TPCA Tallahassee Primary Care Associates

Our primary care is you.

Behavioral Health Department

1803 Miccosukee Commons Dr.
Tallahassee, FL 32308
Ph: 850-402-6202 Fax: 850-219-1045

Patient Registration Form

Patient Information

Name/First	Middle			Last
Address	City		State	Zip
Home Phone ( )	Work Phone ( )			Cell Phone ( )
SSN	Date of Birth	Age	Gender M F	Spouse's Name

Financially Responsible Party (IF OTHER THAN PATIENT)

Name/First	Middle			Last
Address	City		State	Zip
Home Phone ( )	Work Phone ( )			Cell Phone ( )
SSN	Date of Birth	Age	Gender M F	Spouse's Name

Emergency Contact

Name/First		Relationship
Home Phone ( )	Work Phone ( )	Cell Phone ( )

Insurance Information

Primary Insurance Company			Insurance Phone #
Claims Address	City	State	Zip
Primary Cardholder's Name	ID #	SSN	Group#
Insured's Employer	Home Phone ( )	Work Phone ( )	Date of Birth

Secondary Insurance Company			Insurance Phone #
Claims Address	City	State	Zip
Primary Cardholder's Name	ID #	SSN	Group#
Insured's Employer	Home Phone ( )	Work Phone ( )	Date of Birth

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Name_____ **Date of Birth** _____

Date_____ **Primary Care Physician** _____

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

1._____
2._____
3._____

What are your treatment goals?_____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood	( ) Racing thoughts	( ) Excessive worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety attacks
( ) Sleep pattern disturbance	( ) Increase risky behavior	( ) Avoidance
( ) Loss of interest	( ) Increased libido	( ) Hallucinations
( ) Concentration/forgetfulness	( ) Decrease libido	( ) Suspiciousness
( ) Change in appetite	( ) Decrease need for sleep	( ) Excessive energy
( ) Excessive guilt	( ) Increased irritability	( ) Crying spells
( ) Fatigue	( ) Other_____	( ) Other_____

Suicide Risk Assessment:

Have you ever had feeling or thought that you didn't want to live? **( ) Yes ( ) No**

If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? **( ) Yes ( ) No**

How often do you have these thoughts?_____

When was the last time you has thoughts of dying?_____

Has anything happened recently to make you feel this way?_____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?_____

Would anything make it better?_____

Have you ever thought about how you would kill yourself? Is the method you would use readily available?_____

_____

Have you planned a time for this?_____

Is there anything that would stop you from killing yourself?_____

Do you feel hopeless and/or worthless?_____

Have you ever tried to kill or harm yourself before?_____

Do you have access to guns? If yes, please explain. _____

_____

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Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No

If yes, Please describe when, by whom, and the nature of your treatment_____

_____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No

If yes, describe for what reason you were hospitalized, Date, and Where: _____

_____

_____

_____

Past & Current Psychiatric Medications:

Please indicate dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember). Dates, Dosage, Response/Side-Effects: _____

_____

_____

_____

_____

_____

Family Psychiatric History: (Has anyone in your family been diagnosed with or treated for)

		Which Family Member?
Bipolar disorder	( ) Yes ( ) No	_____
Depression	( ) Yes ( ) No	_____
Anxiety	( ) Yes ( ) No	_____
Anger	( ) Yes ( ) No	_____
Suicide	( ) Yes ( ) No	_____
Schizophrenia	( ) Yes ( ) No	_____
Post-traumatic stress	( ) Yes ( ) No	_____
Alcohol abuse	( ) Yes ( ) No	_____
Other substance abuse	( ) Yes ( ) No	_____
Violence	( ) Yes ( ) No	_____

Has any family member been treated with a psychiatric medication? **( ) Yes ( ) No**

If yes, who was treated, what medications did they take, and how effective was the treatment._____

_____

_____

_____

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Substance Use:

Have you ever been treated for alcohol or drug use or abuse? **( ) Yes ( ) No**
If yes, for which substance? _____
If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol?_____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?

_____

Have you ever felt you ought to cut down on your drinking or drug use? **( ) Yes ( ) No**
Have people annoyed you by criticizing you're drinking or drug use? **( ) Yes ( ) No**
Have you ever felt bad or guilty about your drinking or drug use? **( ) Yes ( ) No**
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?**( ) Yes ( ) No**
Do you think you may have a problem with alcohol or drug us? **( ) Yes ( ) No**
Have you used any street drugs in the past 3 months? **( ) Yes ( ) No**
If yes, which ones? _____
Have you ever abused prescription medication? **( ) Yes ( ) No**
If yes, which ones and for how long?_____

_____

Check if you have ever tried the following: If yes, how long and when did you last use?

