Mindful
Behavioral Healthcare

Welcome to Mindful Behavioral Healthcare!

We always strive to provide the best treatment possible for our patients. We appreciate that you have chosen Mindful Behavioral Healthcare and Counseling Services to obtain your mental health needs.

In this packet, you will find everything that you need to assist us in getting to know you better.

We will appreciate you bringing to our office all of the enclosed forms completed. In addition, the following is a checklist of all the information you need to bring for your visit:

- ☐ A list of all current medications with their dosage and frequency
- ☐ Copy of insurance card and valid ID (If child, bring parent/guardian ID)
- ☐ Copy of the following (if available):
  - Psychological Evaluation
  - School Records
  - Prior Mental Health Treatment Records
- ☐ If recently discharged from a psychiatric facility, bring a copy of the medical records or summary of the visit
- ☐ Information about your primary care provider
- ☐ Pharmacy information
- ☐ Completion of the following forms:
  - New Patient Information Form
  - Authorization to Release or Obtain Confidential Information
  - Behavioral Questionnaire [if minor, to be completed by teacher(s)]
- ☐ Read through and sign the following:
  - Patient Rights and Responsibilities
  - Office Policies

Thank you for choosing Mindful Behavioral Healthcare! We look forward to providing you with the highest quality of mental health services.

Mindful
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New Patient Information Form
(Formulario de Información para Pacientes Nuevos)

Date (Fecha): _____/_____/_____

Last Name (Apellido): _____ First Name (Nombre): _____ Middle Initial (Segundo Inicial): _____

Address (Dirección): _____

City (Ciudad): _____ State (Estado): _____ Zip Code (Zona Postal): _____

Home Phone (Teléfono del Hogar): (_____) _____ Cell Phone (Celular): (_____) _____

Date of Birth (Fecha de Nacimiento): _____ Social Security # (Seguro Social): _____

Legal Status (Estatus Legal): □Minor (Menor) □Single (Soltero[a]) □Married (Casado[a]) □Widowed (Viudo[a]) □Separated (Separado[a]) □Divorced (Divorciado[a])

Employer (Empleo): _____ Occupation (Ocupación): _____

E-mail: _____ How can we best remind you of your appointments? □ Text □ E-mail □ Phone Call
(Como podemos comunicarnos con usted para recordarle de su cita? □ Texto □ E-mail □ Llamada Telefonica)

Please be aware that if you choose the text option to receive appointment reminders, message and data rates may apply. Please consult your telephone company.
(Queremos recordarle que si utiliza el sistema the mensajes atraves del telefono, algunos cargos pueden aplicar. Favor de consultar su compañía telefónica.)

If you are not 18 years of age, a parent or guardian must sign these forms for consent to treat you and financial responsibility.
(Si es menor de 18 años de edad, el padre o guardián tiene que firmar estos formularios de consentimiento para proveer tratamiento y confirmar la responsabilidad financiera.)

Parent/Guardian Name (Nombre de Padre/Guardián): _____

Insurance Information
(Información del Seguro)

Name of Insured (Nombre del Asegurado): _____ Date of Birth (Fecha de Nacimiento): _____
If you are financially responsible for all charges, please check here (Si usted es financieramente responsable de todos los cargos, por favor marque aquí): ☐

Relation to Patient (Relación con el Paciente): _____ Social Security # (Seguro Social): _____

Insurance Company (Compañía de Seguro): _____ Group # (Número del Grupo): _____

ID #: _____ Phone: (Teléfono): (_____) _____

Address (Dirección): _____ City (Ciudad): _____ State (Estado): _____ Zip Code (Zona Postal): _____

Primary Care Physician
(Proveedor Médico Primario)

Name (Nombre): _____

Phone (Teléfono): (_____) _____ Fax: (_____) _____

Address (Dirección): _____ City (Ciudad): _____ State (Estado): _____ Zip Code (Zona Postal): _____

Medication
(Medicamentos)

Pharmacy Name (Nombre de su Farmacia): _____ Phone (Teléfono): (_____) _____

Current Medications (Medicamentos Actuales):

Name (Nombre)	**Dosage & Frequency (Dosis y Frecuencia)**	**Name (Nombre)**	**Dosage & Frequency (Dosis y Frecuencia)**
1.		5.	
2.		6.	
3.		7.	
4.		8.	

