BEACHES TMS & BRAIN HEALTH
BEACHES BEHAVIORAL
ALINA M GALLIANO-PARDO, MD, FAPA, FASAM
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GENERAL INFORMATION

We appreciate your interest in Beaches Behavioral. We have more than 20 years of experience working with people who are struggling with mental health and substance abuse issues. We want to give you some details about our practice so you can decide if ours is the best option for you. We specialize in high functioning individuals with acute or chronic mental health issues and/or substance abuse disorders.

Dr. Galliano-Pardo, is Board Certified in General Psychiatry and Addiction Medicine. She is in the office part-time Monday- Thursday 7:30am to 1:30pm. Our office has successfully transitioned to a Telepsychiatry Virtual office for **Florida Residents**. New patient appointments are scheduled for 1 hour, and all paperwork and required information should be submitted prior to scheduling. New Patients will meet with a staff member for approximately 15 minutes to obtain background information and collect any co-payments/ deductibles, prior to the appointment. New Patients have the option for an In-person or Telehealth Evaluation at our locations in Southpoint Jacksonville or Jacksonville Beach. All subsequent follow up appointments will be done via Telehealth with some exceptions (Patients prescribed injectible medications or who require UDS monitoring).

The services that we offer are exclusively provided with the purpose of treatment. We want to offer you the best service possible and evaluate if what we offer can meet your individual needs. We encourage an initial evaluation with the purpose of identifying your individual needs and treatment options.

We treat people with depression, anxiety, bipolar disorder, OCD, attention problems, alcoholism, drug addiction, and many other problems.

Since Dr. Galliano-Pardo is a solo practitioner with limited office staff, our office has certain exclusion criteria to avoid the frustration on you and us regarding the services we cannot provide properly. The following will give you some important information that will help you decide if our office can assist with your needs:

1. If the main reason you are seeking treatment is regarding a legal problem, you should consider finding other options. Dr. Galliano does not provide this service at this time.

2. If you are in process of getting a disability claim. The only commitment that we can make is to send your lawyer or agency copies of your medical records with a signed release of information from the patient. All disability and FMLA paperwork will be evaluated and may take up to 1- 2 weeks to complete. Dr. Galliano may decline filling out disability paperwork at her discretion.

3. If you have 3 or more systematic illnesses or are above the age of 75, I will advise you to consider an evaluation with a psychiatrist that specializes in psychosomatic medicine or a geriatric psychiatrist.

4. If you take several controlled substances (such as Xanax or Klonopin), and you are convinced that they are the only medication that will work for you, or if you are not open to consider other options, you should consider finding another office.

5. We do not accept patients that are on Buprenorphine (Suboxone) or candidates for Buprenorphine (Suboxone) that are planning on taking tranquilizers such as Xanax, Klonopin, or Ambien amongst others.

6. We do not accept patients that are on Buprenorphine (Suboxone) or candidates for Buprenorphine (Suboxone) that are currently issued or planning to get a medical marijuana card. **The current clinical evidence does not support the use of THC products for patients with history of substance abuse or other mental health disorders.**

7. We do not accept patients that want to take Buprenorphine/Naloxone primarily for pain or that have several medical comorbidities.

8. We believe that controlled medications are useful tools to manage some conditions but our practice minimizes their use and follows the guidelines of the American Psychiatric Association and the American Society of Addiction Medicine as a core base of knowledge to make decisions about your treatment and medications. If you are prescribed controlled medications, please review our controlled substance policy.

9. If you are an adult that is only concerned about a possibility of ADHD or ADD and have never had a clinical psychological evaluation conducted, our advice is to consider contacting a psychologist to get an evaluation before coming in for a psychiatric evaluation and consider medications. Our office will not prescribe ADHD/ADD medications if you are not currently on them, have not previously had an evaluation, or do not receive a copy of prior evaluations.

10. We do our best effort to minimize your waiting time but human behavior can be, to a certain extent, unpredictable and sometimes there will be delays. We ask that you respond with patience and understanding. It is our goal to start all appointments on time, but be aware there may be a wait, as each individual is different and has different needs.

11. We take most major insurances and most medicare products. Please review our financial policies and understand that appointments that are not canceled within 24 business hours will be subject to a late cancellation fee of $100. **No exceptions.**

12. We give priority to patients that have in-network insurance providers. For a complete list of insurances we accept, please visit our website www.beachesbehavioral.com or contact our office.

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DRUG SCREEN POLICY

Please Read Each Item

Your physician, Alina M. Galliano-Pardo, M.D., **may order** urine/saliva specimens to be collected for the purpose of drug screening at any time if it is deemed necessary. You will be tested upon admission and randomly during follow up visits at the doctor's discretion.