Methamphetamine	( ) Yes ( ) No	_____
Cocaine	( ) Yes ( ) No	_____
Stimulants (pills)	( ) Yes ( ) No	_____
Heroin	( ) Yes ( ) No	_____
LSD or Hallucinogens	( ) Yes ( ) No	_____
Marijuana	( ) Yes ( ) No	_____
Pain killers(not as prescribed)	( ) Yes ( ) No	_____
Methadone	( ) Yes ( ) No	_____
Tranquilizer/sleeping pills	( ) Yes ( ) No	_____
Alcohol	( ) Yes ( ) No	_____
Ecstasy	( ) Yes ( ) No	_____

Other: _____

You're Exercise Level:

Do you exercise regularly? **( ) Yes ( ) No**
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

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

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Tobacco History:
Have you ever smoked cigarettes? **( ) Yes ( ) No**
Currently? **( ) Yes ( ) No,** How many packs per day on average?_____How many years? _____
In the past? **( ) Yes ( ) No,** How many years did you smoke?_____When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently **( ) Yes ( ) No** In the past? **( ) Yes ( ) No**
What kind?_____How often per day on average?_____How many years? _____

Family Background and Childhood History:
Were you adopted? **( ) Yes ( ) No,** Where did you grow up?_____
List your siblings and their ages:_____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did you parents' divorce? **( ) Yes ( ) No,** If so, how old were you when they divorced? _____
If your parents divorced, who did you live with? _____
Describe your father and your relationship with him:_____
_____
_____
Describe your mother and your relationship with her:_____
_____
_____
How old were you when you left home? _____
Has anyone in you immediate family died?_____
Who and when?_____

Trauma History:
Do you have a history of being abuse emotionally, sexually, physically or by neglect? **( ) Yes ( ) No**
Please describe when, where, and by whom:_____
_____
_____

Educational History:
Highest Grade Completed?_____Where? _____
Did you attend college? **( ) Yes ( ) No**, Where?_____Major?_____
What is your highest educational level or degree attained?_____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disable ( ) Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____

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Relationship History and Current Family:

Are you currently: ( ) Married ( ) Divorced ( ) Single ( ) Widowed, How long? _____

If not married, are you currently in a relationship? **( ) Yes ( ) No,** If yes, how long? _____

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

_____

Have you had any prior marriages? **( ) Yes ( ) No,** If so, how many?_____How long?_____

Do you have children? **( ) Yes ( ) No,** If yes, list age and gender:_____

_____

Describe your relationship with your children:_____

_____

_____

_____

List everyone who currently lives with you:_____

_____

_____

Spiritual Life:

Do you belong to a particular religion or spiritual group? **( ) Yes ( ) No**

If yes, what is the level of your involvement?_____

Do you find your involvement helpful during this illness, or does the involvement make this more difficult or stressful for you?

( ) More helpful ( ) Stressful

Is there anything else that you would like us to know?_____

_____

_____

_____

_____

Signature_____Date_____

Guardian Signature (if under age 18)_____

Emergency Contact/s:_____

Telephone #_____

For Office Use Only:

Reviewed by_____Date_____

Reviewed by_____Date_____

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Patient's Communication Instructions, Patient's Release and Acknowledgement

Patient Name (Print)_____**Date of Birth** _____

Patient Address _____

TELL US WHAT YOU WOULD LIKE TO AUTHORIZE OR LIMIT WITH THIS FORM (check all that apply):

____**I would like to UPDATE or CHANGE my telephone and/or email contact information**

____**I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communication and disclosures concerning my healthcare**

____**I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/or received communication and disclosures concerning my healthcare**

Which of the following communication means are appropriate/acceptable for our office to communicate with you?
(Please check all that apply)

____Home phone number - leave text/voice message with particulars NUMBER:_____

____Work phone number – leave text/voice message with particulars NUMBER:_____

____Cell number – leave text/voice message with particulars NUMBER:_____

____**Email**_____(Please do not assume that email will be used by your physician for communication. Please talk to your physician about the use of email as a means of communication.

