SUNCOAST BEHAVIORAL MEDICINE, INC.
4370 S. Tamiami Trail
Sarasota, FL 34231

(941) 926-2474 email:jobaker@sunpsych.com
(941) 926-2440 Fax www.sunpsych.com

William K. Baker, EdD, M.S. Joanna R. Baker, LMHC, PT
Licensed Psychologist Licensed Physical Therapist
PY5729 Licensed Mental Health Counselor

NEW PATIENT REGISTRATION PACKET

Welcome to Suncoast Behavioral Medicine! We are pleased that you have chosen our practice to assist you in reaching your current therapeutic goals.

To facilitate getting you started right away, the following information, including permission and consent forms must be completed and returned to us as soon as possible.

Identification and Insurance Documents: Please FAX (941-926-2440) or send via scanned email (@sunpsych.com) attachment:

- A Picture ID Such as a valid Driver's License
- A copy of your Primary Insurance Card
- A copy of your Secondary/Supplemental Insurance Card (if applicable)

HIPAA rules as well as other federal and state laws and professional guidelines require us to have the applicable forms and permission signatures on file prior to scheduling your first session.

1. **HIPAA Privacy Notice** (Notice of Policies and Practices to Protect the Privacy of Your Health Information)
2. **Patient Registration Form**
3. **Authorization/ Release of Information Form** (Authorizes us to collaborate and/or share information with your other caregivers/providers, or other specific person. You can opt not to authorize us to share info, except in certain circumstances, such as when you are taking prescribed medication from another provider; we may need to require you to let us discuss your care with those providers, i.e. a Psychiatrist or other clinician who provides psychiatric medications for you.
4. **Consent to use and disclose health information (**Required for treatment to proceed)
5. **Telemedicine Treatment Authorization Form.**
6. **Signed HCFA Billing Form** (Sign boxes 12 & 13). This form authorizes us to bill your Medicare or Insurance Payor. It also authorizes direct payment to Suncoast Behavioral Medicine.
7. **Other Forms** (Specific forms which may be required to facilitate treatment)

As noted above, scheduling or treatment cannot proceed until the listed forms and permissions are signed and returned.

SUNCOAST BEHAVIORAL MEDICINE, INC
(941) 926-2474 FAX (941) 926-2440 www.sunpsych.com email:jobaker@sunpsych.com

Form #1

Date:_____ Patient Name:_____

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another Provider.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my clinic, practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.

- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- **Health Oversight:** If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

- **Worker's Compensation:** If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

IV. Patient's Rights and Provider's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Provider's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you either by written communication or via email.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Joanna R. Baker, LMHC, at Suncoast Behavioral Medicine, Inc. The contact telephone number is 941-926-2474.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint, or discuss the issue with Joanna R. Baker, LMHC, at Suncoast Behavioral Medicine, Inc. The contact telephone number is 941-926-2474.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice is in effect as of 6/18/2014.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. In that event, I will provide you with a revised notice.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____

Name (Please Print)

_____

Signature

_____

Date of Signature

SUNCOAST BEHAVIORAL MEDICINE, INC
(941) 926-2474 FAX (941) 926-2440 www.sunpsych.com email:jobaker@sunpsych.com

Form #2
REGISTRATION FORM
(Please Print)

Today's date:				Primary MD:		
PATIENT INFORMATION						
Patient's last name: First: Middle:					Marital status (circle one) Single / Mar / Div. / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?		Birth date: / /	Age:		
Street address:		Social Security no.:				
P.O. box:	City:		State:	ZIP Code:		
Preferred Contact: ☐ Phone ☐Cell ☐Text ☐E-Mail	Home phone #: ( )_____ Cell phone #: ( )_____ Other phone # ( )_____ E-Mail Address: _____			Permission to leave message: ☐ Phone ☐Cell ☐Text ☐E-Mail ☐Do Not Leave Messages ☐Scheduling Messages only		
Chose our practice because OR Referred by (please check one box):		❑ Dr. Name		❑ Insurance Plan	❑ Hospital	
❑ Family	❑ Friend	❑ Close to home/work	❑ Other			
Other family members seen here:						

INSURANCE INFORMATION					
(Please provide your insurance card(s)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone#: ( )	
Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