We **require** urine screening if you are taking **any controlled medication** including Buprenorphine (Suboxone/Zubsolv) prescribed by this office. If you refuse drug screening, you may not be allowed to see the doctor and your prescription may not be renewed.

You may refuse testing at any time. Your physician will be informed of this and could interfere with your continued participation in treatment at this office.

Most insurance plans **do not** pay for drug screening at the office. If they do not, you agree to pay our $25.00 charge. Drug screening charges are already included in self-pay patient visit charges. Patients that come into the office for a drug screen outside of an appointment will be required to pay a $25.00 charge.

If your drug screening is positive and you believe this is an error, you can request the sample to be sent for confirmation to a certified lab. If your insurance does not cover the external lab charges, you will be responsible for payment of those charges.

BEACHES TMS & BRAIN HEALTH BEACHES BEHAVIORAL

OFFICE AND FINANCIAL POLICIES

This document includes very important information about our services and policies. By signing this document, you are agreeing and acknowledging you understand our services and policies.

PLEASE READ EACH ITEM

Duration and nature of treatment

Psychiatric and/or substance abuse treatment typically involves regularly scheduled bi-weekly or monthly appointments. Medication management treatment, when stable, is typically one to three months apart, but may be more frequent when medication changes are being made. The total duration of treatment depends upon your diagnosis, your compliance with treatment, your response to treatment, and other individual variables.

As a part of psychiatric evaluation and treatment you need to have a minimum of one annual physical examination and blood work at least twice a year. You are responsible to coordinate those appointments. Please sign a release of information in order for your PCP to send us the results.

Medical problems can cause psychiatric symptoms and medications could potentially cause a negative impact on your health. Careful monitoring is extremely important.

You MUST come to your appointments to receive proper care. We cannot treat you or manage your medication by phone. You are responsible for making and keeping your appointments. All patients should make a follow up appointment prior to leaving the office. If a follow up appointment is not made there is no guarantee an appointment will be available at a later date.

If you miss a scheduled appointment and are otherwise in good standing in this practice, we will reschedule you on a space-available basis AFTER the No Show fee is paid. However, if you have a pattern of missing appointments, or if you do not schedule a follow-up appointment within 120 days, you are considered to have discontinued treatment. We will consider you discharged from this practice. In some cases, you will need to start as a new patient.

Office Hours

The Front Office and phone lines are open Monday through Thursday 8 am-4 pm. Patient follow up appointments are Monday through Thursday starting at 7:30am and are every 30 minutes until 1:00pm.

Emergency Appointments

Always remember: if you have a potentially life-threatening emergency and need help IMMEDIATELY, CALL 911 or GO TO AN EMERGENCY ROOM. You can contact us once the situation is stabilized.

Our office is NOT equipped to handle psychiatric or other medical emergencies; thus, we do not suggest coming to our office, if you feel the crisis is extreme.

For general questions or concerns you can call our office during hours listed above and speak to a staff member. Be prepared to give a detailed message to the staff member. They will consult with your physician and will call you back. If you chose to leave a detailed voicemail, please be aware that calls are returned within 24 business hours.

If you call after the office is closed you can leave a message and we will call you back on the next business day. If you have an urgent matter that can't wait until the next business day, please email **information@beachesbehavioral.com** to get a call back.

Prescription Refills

Your attendance at appointments, face-to-face with your physician is essential to successful treatment. We cannot treat you without seeing you. Therefore, we handle your medications, medication changes and refills at your regular office appointment during normal business hours. **We do not accept refills requested by pharmacies and we do not refill any controlled medications without being seen at the office. We do not replace lost/ stolen controlled prescriptions - NO EXCEPTIONS.** In general, Dr. Galliano does not refill medications without a visit. If in a particular situation, refill of medication or new prescription is ordered by phone you may be charged $25 for the service. **Please review our controlled medication policy on page 11 for further details**.

Appointments

Your appointment time is scheduled only for you; there is no double booking at our office. All appointments need to be confirmed within twenty-four (24) business hours of the time scheduled. If your appointment is not confirmed, it is subject to being canceled.

If you need to cancel an appointment you will need to do it with at least twenty-four (24) business hours' notice by calling and talking to a staff member or emailing our office. Late cancellation fees are as follows: $100 for Follow up appointments and $200 for New Patient appointments.

Electronic Communication Authorization

Beaches Behavioral may communicate with me using electronic (Non-HIPPA compliant) communications including email, text messages, and voicemail. I may be contacted using the numbers or addresses that I have provided to Beaches Behavioral or that I have used to initiate contact with Beaches Behavioral. These communications may include appointment information, protected health information and confidential information. I understand that these electronic communications are not encrypted. We use reasonable means to ensure security of communication with these methods, however we can not guarantee the security of non-HIPPA compliant methods.

