***Adjuva Psychiatry***

2449 NE 13th Ave, Wilton Manors, Fl, 33305

Dr. Ashton Thompson, DO

**PATIENT IDENTIFICATION:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone Number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Information:

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

**PURPOSE OF CONSULTATION**: (Please describe your reasons for seeking treatment at this time):

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

**PRESENTING SYMPTOMS**: Please check any symptoms that may pertain to you:

□ Depressed or sad mood □ Difficulty enjoying usual activities □ Unintentional weight loss or weight gain □ Sleeping too much or not enough □ Feeling agitated or sluggish □ Lacking energy/always tired □ Feeling guilty or worthless □ Poor focus and concentration □ Thoughts of death or suicide □ Inflated self-esteem □ Decreased need for sleep or going for days without sleeping □ Excessive talking □ Racing thoughts

 □ Feeling highly distractible □ Try to do or accomplish way too much in a day □ Impulsive behavior □ Seeing or hearing things that may not be real □ Feeling like people are watching you or out to get you □ Often tense or unable to relax

□ Excessive worrying □ Panic Attacks □ Extreme unreasonable fears □ Afraid/unable to leave home □ Intense fear of social situations □ Cannot prevent repetitive thoughts □ Cannot prevent repetitive behaviors □ Intrusive, upsetting memories of past events □ Always on guard or never feel safe □ Body overreacts to “stress”

**PAST PSYCHIATRIC HISTORY:**

Have you ever been hospitalized for psychiatric reasons? YES \_\_ NO \_\_. If yes, please elaborate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever seen a psychiatrist on an outpatient basis? YES \_\_ NO \_\_. If yes, please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received counseling or psychotherapy in the past? YES \_\_ NO \_\_. If yes, please elaborate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which psychiatric medications have you taken in the past and what were the benefits and/or side effects you experienced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any psychiatric medications? YES \_\_ NO\_\_ . If yes, please list all current medications along with dosages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL MEDICAL HISTORY:**

Do you have a Primary Care Physician (PCP)? YES \_\_ NO \_\_ . \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Lab Work up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Last menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from any of the following general medical problems? Please check all that apply:

□ Chest Pain □ Diabetes □ Thyroid Disease □ Hormone Problems □ Fever or Sweats □ Blood Disease □ Anemia □ Bruise Easily □ Nosebleed □ Liver Disease □ Jaundice □ Hepatitis □ Stomach Ulcers □ Nausea/Vomiting □ Unusual Diet □ Abdominal Pain □ Skin Rash □ Neurological Disorder □ Sexually Transmitted Disease □ HIV □ Sexual Difficulties □ Gynecological Problems □ Prostate Problems

□ Glaucoma □ Visual Spots □ Double Vision □ Hearing Problems □ Speaking Problems □ Memory Problems □ Early Fatigue □ Daytime Sleepiness □ Difficulty Sleeping □ Concentration Problems □ Sinus or Nasal Problems □ Heart Attack □ Coronary Artery Disease □ Rheumatic Fever □ High Blood Pressure □ High Blood Pressure □ Stroke □ Heart Palpitations □ Heart Surgery □ Pacemaker Implant □ Cancer □ Lung Disease □ Asthma □ Emphysema □ Chronic Cough □ Bronchitis □ Pneumonia □ Tuberculosis □ Skin Ulcer/Lesion □ Seizures □ Fainting □ Vertigo/Dizziness □ Motor Difficulties □ Serious Head Injury □ Recurring Headaches □ Arthritis □ Muscle Cramps □ Muscle Stiffness □ Weakness □ Tremors □ Numbness □ Difficulty Walking □ Uncontrolled movements □ Recurrent Infection of any kind □ Depressed Immune System

Do you take over-the-counter medications, herbal or dietary supplements, or vitamins? YES \_\_ NO \_\_. If yes, please list:

Are you allergic to any medications? YES \_\_ NO \_\_. If yes, please list medications and allergic reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you undergone any surgical procedures? YES \_\_ NO \_\_. If yes, please list all \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALCOHOL, DRUG AND TOBACCO USE:**

ALCOHOL: Please describe the frequency of your alcohol use and what kind of alcohol and how much you drink, including date of last use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any problems related to use or undergone treatment for use?

YES \_\_ NO \_\_ . If yes, please describe (Legal, Financial, Health, or Relationship problems): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DRUG AND/OR PRESCRIPTION DRUG USE**:

Check if none \_\_\_\_ .

Would you say you are a recreational drug user? have a drug problem? have a drug addiction?