SUNCOAST BEHAVIORAL MEDICINE, INC
(941) 926-2474 FAX (941) 926-2440 www.sunpsych.com email:jobaker@sunpsych.com

Please List all Medications you are currently taking:

1	6	11
2	7	12
3	8	13
4	9	14
5	10	15

Other Substances:

Caffeine	Chocolate	Soda
Energy Drinks	Alcohol	Tobacco
Other		

Other information you would like your clinician to know about today:

SUNCOAST BEHAVIORAL MEDICINE, INC
(941) 926-2474 FAX (941) 926-2440 www.sunpsych.com email:jobaker@sunpsych.com

Form #3
Authorization Form

This form, when completed and signed by you, authorizes Suncoast Behavioral Medicine to release protected information from your clinical record to the person you designate.

I authorize my Provider, _____, to release information about my Diagnoses and Treatment. This information should only be released to:

Name: Address Telephone # FAX #

_____

_____

_____

I am requesting my Provider to release this information for the following reasons:
___at the request of the individual.
___Coordination of Care
___Other: _____

This authorization shall remain in effect until_____ or until the completion or termination of my Care and Treatment at Suncoast Behavioral Medicine, Inc.

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my Provider generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

☐I **DO NOT** authorize release of protected information from my clinical record to another clinician or Health Care provider at this time.

_____ _____
Signature of Patient Date

_____
If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

SUNCOAST BEHAVIORAL MEDICINE, INC
(941) 926-2474 FAX (941) 926-2440 www.sunpsych.com email:jobaker@sunpsych.com

Form #4

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and me/us _____. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our Web Site, www.sunpsych.com, or by calling us at 941-926-2474, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

Signature of client or his or her personal representative: _____

Date:_____

Printed name of client or personal representative:_____

Relationship to the client:_____

Description of personal representative's authority: _____

Signature of authorized representative of this practice: _____

Date of NPP _____Copy give to the client/parent/representative.

SUNCOAST BEHAVIORAL MEDICINE, INC
(941) 926-2474 FAX (941) 926-2440 www.sunpsych.com email:jobaker@sunpsych.com

Form #5

CONSENT FOR TREATMENT USING TELETHERAPY

I, _____, agree to participate in teletherapy with a mental health provider at *Suncoast Behavioral Medicine, Inc*. This means that:

• I authorize information about my medical and mental health care to be transferred electronically through an interactive video connection between myself and *Suncoast Behavioral Medicine, Inc*

• I understand that I will be informed of the identities of all people who are present during the teletherapy session and informed of their purpose for attending the session.

• My therapist has explained how the teletherapy system works and how it will be used for my treatment.

• My therapist has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.

• I understand that my therapist will not be physically present during my teletherapy session. Instead, we will see each other electronically.

• I understand that teletherapy is a new form of treatment that is not yet validated by research. As such, there may be potential risks that may not yet be recognized.

• Potential risks include the following: (a) at times the video image may be unclear or inadequate;

(b) a disruption in the connection may occur; and (c) in rare circumstances, the information may be intercepted by unauthorized persons.

• I authorize the release of information pertaining to me determined by my mental healthcare providers or by my insurance company for the purpose of processing insurance claims.

• I understand that at any time, I may decide to discontinue teletherapy sessions with my provider. My therapist will refer me to a local mental health provider who can provide face-to-face services.

• I understand that, under the law, my mental health provider may be required to report to the authorities any information suggesting that I have engaged in behaviors that are dangerous to myself or others.

• My therapist has explained the risks and benefits of receiving teletherapy. I understand that I still may need to see a specialist in person.

• I understand that information from my teletherapy sessions will be protected by HIPPA privacy laws.

<u>These are the names and phone numbers of my local emergency contacts:</u>

Primary Emergency Contact:_____Phone:_____

• Psychiatrist: _____Phone:_____

• Primary care physician: _____Phone:_____

• Local hospital emergency room:_____Phone:_____

I voluntarily consent to participate in telemental health services using videoconferencing equipment for the care, treatment, and services deemed necessary and advisable under the terms set forth herein.