Financial Agreement

We strongly believe that all patients deserve the best behavioral health care that we can provide. Further, your understanding of our Financial Policy is important for our professional relationship and we feel that everyone benefits when clear financial policies are outlined and agreed upon.

Our professional services are rendered to you, not the insurance company. Therefore, payment for services is your responsibility.

You are directly and fully responsible for charges not covered by your insurance company, such as co-payments, deductibles and any balance for non-covered services.

If your insurance company fails to pay your balance in full, or there is no payment made within 45 days, it is your responsibility to pay for services rendered.

If you fail to make timely payments on your account, your account will be frozen and you will be unable to schedule any future appointments.

Payment and Insurance

Payments for services are due at the time of your appointment, and your account must be settled by the end of each visit in order to schedule a follow up appointment. If you have an outstanding balance with this office, you will not be allowed to schedule your follow up until your balance had been paid in full. You may pay with cash or credit card. We **DO NOT** accept checks. We also have payment plan options if discussed and approved by the front-office administration.

Payment for the initial Psychiatric Evaluation is due prior to seeing the doctor.

For self-pay patients, the Psychiatric Evaluation has a cost of $300 and Follow Ups $175, both with payment due at the time and date of service.

If you are not using insurance, or if you are using insurance but haven't met the deductible, your payment may be the entire cost of the session.

If the doctor is in network with your insurance company, you will pay a fixed cost as determined by your insurance company. If the doctor is out of network, you will have to pay the doctor rate for the session and you will be provided the documentation necessary for you to submit the claim to your insurance for reimbursement. **We do not submit out of network claims.**

If your insurance company refuses to authorize your care for any reason, you will be responsible for all charges and payments for services rendered.

If you change your insurance policy or company, please notify our office **PRIOR** to your next appointment. Your benefits and eligibility must be verified **PRIOR** to services being rendered. If you decide not to inform us of changes, you will be responsible for any charges not covered by your insurance company.

If your visits require preauthorization, you are responsible for notifying our staff in order to call the insurance provider before the visit. If preauthorization is not completed prior to the visit, you will be responsible for payment of **ALL** charges.

Medical Records

Medical records may be requested and sent if approved. Our fees are compliant with the Florida Statues and are $1 per page up to 25 pages, and $0.25 cents per page thereafter. Patient is responsible for fees not paid by requesting party within 60 days.

Fee disclosure for Non-Covered Costs

Many services that our patients need are not covered by insurance. Letters and other paperwork, and consultations with other professionals are just some of these services. This type of work requires a substantial amount of time outside of scheduled appointments. Since we are a small practice and the doctor does all paperwork herself, we ask that you give us 5 business days for all requests made through the office. Depending on your request, the following charges will apply:

- Letters to employers, schools, lawyers , etc.	Based on provider hourly rate $250/hour
- Comprehensive chart reviews	Based on provider hourly rate $250/hour
- Consultation with schools, insurances, etc.	Based on provider hourly rate $250/hour
- Insurance-required prior authorizations for medications	$10-$25 per chart pulled/reviewed (called, faxed)
- Late cancelled appointments less than 24 hour notice	$100
- Late arrival to appointment	$25
- Missed appointments Psychiatric Evaluation	$200
- Missed appointments Follow-up	$100

Notice of Privacy Practice

You may request a copy of the Privacy Practice Form as required by HIPAA at any time during your treatment. You can also find it on our website for your review.

Dr. Galliano does NOT talk to lawyers regarding her patients and does NOT do forensic psychiatry.

Dr. Galliano does NOT provide evaluations or treatment for disability claims, short term or long term.

You have the right to request your psychiatric records for that purpose but Dr. Galliano does not commit to completing forms for disability purposes. Records will only be released to the requesting entity and not directly to the patient. **Forms to be completed by the physician will be finished within 5 business days, and the provider hourly rate will apply.**

Termination of Treatment

Dr. Alina Galliano-Pardo will deem treatment ineffective and advise a patient to seek treatment elsewhere when a patient's actions indicate that he or she has disengaged from treatment. Following are some examples of situations warranting termination of treatment:

- The patient misses two or more appointments
- The patient ceases paying for treatment
- The patient is noncompliant with treatment recommendations
- The patient misuses or abuses prescribed medications
- The patient behaves in an abusive, threatening or inappropriate manner toward staff, or other patients
- The patient fails multiple drug screenings (Suboxone or controlled medication patients)

COVID-19 Informed Consent

Our office is taking all necessary steps and measures to insure the safety of our patients and staff. We are following all recommended CDC and state guidelines to help reduce the spread of COVID-19.

TELEPSYCHIATRY POLICY

Telepsychiatry is the delivery of psychiatric services using interactive video conferencing that enables a psychiatrist or his associates at a distant location to provide treatment to me. I understand that this consultation will not be the same as direct patient/psychiatrist visit. Telepsychiatry will allow me to receive medical care without the need to visit the office and travel long distance.