If additional space is needed, please write information on the back of this page and check here: ☐

(Si necesita espacio adicional, por favor escriba la información en el reverso de esta página y marque aquí): ☐

Emergency Contact
(Persona Contacto en Caso de Emergencia)

Name (Nombre): _____ Relationship to the Patient (Relación con el Paciente): _____

Home Phone (Teléfono del Hogar): (_____) _____ Cell Phone (Celular) (_____) _____

Consent for Treatment
(Consentimiento Para Tratamiento)

I, _____, authorize **Mindful Behavioral Healthcare** to provide evaluation and treatment services for myself or _____ (patient's name if minor). I understand that although **Mindful Behavioral Healthcare** strives in providing the best treatment possible for their patients, the treatment provided may not always yield the desired results and that there are no guarantees. Every treatment will be conducted in a **confidential** manner, as stated under the **HIPAA Regulations.** Disclosure of confidential information will not be permitted unless specifically authorized in writing by the patient or guardian or under a subpoena issued by a court. I understand that Mindful Behavioral Healthcare is obligated by Florida Stature to report any suspiciousness of child abuse and/or neglect or if they demonstrate potential to cause harm to self or others. I am aware that **Mindful Behavioral Healthcare** is committed to the training and education of individuals in the medical/mental health field. I have the right to authorize or decline giving information and/or be assessed by any staff in training.

(Yo, _____, autorizo a **Mindful Behavioral Healthcare** a ofrecer servicios de evaluación y tratamiento psiquiátrico y consejería para mí o _____ (nombre del paciente si es menor de edad). Entiendo que aunque **Mindful Behavioral Healthcare** se esmera en proporcionar el mejor tratamiento posible a sus pacientes, el tratamiento provisto no siempre produce ni garantiza los resultados deseados. Cada tratamiento se llevará a cabo de una manera **confidencia**l, según las **reglamentaciones de HIPAA**. No se permitirá la divulgación de información confidencial sin la autorización escrita por parte del paciente o guardián o bajo una orden judicial emitida por un tribunal. Entiendo que Mindful Behavioral Healthcare está obligado por ley en el estado de Florida a reportar cualquier sospecha de abuso y/o abandono, o si un paciente demuestra la posibilidad de causar daño a sí mismo o a otros. Al mejor de mi conocimiento, la información anterior es completa y correcta. Entiendo que es mi responsabilidad informar a mi médico si yo, o mi hijo menor de edad, tiene un cambio en la salud.) Entiendo que **Mindful Behavioral Healthcare** entrena y educa a personas en el area medica/salud mental. Me reservo el derecho de autorizar or declinar dar información y/o ser evaluado por cualquier personal en entrenamiento.

To the best of my knowledge, the above information is completed and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, have a change in health.

(Esta información está siendo ofrecida basada en individuo conocimiento, certifico que la información brindada es completa y correcta. Entiendo que es mi responsabilidad el informar a mi médico si yo o mi hijo(a) menor de edad, tiente cambios en su condición de salud.)

_____	_____	_____
Patient or Parent/Guardian Signature (Firma de Paciente o Padre/Guardián)	Parent/Guardian Name (Print) (Nombre del Padre/Guardián en Letra de Molde)	Date (Fecha)

_____	_____
Patient Name (Print) (Nombre de Paciente en Letra de Molde)	Date of Birth (Fecha de Nacimiento)

Patient Rights and Responsibilities

Confidentiality

It is the policy of **Mindful Behavioral Healthcare**, to treat all patient information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. If you have any questions, please ask a front desk representative for additional information. We make every effort to provide our patients with an environment that is safe, private and respectful of our patient's needs. If you have a complaint about our services, facilities, or staff we want to hear from you. We will do everything we can to see that your experience with us is of the highest quality.

Issues of Care

Mindful Behavioral Healthcare is committed to your participation in care decisions. As a client, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask.

Patient Rights

- The patient has the right to receive information from health providers and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.
- The patient has the right to make decisions regarding the health care that is recommended by his or her health provider. Accordingly, patients may accept or refuse any recommended medical treatment.
- The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.
- The patient has the right to confidentiality. The health provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
- The patient has the right to continuity of health care. The health provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care, provided they give the patient reasonable assistance, direction, and sufficient opportunity to make alternative arrangements.