Please check which substances below you regularly use:

□ Benzodiazepines (Klonopin, Valium, Xanax, Ativan)

□ Caffeine

□ Marijuana/THC

□ Cocaine/Crack

□ Designer Drugs, Methamphetamines)

□ Opiates/Methadone (Vicodin, Oxycontin, Heroin/fentanyl):

□ Tobacco: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

Any problems in your early development (learning to walk, talk, read, etc)?

YES \_\_ NO \_\_ . If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the highest educational degree you have obtained? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:**

Is there any family history of mental illness or substance abuse among your blood relatives? YES \_\_ NO \_\_ . If yes, please describe as below:

Father's Side: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother's Side: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL INFORMATION YOU WOULD LIKE DR. THOMPSON TO KNOW:**

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

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

*Thank you for taking the time to fill out this confidential form accurately and thoughtfully.*

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

Patient's Signature

**MISSED APPOINTMENTS:**

Credit card on file will be charged a missed appointment fee of $50 when applicable. You may cancel or reschedule with 24 hour’s notice.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA (Health Insurance Portability and Accountability Act)**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Treatment, Payment and Health Care Operations:**

Payment must be received prior to appointment.

Adjuva Psychiatry uses and discloses your protected health information for treatment, payment and health care operations, including but not limited to:

-sharing test results with other health care providers for confirmation of a diagnosis

-providing your diagnosis or other information about your health to the insurance provider/billing.

**Other Uses and Disclosures:**

Adjuva Psychiatry may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

-providing you with information related to your health

-contacting you regarding appointments, information about treatment alternatives, or other health related services

-incidental uses such as sign-in sheets

-compliance with all laws (including reports of suspected abuse, neglect or violence)

-providing certain specified information to law enforcement or correctional institutions

-public health activities when requested by a public health authority or the FDA

-responding to court or administrative orders, subpoenas, discovery requests or other lawful processes

-research activities

-military affairs, veteran affairs, national security, intelligence threats, etc

-providing information to disaster relief agencies, information to a family member or closest contact when: notification of your location, general condition or death; to assist in your health care (prescriptions, looking at EMR, etc)

client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent for Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have chosen to seek mental health services with Adjuva Psychiatry, understand these services may include but are not limited to counseling, medication management and related services. I understand that these services may offer the opportunity to resolve issues and improve functioning. However, I also understand that there can be no guarantee of specific outcome of treatment. My provider has discussed my treatment options with me. I have been apprised of the potential benefits and risks inherent in such treatment. I understand that as treatment progresses my therapist will discuss with me any change in my treatment plan that would necessitate an additional informed consent to treatment.

Treatment involves a cooperative relationship between provider and client. As such, I understand that a time will be reserved in advance for my sessions. I will keep these appointments or give at least 24-hour notice. Otherwise I may be charged for the missed time. I further understand that I remain responsible for any fees incurred for my treatment. I understand that I agree to relinquish medical information about me to my insurance company for purposes of processing claims. This may include diagnosis, dates and times of treatment and treatment summaries (when requested). Ultimately, I remain responsible for any deductibles, co-pays or remaining balances.

I understand that my sessions are confidential. However that confidentiality has exceptions which may include but are not limited to the following: a) I choose to release information by a signed waiver (in couples counseling both parties must sign the waiver for disclosure of information) b) where a judge makes a court order c) I raise my mental status or competency in a court proceeding d) if there is a reason to believe there is a clear and immediate probability I may injure myself or others – therapist maintains a right to inform intended victim of the threat e) if there is evidence or strong suspicion of child, disabled or elder abuse or neglect.

I understand that I may terminate treatment at any time. It is advised that I discuss these considerations with my therapist so that any unresolved issues could be addressed. I understand that this is a recommendation only and that I am free to decide how to end my sessions. I understand that I am free to discuss with my therapist any relevant referral options for additional or adjunct treatment.

I have read and discussed the above information with my therapist and I freely consent to treatment.

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

Patient Signature Date

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

Guardian Signature Date

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

**Consent To Release Confidential Information**

Authorization to Obtain and Release Information

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This will authorize **Adjuva Psychiatry** to disclose and/or to obtain form:

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

Name of Doctor or Organization, address and phone number

**Description of Information to be Disclosed:**

(Patient should initial each item to be disclosed)

Presence in Treatment: \_\_\_\_\_\_\_                               Psychiatric Evaluation:  \_\_\_\_\_\_\_

Entire Contents of Chart: \_\_\_\_\_\_\_                            Labs Reports / Drug Screen:  \_\_\_\_\_\_\_

Discharge / Transfer Summary: \_\_\_\_\_\_\_                  Treatment Plan:  \_\_\_\_\_\_\_

Medical Information: \_\_\_\_\_\_\_                                   Diagnosis: \_\_\_\_\_\_\_

Medication History Log: \_\_\_\_\_\_\_                              Other: \_\_\_\_\_\_\_

Progress Notes: \_\_\_\_\_\_\_

**Purpose:**

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purposes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Right to Revocation:**

I understand that I have a right to revoke this authorization, in writing, at any time by sending a written notification.