The interactive electronic systems used in telepsychiatry 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. Our practice currently uses Doxy, a HIPAA compliant telehealth platform. You can review the security features of Doxy at https://doxy.me/en/patients/. We may use the landline telephone to enhance the audio connection.

During the telepsychiatry consultation

- Details of my medical history, current medications, and results of medical tests will be discussed.
- Non-medical personnel may be present to assist in operating conferencing equipment, if needed.
- At times students may be present during the session. I will be informed about who is present in the office.

The potential benefits of telepsychiatry:

- Increased accessibility to psychiatric care
- Patient convenience

The potential risks of telepsychiatry include, but are not limited to:

- There could be some technical problems (video quality, internet connection) that may affect the telepsychiatry session and affect the decision-making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
- Information transmitted may not be sufficient (e.g., poor resolution) to allow for appropriate medical decision making by the provider
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information. This risk is small, but it does exist.

Alternatives to the use of telepsychiatry: Traditional face-to-face sessions.

Options for New Patients:

It is our office policy to give new patients the option for an **in-person visit** at our locations in Jacksonville Beach or Southpoint or through **Telehealth**. All follow up appointments will be Telehealth appointments.
Telehealth appointments are conducted through a HIPPA- compliant platform that requires video and audio capabilities. You can visit our website www.beachesbehavioral.com for more information and further instructions. You will also receive an email 24-48 hours before your appointment with instructions. If you have any questions or concerns please contact the office.

For your appointment(s), please make sure:

- You are a *Florida Resident*
- You have the proper equipment- video and audio capabilities on a mobile device or computer.
- You are in a quiet, Private location with reliable service.
- If you are driving, please pull over to a safe location for the duration on your session.

I understand that I have the following rights with respect to telepsychiatry:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
- I understand that the Doxy technology used Beaches Behavioral is encrypted to prevent the unauthorized access to my private medical information.
- In addition, I understand that telepsychiatry based services and care may not be as complete as face-to-face services. I also understand that if my psychiatrist believes I would be better served by another form of psychiatric services (e.g.face-to-face services) I will be referred to a psychiatrist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry and that despite my efforts and the efforts of my psychiatrist, my condition may not be improved, and in some cases may even get worse.
- I understand that the all rules and regulations which apply to the practice of medicine in the state of Florida also apply to telepsychiatry

Patient Responsibilities:
I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.
I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.

I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

I understand that I must be a **resident of the State of Florida** to be eligible for telepsychiatry services from Beaches Behavioral. Additionally, **I understand that I must be physically in the State of Florida to receive this service.**

I understand that my psychiatrist determines whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.

I understand that it is my responsibility to keep my contact information (phone number, email, address) updated to ensure I receive communications regarding my care.

I understand that I may be required to come in person to the office, laboratory, or other facility recommended to monitor: vital signs, laboratory orders, etc.

Some patients may still need to come to the office for UDS if it is requested or a part of their treatment plan

Patient Consent to The Use of Telepsychiatry:

I have read and understand the information provided above regarding telepsychiatry, have discussed it with Beaches Behavioral and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize Beaches Behavioral, to use telemedicine in the course of my diagnosis and treatment. If for any reason/s, telepsychiatry will not work for my treatment, my provider will talk to me about my choices. I understand that I will be responsible for any charges not covered by my health insurance.

CONTROLLED MEDICATION POLICY

Updated 06/2021

The purpose of this policy is to ascertain that long-term controlled medications are prescribed in the safest, most effective manner in compliance with state and federal law. Utilization of controlled substances may be medically useful but, if used inappropriately, carries risks. In order to receive controlled medications from our office, please review the following policies.

