APC

# PATIENT INFORMATION

Name: _____
First MI Last

Date of Birth: _____

Local Address: _____
Street No

_____
City State Zip Code

_____
Telephone Yes or No
Text Message reminders YES or NO Leave Voicemail YES or NO

Your Email address_____

Pharmacy_____Phone Number_____

Emergency Contact Person and Number: _____
Emergency person does not give authorization for access to your medical records. Please sign the release of records if you would like someone to have access to your records, schedule or refill medications.

I acknowledge that the Notice of Privacy Practices (HIPAA) are made available for my review. I am also encouraged to read and become familiar with them. Should I have any questions, I am instructed to contact the Privacy Officer.

_____
Signature Date

# Medical Information

Name:_____DOB_____

How were you referred to us?_____

Reason for your visit today:_____

_____

Have you seen a psychiatrist within the last 12 months? YES/NO

List medical problems for which you are currently being treated:

_____ _____

Name of Primary Care Doctor:_____

Name of your last Psychiatrist_____

Medication Allergies:_____

List ALL medications you are taking with the dosage and how often:

_____ _____

_____ _____

_____ _____

_____ _____

Females only, Date of last Menstrual Cycle:_____

Females only, Are you pregnant YES/NO

Medications that have not worked in the past for

you:_____

_____

_____

Advanced Psychiatric Care PC 6700 Winkler Road, Unit 4, Fort Myers, FL 33919
(239)935-5599 Phone (239)313-5614 Fax Advancedpsychcare9400@gmail.xom

# Rapid Mood Screener (RMS)

Are you among the millions of people who have depressive symptoms? Answer the following questionnaire about your medical history and provide it to your doctor or nurse to assist in an important conversation about your mood.

Please select one response for each question. You can complete the RMS in less than 2 minutes.

Patient Name _____ Date _____

| | YES | NO |
|---|---|---|
| 1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed? | ☐ | ☐ |
| 2. Did you have problems with depression before the age of 18? | ☐ | ☐ |
| 3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper? | ☐ | ☐ |
| 4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head? | ☐ | ☐ |
| 5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic? | ☐ | ☐ |
| 6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual? | ☐ | ☐ |

RMS Copyright © 2020 AbbVie. All rights reserved.
AbbVie Medical

**Financial Agreement & Office Policies**

**Scheduling:**
Our office requires a $140 deposit when scheduling an appointment after a No call No show APPOINTMENT. This money is applied towards your balance. It is fully refundable if there is no outstanding balance on the account. Our office will make every effort to schedule your appointment as promptly as our schedule allows. We maintain a cancellation list and will contact you should there be an earlier opportunity to see you.We do send Text Message appointment reminders and also Email reminders

**Missed Appointments:**
There is a charge of $140 for missed appointments, when you fail to give 24-hour notice. We ask that you kindly give advance notice to avoid being charged. For therapy missed appointments you will be charged the fee for the session missed. Insurance companies DO NOT pay for appointments missed without notice.

**Completion of Form, Denial Letters, Review of Records, etc:**
Our providers are busy seeing patients during clinical hours. Should you need or require completion of forms, medication override authorizations, Social Security Disability, or any other clerical matter, our office will charge you accordingly, as this will require additional work on the part of the entire office staff. This service is not covered by insurance. It is an out-of-pocket expense to you. $35.00 for the first 3 pages. $50.00 for more than 3 pages

**Payment Methods:**
Our office accepts Visa, MasterCard, Debit, Discover, Money Orders, Checks and Cash. No insurance is accepted in our office.

**Non-Sufficient Funds:**
There is a charge for dishonored checks ranging from $25 to $50, depending on the amount of the check. This amount will be added to the existing balance and it will accrue interest as per Florida Statute on maximum allowed interest collection of a debt.

**Collections and Balances $280.00 and above:**
**Refills will NOT be sent on balances $280.00 and above. And no further appointments will be scheduled until Payment in full.**
Any account that has aged more than 60-days will become the financial responsibility of the patient. It is our policy to try and resolve outstanding balances by providing information that will hopefully help settle the debt. Our contract is with you, the patient. We also reserve the right to forward outstanding balances to collections in the event that there is no resolution within a reasonable period of time.

**Confidentiality of Information:**

It is our policy and Federal Regulation (HIPAA) not to release medical information of any kind without your express written consent. Please be advised that when authorizing us to release your medical record to a third-party, we have no control over future outcomes. Our office will provide you with a copy of HIPAA, at your request. We also provide an electronic copy as a download, on our website, for your convenience.

**Electronic Communication:**
In an effort to protect your privacy, we do not communicate directly with patients via Twitter, chat, FaceBook, or by any medium other than in person or by telephone or Doxy.Me or Telemedicine.

**Emergencies:**
If you believe that you are experiencing an emergency situation, do not delay in trying to contact our office. During weekends, after hours or Holidays we do not have a doctor on call, call 911 with any emergency. We are NOT prepared to deal with medical emergencies. Please immediately call 9-1-1, or go to the nearest emergency room for assistance.

**Medication Refills:**
We will not refill prescriptions on Friday, weekends, or holidays. Please make sure that you have an ample supply before your next appointment. By signing this page, I acknowledge my financial responsibilities and voluntarily adhere to the policies of the practice. Medications will be called in at the **END of the day within 48 hours.**

**Drug Test:**
**Our providers or any staff member may request a drug test at any time. Anyone prescribed a controlled substance is required to take a drug screen; and may be requested to also perform a pill count at random.**
Our urine drug screen cost is **$25.00**. Our suboxone patients will be drug tested every 30 days. Any patient who is under the influence of narcotics or alcohol, will also be requested to perform a drug test.
**If you have insurance we will be requiring you to have the drug test performed at a laboratory. Our suboxone patient will be provided a laboratory script. The drug results must be into the office prior to your appointment, or the appointment will be rescheduled, without medications.**

_____ _____

Print Name & Signature of Responsible Party Date

Advanced Psychiatric Care PC 6700 Winkler Road, Unit 4, Fort Myers, Fl 33919

(239)935-5599 Phone (239)313-5614 Fax Advancedpsychcare9400@gmail.com