8615 Commodity Circle Ste12
Orlando, FL 32819
Tel 407-476-1212 Fax 407-476-1213

PATIENT INFORMATION

Patient:	**SS#**	**DOB**	o M o F
Insurance id#	Group #	Effective date:	
Address:			
Hm#	Wk# ext	Cell#	
Email:			
MENTAL HEALTH BENEFIT:			
PHARMACY BENEFIT:			

Responsible party info: **If patient is also the responsible party; disregard this portion**

Name:	SS#	**DOB**	o M o F
Relationship to patient: o self o spouse o partner o child o other:			
Address:		Apt:	
City:		St:	
Hm#	Wk# ext	Cell#	
Email:			
Mental Health Benefit:			
Medical Health Insurance:			

If patient is a minor, please list names of caretaker(s) at primary residence
(please indicate relationship - biological parent, step parent, legal guardian, etc.)

	Emergency contact #
	Emergency contact #

In case of emergency, please contact the person below:

	Emergency contact #

❖ I believe the above information to be true to the best of my knowledge and understand that it is my responsibility to advise the therapist of any pertinent changes.

❖ I release ALMA BEHAVIORAL GROUP to make contact with any of the above listed emergency contacts in situations that are deemed an emergency and understand that the contacts are to coordinate access to emergency care.

Patient or Legal Guardian _____ Date _____

ALMA BEHAVIORAL GROUP

PERMISSIONS AND ACKNOWLEDGEMENTS

HIPPA Acknowledgement

Upon request, I can obtain a copy of Alma Behavioral Group's Notice of Privacy Practices.

Signature:_____ Date:_____

Informed Consent for Treatment

I agree to allow the professional staff of ALMA BEHAVIORAL GROUP to administer psychiatric, psychotherapeutic, and/or chemical dependency treatment

I understand that I (or guardian) am entering into treatment and understand that I may discontinue services at any time. I also understand that I may be requested to submit to a random urine drug screen as part of my treatment plan.

I understand that if treatment issues are in need of referral or I am found to be non-compliant with treatment recommendations, services with ALMA BEHAVIORAL GROUP may be terminated with notice.

Signature:_____ Date:_____

O self O spouse O parent O guardian O other:

Patient Responsibility Acknowledgement

❖ I understand that I am responsible for payment of any services rendered regardless of whether the service is covered by an insurance policy. I understand it is my responsibility to provide current and accurate insurance information.

❖If I choose to utilize an insurance carrier, I understand that I am responsible for my co-pay or other fees dependant on my insurance benefit. If there is no insurance carrier, I understand that I am responsible for the agreed upon fee for service rate.

❖I further understand that my responsibility of payment is due upon receipt of services.

❖I understand that appointments are not double booked and reserved specifically for my time. I therefore agree that if I do not give 24 hour notice to change my appointment or fail to attend the appointment, I will pay a **$50 no-show fee**.

❖ I understand that if my account is past due, that it may be sent to a Collection Agency and that the status of my account be reported to the Credit Bureau.

Signature:_____ Date:_____

Insurance Payment Authorization

I authorize Insurance benefits payable to healthcare providers of ALMA BEHAVIORAL GROUP for services rendered by them.

Signature:_____ Date:_____

Insurance Information Release

I authorize the release of any information to my Insurance Carrier for the purpose of validating and determining benefits payable.

Signature:_____ Date:_____

ALMA BEHAVIORAL GROUP

PERMISSIONS AND ACKNOWLEDGEMENTS

Permission to Leave Messages	ALMA BEHAVIORAL GROUP tries it's best to leave appointment reminder messages for their patients. There may also be instances when your provider may need to change an appointment. To protect your confidentiality, your permission is needed to leave a message for you with anyone other than yourself. ALMA BEHAVIORAL GROUP has my permission to leave messages at the identified home number regarding my scheduled appointment. (Please check your choices): O Spouse Name:_____Phone #:_____ O Relative Name:_____ Phone #:_____ O Other Name:_____ Phone #:_____ O Answering Machine Signature:_____ Date:_____

Patient Name: _____

If patient is a minor or has a person designated to make medical decisions

Parent or Guardian:

I, _____, do hereby state that I am the

☐ natural parent ☐ legal guardian ☐ other: of the patient.

As such, I am authorized to make this request for treatment and give my consent to treatment and services mentioned in this form. If there are custody arrangements that impact medical treatment decisions, I will advise my provider at the first visit.