1. After initiation of treatment, the patient will follow up every 1-3 months prior to the writing of medication refills. More frequent visits may be required when medication dosage is being adjusted
2. Any request for refills or changes in prescribed medication will require an appointment to determine the appropriateness of medication changes and to issue any new prescriptions
3. Refills of a controlled substance medication Will **NOT** be made if I "run out early." I am responsible for taking the medication in the dosage prescribed and for keeping track of the amount remaining.
4. Early refill requests will not routinely be issued to accommodate out of town travel.
5. If your pharmacy is out of stock, you are out of town, or are traveling, T**HE FIRST STEP IS TO CALL YOUR PHARMACY AND REQUEST YOUR MEDICATION BE TRANSFERRED TO ANOTHER PHARAMCY.** The only medications that cannot be transferred are stimulants for ADHD.
6. Prescriptions will be sent to your pharmacy electronically only at the time of your appointment. Any patients requesting to change pharmacies, alter dosages, etc. outside their appointment will be issued a written prescription and be subject to a **$25 fee**. Written prescriptions will need to be picked up at the office, no prescriptions will be mailed.
7. In the event of electronic transmission failure, I understand that I may need to pick up a hard copy prescription from the office.
8. If you frequently need to change pharmacies or use several pharmacies to find the best price, please ask the provider for a hard copy prescription. Additionally you can request that your pharmacy transfer your prescription to a new pharmacy.
9. I give permission to my primary care physician, prescribing physician and/or his colleagues to communicate with any other physician or health care provider and any pharmacists regarding my use of controlled substances.
10. I understand that I must abstain from use of illegal drugs or alcohol while under treatment by my physician. Failure to do so can result in tapering of controlled medications or refferal to substance abuse treatment.
11. Medical Marijuana has been legalized in the State of Florida; however, we do not recommend the use of marijuana along with controlled substance medications for patients that are being treated for mental health disorders. Use of medical/recreational marijuana, while under contract, will be considered a violation of our controlled substance policy.
12. I will follow the advice of my primary care physician, prescribing physician and/or his colleagues in regard to stopping my use of controlled substances, should they feel it advisable
13. I agree to notify my prescribing physician of controlled substance prescriptions from outside providers.
14. I understand that I need to accurately disclose my medications to all of my medical providers
15. If you are being evaluated by another physician for a medical problem, procedure or surgery and are expecting to be prescribed or given other controlled medications (temporarily or on-going), you need to notify our office to determine if medication adjustment or reevaluation is necessary.
16. I understand that it is a felony to obtain these medications by fraudulent means, to possess these medications without a legitimate prescription, and to give or sell these medications to others.
17. I understand that allowances will not be made for lost, stolen or misplaced prescription or drugs. Any stolen prescription must be reported to the police and my provider immediately. A police report must be presented. Lost prescriptions must be reported to my provider within 24 hours

CONTROLLED MEDICATION POLICY

15. If there is any suspicious behavior including frequent, early refill requests or multiple "lost" prescriptions we have the right to terminate this agreement and refuse further prescription requests.
16. I understand that any form of abusive behavior (including abusive language) toward office staff will not be tolerated and will constitute a termination of this contract and/or immediate dismissal from the practice
17. Patient is required to release Beaches Behavioral from any liability related to their misuse of the controlled substance prescribed.

My physician has the right to discontinue controlled substance medications and discharge me from care if any of the following occur.

- I trade, sell, misuse or share medication with others;
- My blood or urine shows signs of adulteration or the presence of medications that my physician is not aware of, the presence of Illegal drugs or does not show medications that I am receiving a prescription for;
- I get controlled substances from sources other than at Beaches Behavioral without notification;
- The clinic discovers I have broken any part of this agreement;
- I consistently miss appointments
- I do not go for blood work or urine tests when asked;

I have read this document, understand it, and agree to the terms. I voluntarily consent to the use of controlled substances to help control my condition, and I understand that my treatment with controlled substances will be carried out in accordance with the conditions stated above.

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Please check all that apply:

I have reviewed and agree to the:

- ☐ 1. General Office Policies
- ☐ 2. Urine Drug Screen Policy
- ☐ 3. COVID-19 Informed Consent
- ☐ 4. Telepsychiatry Policy
- ☐ 5. Controlled Substance Policy
- ☐ 6. Notice of Privacy Practice (Located on our website for your review)
- ☐ 7. Buprenorphine Treatment Contract (if applicable)

By signing below, you are agreeing and acknowledging you understand our services and policies.

_____ _____

Signature **Date**

BEACHES TMS & BRAIN HEALTH BEACHES BEHAVIORAL

Card Holder Authorization for Credit Card Charges

Patient Information

Name of Patient: _____

Credit Card Information

First Name (as it appears on credit card): _____

Last Name (as it appears on credit card): _____

Relationship to Patient: _____

Credit Card Type ☐ **AmEx** ☐ **Discover** ☐ **MC** ☐ **Visa**

Credit Card Number: _____-_____-_____-_____

Expiration Date: _____ **CCV Code:** _____

Credit Card Billing Address

Street/PO Box: _____

City: _____

State/Zipcode: _____

Billing Phone: _____

Acknowledgement

I authorize Alina M. Galliano-Pardo, M.D., P.A. to charge this credit/debit/HAS debit card for any and/or all co-payments, patient responsibility portions of my insurance explanations of benefits (if applicable), fee for the completion of any forms and/or letters I request, lost prescriptions, prescription refills, and missed/no-show or late appointment fees.

I certify that I am an authorized signer on the card provided and that the credit card number provided and signature below are the same as those on file with the credit card issuer.