**Expiration:**

This information release is for a specific instance, valid for 90 days and will expire on the following date:\_\_\_\_\_\_\_\_. Unless sooner revoked, this consent is valid for one year due to the need for ongoing communication for the coordination of treatment and will expire on the following date:\_\_\_\_\_\_\_\_\_\_\_.

**Conditions:**

I understand that **Adjuva Psychiatry** will not condition my treatment on whether I give authorization for the requested disclosure. The consequence of refusing to sign this authorization have been explained to me.

**Form of Disclosure:**

Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we dem to be appropriate and consistent with applicable law, included by not limited to verbally, in paper format or electronically.

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

Signature of Patient                                                                Date

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

Signature of Parent / Guardian                                     Date

**Telepsychiatry Consent Form**

Telepsychiatry provides psychiatric services using interactive video conferencing tools, such as Skype, Zoom, Whatsapp, FaceTime, Doxy, in which the psychiatrist and the patient are not at the same location. Telepsychiatry will allow the patient to receive medical care without the need to visit the office. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in medical judgment. Alternative to telepsychiatry include traditional face to face sessions.

**Your Rights:** 1) I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry; 2) I understand that the aforementioned video-conferencing programs  are known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. 3) I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time. 4) I understand that Adjuva Psychiatry has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time; 5) I understand that all rules and regulations which apply to the practice of medicine in the State of Florida also apply to telepsychiatry.

**Your Responsibilities:** 1) I will not record any telepsychiatry sessions without the prior written consent of  the psychiatrists Adjuva psychiatry from here in referred to as psychiatrist,   and I understand that the psychiatrist will not record telepsychiatry sessions without my consent; 2) I will inform the psychiatrist  if any other person can hear or see any part of our session before the session begins. Likewise, the psychiatrist will inform me if any other person can hear or see any part of the session before the session begins. 3) I understand that I MUST be a resident of Florida to be eligible for telepsychiatry services from the psychiatrists at Adjuva Psychiatry. 4) I understand that my Initial Consultation will not be done by telepsychiatry except in special circumstances under which I will be required to verify my identity to the psychiatrist’s satisfaction before the evaluation.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize the psychiatrist to use telepsychiatry in the course of diagnosis and treatment.

 X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient or Parent/Legal Guardian Signature Date

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s name Relationship to patient

**Severe weather/health crisis/etc**

-In cases of widespread health crises (e.g. highly contagious disease, global pandemic) or severe weather conditions (e.g. severe flooding, tornado watches, tropical storm watch or warning, hurricane watch or warning, earthquake) the physician will monitor conditions via local news outlets and will follow the lead of the local school district. If the local school district closes its schools to limit the spread of disease or due to severe weather conditions, the office will contact you to convert in person sessions to telehealth or reschedule your appointment to ensure your safety and that of the clinicians/staff and premises of Adjuva Psychiatry.

**Court-related policies and fees**

At the initiation of treatment, the patient(s) and collateral parties agree not to solicit the physician’s written or in-person testimony in legal cases. However, the court may order the physician to testify. If court-ordered to testify, the physician will testify as a fact or percipient witness. The physician requests that subpoenas be personally served during the regular business hours of 9am-5pm. The physician’s scheduled meetings or appointment times cannot be interrupted or misrepresented in order to personally serve the physician with a subpoena. The entity or party initiating the subpoena agrees to compensate the physician for his/her professional time. According to the legal fees stated in this document and all legal expenses the physician incurs from consultation from his/her attorney in preparation for a legal case. Professional time is defined as any activity the physician undertakes or support required to provide testimony, which includes, but is not limited to, time spent in preparation for testimony, time spent in consultation to prepare for testimony, travel to provide testimony, travel from providing testimony, lodging, and parking fees. The physician charges a higher rate for his/her professional time in a legal proceeding that requires the physician’s participation due to the complexity and difficulty of legal involvement. The physician will attend agreed up and scheduled depositions, court appearances, or legal conferences. The physician will not participate in on-call court appearances. Legal fees are as follows: $855 per hour for preparation and review of legal records. Full payment of legal fees must be rendered at least 48 hours prior to the physician’s scheduled deposition, court appearance or legal conference. Court-related legal rates may be raised periodically at the discretion of the physician and without additional notice.

Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Paperwork**

>Paperwork requires an appointment.

> Emotional support animal letters cost $125 and are valid generally for one year.

>Paperwork completed outside of an appointment costs between $40-125 pending volume of work required.

Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_