintended recipients; emails messages can be forwarded without sender's or intended recipient's permission or knowledge; emails can easily be misaddressed; back-up copies of emails may exist after the sender, or the recipient has deleted them; and email is easier to falsify than documents that are signed and sent by regular mail.

Privacy concerns related to a one's personal health information also need to be considered. It is the policy of our office to make all email messages concerning diagnosis and/or treatment part of that client's medical record and to treat these with the same degree of confidentiality as other portions of the medical record. We take all reasonable means to protect clients' confidentiality but cannot guarantee the security and confidentiality of email communication. Please read the following information outlining our office's conditions for the use of email.

- We cannot guarantee that electronic communications will be private. We take reasonable steps to protect confidentiality but is not liable for improper disclosure of confidential information not caused by negligence or misconduct.
- If the client chooses to use email, the client is responsible for informing our office of any limitations to the kind of information that will be sent by email.
- The client is responsible for protection of their own password or other means of access to email sent or received. We are not liable for breaches of confidentiality caused by the client.
- Because employees do not have a right of privacy in their employer's email system, clients should not use their work/business system to send or receive confidential medical information.
- When an email is received by the therapist /psychiatrist or administrative staff person there will be an attempt made to read it promptly and, when appropriate, respond. However, we cannot assure a specific time frame and suggests sending a follow-up email or phone call if some time has passed.
- Emails concerning diagnosis and/or treatment become part of the client's medical record and is available to certain authorized entities such as health care providers and insurers for the purpose of treatment and reimbursement. While emails may be forwarded with the agency for these purposes, we will not forward the email outside the agency without the consent of the client or as required by law.
- **Email should not be used when transmitting sensitive medical information.**
- **Email should not be used in the case of a medical emergency.**

I have read the above privacy concerns and conditions for the use of email and consent to the use of email for communications.

_____ _____

Patient' signature E-mail address

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Informed Consent for use of Telemedicine Platform

I consent to the use of Telemedicine Platform, for the purpose of participating in the evaluation and/ or treatment with Continental Psychiatric Services, PLLC.

I am aware of the potential risks and consequences of holding the session via phone, Facetime, Skype, or any other HIPAA non-compliant platform, in the situation I will choose to use a HIPAA non-compliant platform. I understand that legitimate concerns exist about privacy, security, patient safety and interoperability and I will not hold Continental Psychiatric Services, PLLC (DBA Continental Psychiatry) and its providers liable for information that was shared over the internet due to Telemedicine Platform connection, and without their knowledge. I agree to comply with the requirements provided below, and that I will abide by Continental Psychiatric Services, PLLC's cancelation policy for Telemedicine consultations. (24-hour notice is required in order to avoid additional charges.)

Signature: _____

What the patient needs to do and know prior of holding a telemedicine session with their provider:

1. Create a client portal upon invitation from Continental Psychiatric Services, PLLC.
2. Payments for telemedicine sessions need to be made upfront, through the client portal or simply call Continental Psychiatric Services, P.C. office to process the payment over the phone.
3. Some insurance companies may limit your benefits for the use of telemedicine. We suggest that you call your insurance company in advance to ask about your policy, benefits and plan of limitations, as you might be responsible for the full amount of the session.

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Medical Information Form

Please provide an answer to all the below questions or write NA (Not Applicable)

Please list your current medical problems, serious medical illness, accidents, surgeries or operations, hospitalizations (Identify each of them and provide dates if applicable):

_____

_____

_____

_____

_____

Primary Care Physician Information

Your last appointment with your Primary Care Physician (date): _____

Last blood work done (date): _____

Current Weight: _____ Current Height: _____

Have you been under **psychiatric care** before? If yes, please provide name of your counselor or psychiatrist, the dates of treatment, the reason and any other pertinent information regarding the treatment and/ or discontinuation of treatment:

_____

_____

_____

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Please list **any current medications** and provide the following information:

Medication Name & Dosage	Prescribing Provider

Please list **any past psychiatric medications** and provide the following information:

Medication Name & Dosage	Start Date	End Date	Response/ Side Effects

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Do you have **allergies to any medications**? If yes, please mention to which medications and describe:

Medication Name	Response/ Describe

Primary Reason/ Chief Complaint for visiting Continental Psychiatric Services, PLLC:

_____

_____

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	Now	Past	Never	Family History	What treatment received and date
Abscesses					
Anemia					
Arthritis					
Asthma					
Bleeding Disorder					
Blood pressure (high or low)					
Bone/Joint problem					
Cancer					
Cirrhosis/Liver disease					
Diabetes					
Drug Overdose					
Endocarditis					
Epilepsy/Seizures					
Eye disease/Difficulties					
Fibromyalgia/Muscle pain					
Headaches					
head injury/brain tumor					
Hearing Problems/deafness					
Heart Disease					
Hepatitis (type?)					
Kidney Disease					
Lung Disease					
Menstrual Pain					
Oral health/Dental					
Sickle Cell Anemia or Trait					
Stomach/Bowel movement					
Stroke					
Thyroid					
Tuberculosis					
AIDS/HIV					
Sexually Transmitted Diseases					
Eating Disorder					
Sleep Difficulties					
Other					

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**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

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**

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The Mood Disorder Questionnaire

Instructions: Please answer each question to the best of your ability.

Has there ever been a period of time when you were not your usual self and…	**YES**	**NO**
… you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?		
… you were so irritable that you shouted at people or started fights or arguments?		
… you felt so much more self-confident than usual?		
… you got much less sleep than usual and found you didn't really miss it?		
… you were much more talkative or spoke much faster than usual?		
… thoughts raced through your head, or you couldn't slow your mind down?		
… you were so easily distracted by things around you that you had trouble concentration or staying on track?		
… you had much more energy than usual?		
… you were much more active and did many more things than usual?		
… you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
… you were much more interested in sex than usual?		
… you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
… spending money got you or your family into trouble?		
If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		
How much of a problem did any of these cause you- like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* **No Problem. Minor Problem. Moderate Problem. Serious Problem.**		
Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

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Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by checking the corresponding space in the column next to each symptom.

	Not At All	**Mildly- it didn't bother me much**	**Moderately- it wasn't pleasant at times**	**Severely- it bothered me a lot**
Numbness or tingling				
Feeling hot				
Wobbliness in legs				
Unable to relax				
Fear of worst happening				
Dizzy or lightheaded				
Heart pounding/ racing				
Unsteady				
Terrified or afraid				
Nervous				
Feeling of chocking				
Hands trembling				
Shaky/ unsteady				
Fear of losing control				
Difficulty in breathing				
Fear of dying				
Scared				
Indigestion				
Faint/ lightheaded				
Face flushed				
Hot/ cold sweats				