_____ _____

Cardholder's Signature Date

_____

Printed Employee Name

BEACHES TMS & BRAIN HEALTH BEACHES BEHAVIORAL

Family and Multiple Provider Release of Information (ROI) Form

Providing information regarding your family members, friends, and other providers can be helpful in facilitatingyour care and ensures we are able to provide you with the best possible care. This form is optional and allows you to choose who you would like your informational potentially shared with.

I hereby authorize Beaches Behavioral to release/receive information from my medical record including general medical information as well as Acquired Immunodeficiency Syndrome and/or HIV tests, psychiatric, psychological, drug and/or alcohol records in compliance with Florida Statutes90.503.394.459, 395.017, 396.112, 397.053 and Federal Regulation 42 CFR, Part 2. The type of information authorized for disclosure includes, but may not be limited to

Patient Name:		**DOB:**	**Initial each specific consent to release**
Family Members orSignificant Others	Name/Relationship Name/Relationship Name/Relationship	**Purpose:** • To facilitate understandingand support in treatment. • To aid in diagnosis and continuity of care. **Type of information to be disclosed:** • All medical records • Progress Notes • Labs • Medications • Evaluations • Other: _____ _____	☐ Yes ☐ No _____ Initial
Mental Health Professionals	Psychiatrist Phone Therapist Phone Other Phone		☐ Yes ☐ No _____ Initial
Primary Care Physician	Name/ Group Phone		☐ Yes ☐ No _____ Initial
Other Specialists	Name/ Group/ Phone Name/ Group/ Phone Name/ Group/ Phone		☐ Yes ☐ No _____ Initial

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to , diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus also known as acquired immune deficiencysyndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the or use of my health care information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is release with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Beaches Behavioral Office, except to the extent that action has already been taken in reliance on it.

_____ _____

Patient Signature/ Guardian Date

PATIENT DEMOGRAPHICS

Last Name: First Name: Middle Name:

Address: City: State: Zip:

Home Phone: Cell Phone:

Social Security Number: DOB: Gender: M ◯ F ◯

Marital Status: Ethnicity:

Employer Name:

Employer Address and Phone:

PRIMARY INSURANCE INFORMATION

Insurance Carrier: Policy ID: Group Number:

Policy Holder's Name: Group Name:

Policy Holder's DOB: Relationship to Patient:

Policy Holder's Social Sec Number:

Policy Holder's Employer:

Employer Address and Phone:

SECONDARY INSURANCE INFORMATION

Insurance Carrier: Policy ID: Group Number:

Policy Holder's Name: Group Name:

Policy Holder's DOB: Relationship to Patient:

Employer Address and Phone:

IF YOU HAVE A SECONDARY INSURANCE POLICY, IT IS YOUR RESPONSABILITY TO ADVISE THE STAFF WHICH IS THE PRIMARY AND WHICH IS THE SECONDARY INSURER. FAILURE TO DO SO MAY CAUSE SUBMISSION TO THE INCORRECT INSURANCE COMPANY. INSURERS HAVE TWO (2) YEARS TO RECOUP MONIES THAT HAVE BEEN DISPENSED IN ERROR, AND ONCE THE NOTICE OF RECOUPMENT IS RECEIVED, IT IS LIKELY THAT THE TIMELY FILING LIMIT FOR THE CORRECT INSURER HAS PASSED. IF THAT SHOULD HAPPEN, IT BECOMES THE PATIENT'S RESPONSABILITY FOR THE CHARGES INCURRED. PATIENT'S INITIALS:

EMERGENCY CONTACT INFORMATION

Emergency Name: Relationship:

Emergency Address: City: State: Zip:

Emergency Phone #1: Emergency Phone #2:

FINANCIALLY RESPONSIBLE PARTY INFORMATION

☐ Same as patient demographics

Last Name: First Name: Middle Name:

Address: City: State: Zip:

Relationship to Patient:

Home Phone: Cell Phone:

Social Security Number: DOB: Gender: M ◯ F ◯

Employer Address and Phone:

DO YOU HAVE A HEALTH CARE SURROGATE OR A LEGAL GUARDIAN? YES ◯ NO ◯

Surrogate/Guardian Name: Relationship:

Surrogate/Guardian Address: City: State: Zip:

Surrogate/Guardian Phone #1: Surrogate/Guardian Phone #2:

BEACHES TMS & BRAIN HEALTH BEACHES BEHAVIORAL

New Patient Medical History Form

Please complete all information on this form and fax, email, or bring it to the office prior to your first visit

Email: information@beachesbehavioral.com Fax: 904-853-5885

Name_____ Date of Birth _____

Phone Number_____ Email: _____

What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

_____

_____

Pharmacy Name & Location _____ Phone #_____

Secondary Pharmacy _____ Phone# _____

Mail Order Pharmacy (if applies) _____

Medical History

Do you have any known allergies? ◯ **Yes** ◯ **No**

If yes please explain:

_____

_____

Do you have any adverse drug reactions? ◯ **Yes** ◯ **No**

If yes please explain:

_____

_____

What are your other **non-psychiatric** medical diagnoses? (ie. Asthma, diabetes, high blood pressure etc.)