Patient Responsibilities

- Good communication is essential to a successful health provider-patient relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their health providers.
- Patients have a responsibility to provide a complete medical history, to the best of their knowledge, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health.
- Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.
- Once patients and health providers agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with their health provider's instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
- Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that places the health of others at risk.

I, hereby understand my rights and responsibilities as a patient/client of Mindful Behavioral Healthcare. I have read and understand the terms described above:

_____	_____	_____
Patient or Parent/Guardian Signature	Parent/Guardian Name (Print)	Date
_____	_____	
Patient Name (Print)	Date of Birth	

Mindful
Behavioral Healthcare

Office Policies

We are here to serve the mental health needs of every patient and we request your cooperation in adhering to the following office policies in order to better help you and others.

Payments

Every patient is responsible for paying fees and any balance that is not covered by his/her insurance at the time of the appointment. If you need to make special payment arrangements, please discuss this with our office staff **before** the visit. **A $30 fee will be charged for all returned checks.** If a patient fails to make the proper restitution of any pending balance within a reasonable time, we will proceed to refer his/her account to a collection agency according to our financial policy and those terms under the Fair Debt Collection Practices Act.

Prescription Refills and Prior Authorizations

An administrative fee of $25.00 will be charged to the patient's account for every pharmacy phone-in, mail away and fax-up prescription requests as a result of a patient's actions (lost prescription, failure to take new prescription to be filled on time and missed appointments). All medication will be prescribed only if the physician feels that it is clinically appropriate. Insurance will not reimburse the patient for these charges nor will Mindful Behavioral Healthcare bill the patient's insurance for them.

Check-In Time

Appointment times are reserved for you and should start promptly. **We advise you to arrive at the office 15 minutes prior to your scheduled appointment in order to properly ensure your appointment.** If you arrive five minutes past your appointment time, you may have to reschedule your visit for another date. Although patients are scheduled at a specific time, the actual time in which they are seen could vary as certain clinical situations may arise, requiring additional time.

No Show/Late Cancellations

Missed appointments or appointments that are not canceled with a minimum of 48 hours' notice will be assessed **a fee of $30.00.** Insurance will not reimburse the patient for this charge, nor will **Mindful Behavioral Healthcare** bill the insurance for it. Our reminder service sends confirmation calls, emails, and texts as a courtesy only to our patients, but it is the patient's responsibility to keep track of appointments.

Patient Responsibilities

It is the patient's and/or guardian's responsibility to inform **Mindful Behavioral Healthcare**, of any telephone, address, and insurance information changes in order to properly ensure continuation of your appointments.

Other Service Charges

There will be a charge for the preparation and completion of reports, letters, certificates and forms related to the services provided at this office. With few exceptions, the fees for the completion of these documents will be the responsibility of the patient. Please ask our front desk staff for more information regarding fees. **All photocopies and requests of a patient's medical records will be charged $1.00 per page, plus an administrative fee of $10.00.** Any changes to the service fees will be informed in advance.

After Hours and Emergencies

In the event of an emergency situation (including those in which a person is feeling out of control, unable to care for him/herself, or having serious thoughts of harming themselves or others)**, call 911 or go to the nearest Emergency Room**. If you have an urgent concern that you need to discuss with the physician, please call our office to reschedule your appointment to an earlier date. All phone messages left in the voice mail will be returned within 48 business hours by the office staff in the order in which they were received.

Confidentiality

Mindful Behavioral Healthcare adheres to strict confidentiality in accord with federal laws, state laws, and HIPAA regulations. No information will be disclosed unless specifically authorized in writing by the patient or his/her guardian or under subpoena issued by a court. There are rare exceptions to confidentiality for example, if a patient should express or report a specific and serious intent to inflict harm to themselves or others, your psychiatrist may break this agreement, but only when necessary in order to ensure the patient's safety, as well as the safety of others. By law, we also have a duty to report cases of abuse when the victim is a minor, elderly, or disabled.