Signatures

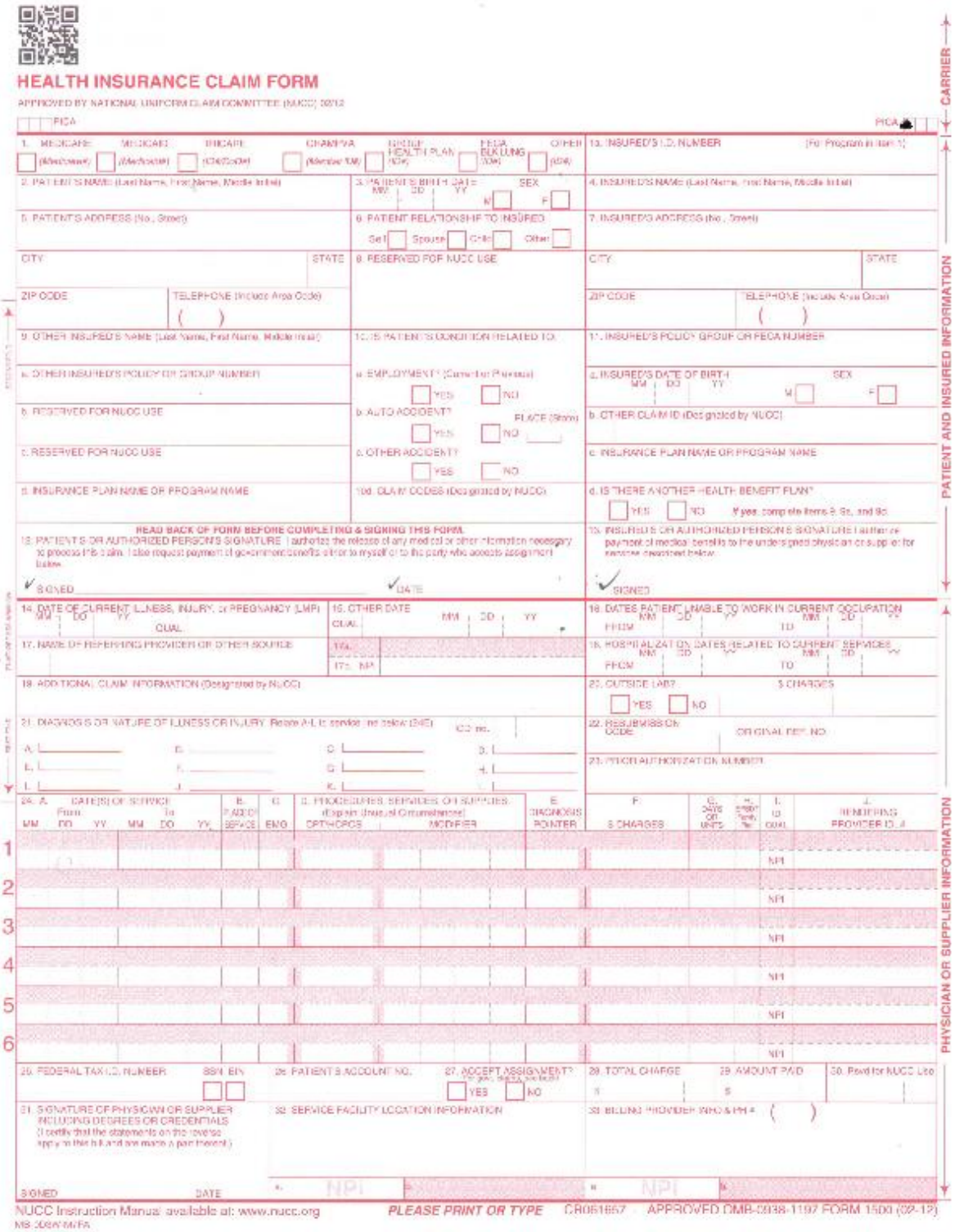
Name: _____Date:_____

Parent or Legal Guardian: _____ _Date:_____

SUNCOAST BEHAVIORAL MEDICINE, INC
(941) 926-2474 FAX (941) 926-2440 www.sunpsych.com email:jobaker@sunpsych.com

Form #6.

SIGNED HCFA MEDICARE/INSURANCE CLAIM Form (Sign Boxes 12 & 13)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (CHAMPUS#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any med cal or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061857 APPROVED OMB-0938-1197 FORM 1500 (02-12)

MB 3084 MFA