_____

_____

_____

_____

_____

_____

List ALL medications you are currently taking (including **non-psychiatric, vitamins, and OTC medications**)

Medication Name	Diagnosis	Daily Dose	How Often	Compliance

List any non-psychiatric hospitalizations including year. (ie. Severe flu, stomach pain etc) If none, write N/A

List any surgeries including type of surgery, location, and year

Do you exercise regularly? ( ) Yes ( ) No

How many caffeinated beverages do you drink a day? Coffee_____ Soda_____ Other_____

Do you have trouble sleeping?( ) None ( ) Yes, falling asleep ( )Yes, staying asleep ( ) Both

On average, how many hours of sleep do you get per night? _____

Are there any sources of stress in your life? ( ) Yes ( ) No

If yes, explain: _____

Do you use tobacco products? ◯ Yes ◯ No

If yes, what form and how often:

_____

Would you like help to quit smoking? ◯ Yes ◯ No

Do you suffer from chronic pain? ◯ Yes ◯ No

If yes, include location, severity and timing of pain:

_____

_____

_____

Name of Primary care Provider: _____Last Seen: _____

Any other medical specialists currently being seen and the reason (example: Optamolgist- for contacts):

_____

_____

_____

_____

_____

Name and location of laboratory usually used: _____

Date of last labwork: _____

List any recent diagnostic testing (labs or imaging). Include type date and location where testing was done

_____

_____

_____

Past Psychiatric History

List any psychiatric disorders you have been diagnosed with including: the age you began treatment and which doctor gave you the diagnosis:

List any psychiatric hospitalizations including the institution name, dates, reason, modality (type of treatment) and outcome

Institution Name	Dates	Reason	MModality(type of therapy)	OOutcome

List any Outpatient treatments including when, by whom and nature of treatment. Please also describe the outcome of the treatment. (Examples: Intensive Outpatient program (IOP) Partial Hospitalization (PHP) Residential Rehabilitation)

Reason	Dates/ Length	Provider Name	Outcome

List all therapists/psychotherapists that you have seen (particularly the last 5 years). Include provider name, dates, reason and outcome

Provider Name	Dates	Reason	Outcome

List all psychiatrists that you have seen (particularly the last 5 years). Include provider name, dates, reason and outcome.

Provider Name	Dates	Reason	Outcome

In the past, have you tried electroconvulsion therapy (ECT)? ( ) Yes ( ) No
If you answered yes, please complete the following questions:

Name of Facility: _____
Dates: _____
Reason: _____
Number of Sessions: _____
Outcome: _____

In the past have you tried Ketamine or Esketamine treatment? ( ) Yes ( ) No
If you answered yes, please complete the following questions:

Name of Facility _____
Dates: _____
Reason:_____
Number of Sessions_____
Outcome:_____

List any psychological/neuropsychological testing you have completed including the name of the provider, year, and reason for testing. If you have, please send the office a copy of your results prior to your appointment.

Name of Provider Year Reason

_____
_____
_____
_____

Have you done genetic testing for psychotropic medications (ie.GeneSight)? ( ) Yes ( ) No
If yes, what is the date of testing? _____
If yes, send the office a copy of your results prior to your appointments

In the past have you been suicidal or self-injurious? ( ) Yes ( ) No

In the past, have you ever made a suicidal attempt? ( ) Yes ( ) No

If yes, please indicate the year(s) it occurred and pertinent details:

_____
_____

In the past, have you been assaultive towards someone else? ( ) Yes ( ) No

Substances Used and History

					Ever considered a Problem?
Alcohol:	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
Amphetamines:	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
Marijuana/hash	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
Anti-anxiety (e.g. Valium)	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
Barbiturates:	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
Cocaine/ Crack:	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
Heroine/morphine:	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
LSD/acid	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
Meth/Crystal meth:	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
Painkillers (e.g. Oxycontin):	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
Caffeine	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐
Other (specify): _____	☐ Never Used	☐Currently using	☐Past use	___ Age 1st Used	☐

Describe type, amount, frequency, and date of of use for each substance indicated above:

_____

_____

Have you ever had treatment for substance abuse disorder? ☐ No ☐ Yes

Have you used drugs and/or alcohol in situations where it is physically dangerous, such as driving while impaired? ☐ No ☐ Yes

If yes, describe: _____

Legal Problems: ☐ None ☐ DUI ☐ Public Intoxication ☐ Other substance- related arrest)

Financial Problems related to substance abuse: ☐ None ☐ Some ☐ Moderate ☐ Severe

Describe: _____

Social Problems related to substance abuse : ☐ None ☐ Some ☐ Moderate ☐ Severe

Describe: _____

Physical or Medical Problems:

☐Increased Tolerance ☐Hangovers ☐Liver disease ☐Stomach ailments

☐Withdrawal symptoms ☐Heart ailments ☐Blackouts ☐Other

Mental health disorders that have been exacerbated by substance use:

_____

Have you ever completed any of the following?