Changes to this Notice

Mindful Behavioral Healthcare reserves the right to amend this Notice at any time in the future, and will make the new provisions available to its patients for all information that it maintains. Upon request, you have the right to a paper copy of this notice at any time.

Mental Health Assessments

I agree upon a request made by **Mindful Behavioral Healthcare**, to complete a free of charge computerized mental health assessment using an IPad provided by this office, administered prior to my appointment with the physician or nurse practitioner, with the purpose measuring, summarizing and determining symptoms of depression, anxiety, and chronic pain.

Drug Testing

I hereby agree, upon the drug/alcohol testing policy of **Mindful Behavioral Healthcare**, to submit to a drug or alcohol test and to furnish a sample of my urine for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to the cancellation of my appointment until said sample is produced. I further authorize and give full permission to have **Mindful Behavioral Healthcare's** medical assistants send the specimen or specimens collected to a laboratory for a screening test to determine the presence of any prohibited substances under the policy and for the laboratory or other testing facility to release any and all documentation relating to the results of such test to **Mindful Behavioral Healthcare** for the purposes of monitoring my treatment.

I, hereby understand that any violation to the Office Policies of Mindful Behavioral Healthcare may lead to my dismissal as a patient from this practice. I have read and agree to comply with the terms described above:

_____	_____	_____
Patient or Parent/Guardian Signature	Parent/Guardian Name (Print)	Date

_____	_____
Patient Name (Print)	Date of Birth

Mindful
Behavioral Healthcare

Authorization to Release or Obtain Confidential Information

Autorización para Divulgar u Obtener Información Confidencial

Patient Name (Nombre del Paciente): _____ Date of Birth (Fecha de Nacimiento): _____

Social Security # (Seguro Social): _____ Phone # (Teléfono): (_____) _____

I hereby authorize **Mindful Behavioral Healthcare** to ☐ **RELEASE or** ☐ **OBTAIN** information by mail or facsimile (fax) to/from:
(Por este medio autorizo ***Mindful Behavioral Healthcare*** a ☐ **PROVEER o** ☐ **OBTENER** información por correo o por fax a/desde:)

Name of Person/Organization (Nombre de Persona/Organización): _____

Address (Dirección): _____

City (Ciudad): _____ State (Estado): _____ ZIP (Zona Postal): _____

Phone (Teléfono): (_____) _____ Fax: (_____) _____

The following information is to be disclosed (La siguiente información debe ser provista)**:**
☐ Medical Records Dates (Fecha de Expedientes Médicos) From (Desde): _____ To (Hasta): _____
☐ Psychiatric Evaluation (Evaluación Psiquiátrica) ☐ Psychotherapy Notes (Notas de Psicoterapia) ☐ Psychological Assessment (Evaluación Psicológica)
☐ Substance Abuse Treatment (Tratamiento para Abuso de Substancias Controladas) ☐ Medication Management Notes (Notas de Administración de Medicamentos)
☐ Other (Otro) _____

For the purpose of (A los efectos de)**:** ☐ Continuing Care (Continuar Tratamiento) ☐ Personal (Personal) ☐ Other (Otro) _____

Notice to Patient and Recipient of Records
Aviso a los Pacientes y Receptor de los Récords

I understand that this form may be used to release information related to mental health treatment. I further understand that the information disclosed may include psychiatric, drug/alcohol abuse and/or HIV data. I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information. If I do not revoke this authorization, it will automatically expire one year from the date of signature unless otherwise noted below.

(Entiendo que este formulario puede ser utilizado para divulgar información relacionada con el tratamiento de salud mental. Entiendo, además, que la información divulgada puede incluir abuso de alcohol y/o drogas psiquiátricas y/o datos sobre el HIV. Yo entiendo que tengo el derecho de negarme a firmar esta Autorización o de rescindir mi consentimiento en cualquier momento antes de la publicación de la información. Si no revoco esta autorización, el plazo vencerá automáticamente un año desde la fecha de la firma a menos que se indique lo contrario a continuación.)