_____ _____

Signature Date

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Coordination of Treatment

ALMA BEHAVIORAL GROUP may send a copy of the Intake Evaluation/Psychiatric Report to your doctor, or other healthcare treatment providers, for the purpose of coordination of treatment. This is essential to provide ongoing communication among your treatment providers about your health.

- ❑ I **decline** to release the above information to my **treatment providers.**
- ❑ I **consent** to release the above information to my **treatment providers.**

Please indicate the name and contact information of your Primary Care Physician and/or other treatment providers:

PCP	**PH#**	**FAX#**
ADDRESS		
Provider	**PH#**	**FAX#**
ADDRESS		
Provider	**PH#**	**FAX#**
ADDRESS		

Signature **Patient/Parent or Legal Guardian**	**Printed Name**	**Date**
Witness Signature	**Printed Name**	**Date**

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ALMA BEHAVIORAL GROUP

OFFICE POLICIES

ALMA BEHAVIORAL GROUP is dedicated to servicing all of our clients in a professional and courteous manner.

- ✓ Appropriate conduct towards clinical and administrative staff is expected at all times, including both in person and during telephone interactions. We request that you behave in a professional and courteous manner. If abusive behavior occurs, discharge from Alma Behavioral Group may be implemented and alternate referrals will be provided.
- ✓ There is a **$35-50 fee** for late cancelations (less than 24 hour's notice) or appointments missed. Subsequent appointments shall be made only upon payment or fee. Two (2) consecutive missed appointments or three (3) late cancellations per year are grounds for discharge from Alma Behavioral Group and alternate referrals will be provided
- ✓ Letters and Forms will be received only during scheduled appointments and will be completed at our discretion. There is a **$25 - $250** fee for completion of such, as well as a fee for medical records.
- ✓ Consultations shall be made during an office visit. Phone consultations will be limited to urgent matters. No medication change shall be done over the phone, except for the reasons approved by us. You may be billed **$25 - $50** fee depending on the complexity of the telephone consults during or after office hours.
- ✓ No faxed or phoned-in prescriptions to pharmacies shall be made due to missed visits or lost prescriptions unless previously authorized by the group and be charged a **$25 fee** for replacement. Please note, all lost or stolen "schedule 2" prescriptions require that you file a police report. You are required to schedule an appointment to obtain a prescription.
- ✓ All client accounts are expected to be kept up to date and outstanding fees are due before services are provided unless prior financial arrangements have been made with the office staff.
- ✓ **Alma Behavioral Group and its clinical office staff do not take part in any legal actions or disputes.**
- ✓ **Any phone calls or emails will be answered within 24 to 48 business hours. Should you need assistance after hours, please go to the nearest emergency room or call 911. Thank you for your cooperation.**

ALMA BEHAVIORAL GROUP

FINANCIAL AGREEMENT

I am responsible for any insurance deductibles and co-payments.

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my insurance carriers.

I understand that I am responsible for my bill even if I do not have medical insurance.

If I am not using insurance, I am responsible for payment in full at the time of service.

I authorize my doctor and office personnel to act as my agent in helping to obtain payment from my insurance companies.

I authorize direct payment to Alma Behavioral Group and Dr. Jose Mendez.

I authorize a copy of this agreement to be used in place of the original.

I am responsible in obtaining a payment agreement if approved by Alma Behavioral Group

I understand that I must follow the office policies and its financial responsibilities and I agree with them.

Name (Please Print) _____

Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

☐ I hereby authorize and request:

_____

_____

_____

to release confidential professional information to **ALMA BEHAVIORAL GROUP**

☐ I hereby authorize and request **ALMA BEHAVIORAL GROUP** to release confidential personal information to:

_____

_____

_____

I understand that confidential professional information includes personal, psychological, psychiatric, substance abuse, AIDS related information, medical information, medical records, and opinions resulting from contacts with my treating clinicians. This request specifically to include the following:

☐ Full record disclosure	☐ Discharge Summary	☐ Progress Notes
☐ Psychological Testing	☐ Psychosocial History	☐ History & Physical
☐ Laboratory Results	☐ Other _____	

From: _____ To: _____

I also authorize_____(or one of his/her associates) to

communicate with _____ regarding the above noted request.

I understand that I am not obligated to disclose requested information. I may revoke this consent at any time by informing any of the above individuals. This release of information shall expire, regardless of notification, one year from the signature dates.
In consideration of this consent, I hereby release the above parties from any and all liability arising therein.

_____ _____

Patient Name in Print Patient Date of Birth

_____ _____

Signature (Patient, Parent, or Legal Guardian) Date of Signature