☐Inpatient detox ☐Intensive Outpatient Program ☐Residential Rehabilitation

If yes, when, and how many times?

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember). When describing the reason stopped please indicate whether it was ineffective or if you experience side effects and if so, what side effects.

Antidepressants	**Dates**	**Dosage**	**Reason Stopped**
Anafranil (clomipramine)			
Celexa (citalopram)			
Cymbalta (duloxetine)			
Effexor (venlafaxine)			
Elavil (amitriptyline)			
Lexapro (escitalopram)			
Luvox (fluvoxamine)			
Pamelor (nortrptyline)			
Paxil (paroxetine)			
Pristiq (desvenlafaxine)			
Prozac (fluoxetine)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Tofranil (imipramine)			
Trintellix (vortioxetine)			
Viibryd (vilazodone)			
Wellbutrin (bupropion)			
Zoloft (sertraline)			
Other			

Mood Stabilizers	**Dates**	**Dosage**	**Reason Stopped**
Depakote (valproate)			
Lamictal (lamotrigine)			
Lithium			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

Typical Antiphsychotics	**Dates**	**Dosage**	**Reason Stopped**
Haldol (haloperidol)			
Loxitane (loxapine)			
Mellaril (thioridazine)			
Moban (molindone)			
Navane (thiothixene)			
Prolixin (fluphenazine)			
Serentil (mesoridazine)			
Stelazine (trifluoperazine)			
Thorazine (chlorpromazine)			
Trilafon (perphenazine)			

Past Psychiatric medications (continued)

Atypical Antipsychotics	Dates	Dosage	Reason Stopped
Abilify (aripiprazole)			
Clozaril (clozapine)			
Geodon (ziprasidone)			
Rexulti (Brexpiprazole)			
Risperdal (risperidone)			
Seroquel (quetiapine)			
Vraylar (Cariprazine)			
Zyprexa (olanzepine)			

Sedative/Hypnotics	Dates	Dosage	Reason Stopped
Ambien (zolpidem)			
Desyrel (trazodone)			
Lunesta (eszopiclone)			
Restoril (temazepam)			
Rozerem (ramelteon)			
Sonata (zaleplon)			
Other			

ADHD Medications	Dates	Dosage	Reason Stopped
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Vyvanse (Lisdexamfetamine)			
Other			

Antianxiety Medications	Dates	Dosage	Reason Stopped
Ativan (lorazepam)			
Buspar (buspirone)			
Centrax (prazepam)			
Hydroxyzine			
Inderal (propranolol)			
Klonopin (clonazepam)			
Librium (chlordiazepoxide)			
Other			
Serax (oxazepam)			
Tenormin (atenolol)			
Tranxene (clorazepate)			
Valium (diazepam)			
Xanax (alprazolam)			

Has anyone in your family been diagnosed with a behavioral health disorder (like Depression/OCD/Anxiety) or substance abuse disorder (suspected or diagnosed)? ◯ Yes ◯ No

If yes, explain which family member and what disorder?

_____

_____

Has anyone, blood related to you, attempted or completed suicide? If yes, please indicate family relationship and year of incident:

_____

_____

Social History

Where were you born:_____

Who were you primarily raised by:_____

What is your birth order and how many siblings do you have? _____

How would you describe the quality of your childhood? _____

Were there any sources of family stressors growing up? _____

How is the relationship quality with your family member?

_____

_____

Education History

Have you received your high school diploma? ◯ Yes ◯ No

Have you received a GED certificate? ◯ Yes ◯ No

Have you attended college ◯ Yes ◯ No

Have you graduated from college ◯ Yes ◯ No

If so, please list area of study _____

Employment History

Occupation: _____

Length of Current position: _____

How would you describe your work quality?_____

Relationship/ Marriage

Are you currently married? ◯ Yes ◯ No

Length of current marriage? _____ Quality of current marriage? _____

How many times have you been married? _____

Children Information

Do you have any children? ◯ Yes ◯ No If yes, how many _____

Are they from your current marriage or previous marriage? _____

How is your relationship with your child/ children _____

Have you ever been in the Military? ◯ Yes ◯ No

If yes, include what branch, type of discharge (if applicable), and any exposure to trauma (brief description)

_____

_____

Have you ever been arrested or have any other legal problems? ◯ Yes ◯ No

If yes, please explain:

_____

_____

_____

Who is currently in your support system?

_____

_____