_____ _____ _____
Patient's Signature (Firma del Paciente) Printed Name (Nombre en Letra de Molde) Date (Fecha)

_____ _____ _____
When applicable, Signature of (Si aplica, firma de): ☐ Parent (Padre) ☐ Guardian (Guardián) ☐ Healthcare Surrogate/Proxy ☐ Power of Attorney (Poder de Abogado)

When applicable, Signature of (Si aplica, firma de): ☐ Parent (Padre) ☐ Guardian (Guardián) ☐ Healthcare Surrogate/Proxy ☐ Power of Attorney (Poder de Abogado)

Date (Fecha)

_____ _____ _____
Signature of Witness (Firma del Testigo) Printed Name of Witness (Nombre en Letra de Molde del Testigo) Date (Fecha)

This information has been disclosed to you from records protected by Federal confidentiality rules Florida Statues 394-459, 397.501, and /or 90.503 and 42 Code of Federal Regulations (42 CFR). This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for privacy of Individually Identifiable Health Information (Privacy Standards) 45 CFR, 160 & 164, and all federal regulations and interpretative guidelines promulgated there under. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Florida Statues 394-459, 397.501, and /or 90.503. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I have been informed that this authorization is subject to revocation by me at any time except to the extent that Mindful Behavioral Healthcare has already taken action in reliance on it. Once the requested protected information is disclosed, the Privacy Regulation may no longer protect it if the PHI's recipient re-discloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Mindful Behavioral Healthcare from all liability should this information be received by someone other than the above-intended recipient.

Mindful
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Authorization for Release of Information to Nonmedical Individuals

Autorización para Divulgar Información Confidencial a Personal No Medico

Patient Name (Nombre del Paciente): _____ Date of Birth (Fecha de Nacimiento): _____

Many of our patients request to allow family members or others to call, pick up documents, and request medical or billing information on their behalf. Under HIPAA requirements, we are not allowed to give this information to anyone unless we have the patient's informed consent. If you wish to have any of this information released to the individuals of your choice, this form needs to be completed. By doing so, you authorize this office to give information to the individual(s) indicated below.

(Muchos de nuestros pacientes solicitan que se les permitan a un familiar u otra persona que recoja documentos y que solicite información de su persona. Bajo los requisites de HIPPA, no estamos autorizado a divulgar esta información a menos que el paciente complete un documento dando su concentimiento. Si desea que esta información sea divulgada a otras personas, esta forma tiene que ser completada. Al hacer esto, estara autorizando esta oficina le provea información a los individuo(s) abajo indentificados.)

I, _____, authorize **Mindful Behavioral Healthcare** to release the following information:

(Yo, _____, autorizo a **Mindful Behavioral Healthcare** a divulgar la siguiente información:)

- ☐ Prescriptions/Medications *(Recetas/Medicamentos)*
- ☐ Medical Records *(Expedientes Medicos)*:
  - ☐ Psychotherapy *(Psicoterapia)*
  - ☐ Medication Management *(Manejo de Medicamentos)*
- ☐ Appointment Dates/Times and/or Change/Cancel *(Fecha/Hora de Citas y/o Cambiar/Cancelar Citas)*
- ☐ Pick Up Forms or Letters *(Recojer Formas o Cartas)*
- ☐ Billing Information *(Información de Facturación)*
- ☐ Other *(Otro)* _____

To the following individual(s) *(A los siquientes individuos)*:

Name *(Nombre)*: _____ DOB: _____ Relationship *(Relación)*: _____

Name *(Nombre)*: _____ DOB: _____ Relationship *(Relación)*: _____

Name *(Nombre)*: _____ DOB: _____ Relationship *(Relación)*: _____

I understand I have the right to revoke this authorization in writing at any time. I understand that by giving this consent, I will be allowing the individual identified above the to inspect or copy the protected health information to be disclosed. As a result, the information disclosed to any above recipient will no longer be protected by federal or state law and that it may be subject to re-disclosure by its recipient.

(Entiendo que tengo el derecho de revocar esta autorización por escrito en cualquier momento. Entiendo que, al dar este consentimiento, estaré permitiendo que el individuo arriba identificado pueda inspecionar o copiar esta información medica protegida. Como resultado, la información divulgada no va ser protegida por las leyes federales y estatales y puede estar sujeta a ser re-divulgada por el individuo que la reciba.)

Patient/Guardian Signature (Firma de Paciente/Guardián): _____ Date (Fecha): _____

Witness Signature (Firma del Testigo): _____ Date (Fecha): _____