____Other (EXPLAIN AND PROVIDE DETAILS) _____

____Other (EXPLAIN AND PROVIDE DETAILS) _____

Who are you authorizing our office to discuss your health situation with? (Please list all names)

____Discuss with no one

____Spouse: circle AUTHORIZED or UNAUTHORIZED Name: _____

____Child: circle AUTHORIZED or UNAUTHORIZED Name: _____

____Sibling: circle AUTHORIZED or UNAUTHORIZED Name: _____

____Other: circle AUTHORIZED or UNAUTHORIZED Name: _____

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name_____

Relationship_____

Phone: _____

This authorization will expire on:_____(If no date is specified, it will expire upon your written amendment and instructions through your execution of a change to the information contained on this form via a completion of a new/replacement form).

By signing below, I acknowledge that I have received and reviewed a copy of Tallahassee Primary Care Associates' Notice of Privacy Policies.

Signature of Patient or Legal Guardian _____

Date_____

If not the patient, explain relationship and legal authority: _____

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PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, ANDTREATMENT AUTHORIZATION

FINAL Form Patient Consent and Acknowledgement 03-31-03 revised 01-05-10 and 09-24-13 Page 1 of 2
I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Tallahassee Primary Care Associates, P.A. ("TPCA") is limited in its ability to release such information, known as Protected Health Information, without my authorization.

I understand I have the right to review the Notice of Privacy Practices of Tallahassee Primary Care Associates prior to signing this document, and I acknowledge that the TPCA Notice of Privacy Practices, which includes a listing of my rights as a patient, has been provided to me. I understand that the Notice of Privacy Practices for Tallahassee Primary Care Associates is also available on the website for TPCA at www.TallahasseePrimaryCare.com. I understand that my physician is a part of TPCA, and that this notice applies to the protected health information that my physician, as a part of TPCA, collects, receives, or creates for my past, present or future physical or mental health.

I hereby consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health-care bills, including my insurance carrier or health maintenance organization, to conduct healthcare operations of TPCA, and/or any other permitted disclosure, as outlined in the Notice of Privacy Practices.

I also understand that TPCA participates with and provides electronic medical records to certain health information exchanges. Information regarding health information exchanges, including as an example www.TallahasseeBigBendHealth.com, is included on page 2 of this document. The information exchanged in these activities may include my protected heath information. I hereby authorize such transmissions. I understand that I may opt out of this transmission at any time by sending a written request specifically stating my desire to opt out of HIE activities directly to our Privacy Officer through email at Compliance@TallahasseePrimaryCare.com or by mailing a written request to Privacy Office at 1803 Miccosukee Commons Drive, Suite 101, Tallahassee, FL 32308.

TPCA reserves the right to revise, make new provisions and or change the terms of these notices at any time. New notices will be effective for all protected health information that we maintain at that time. Such revised notice will be made available to you by posting a copy of the revised notice on our website at www.TallahasseePrimaryCare.com.

I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act by any third-party payors is correct. I assign payment to TPCA of all benefits due me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles; coinsurance or any other charges incurred which are not paid by my insurers or other third-party payers together with all costs of collection, if necessary, including collection fees charged by a third-party collection agency and reasonable attorney's fees if collected by or
through an attorney-at-law.

A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.
The undersigned certifies that he/she has read the foregoing and is the patient or the parent or guardian of the patient and is duly authorized as patient's agent to execute the above and accept its terms, including the provision of treatment authorization.

Patient name:
Print: _____
Sign: _____
Date: _____ Patient Date of Birth: _____

Parent or legal guardian name:
Print: _____
Sign: _____
Date: _____
Explain Your Relationship to Patient: _____
Description of Personal Representative's Authority: _____

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IMPORTANT INFORMATION RELATED TO HEALTH INFORMATION EXCHANGE

Recent important legislation in the American Recovery and Reinvestment Act of 2009, enacted by Congress, includes important provisions which impact health care providers and patients alike. Among the provisions of this Act is the concept of Health Information Exchange ("HIE").

Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

Tallahassee Primary Care Associates, P.A. participates in and provides patient information to HIE's in certain circumstances inorder to facilitate the coordinated continuum and exchange of healthcare information between facilities and providers.

For the purpose of informing you, our patient, concerning HIE in general, and our participation in and commitment to HIE, we have included a brief explanation and an example of a local resource of HIE in Tallahassee through www.BigBendHealth.com, the Big Bend Regional Healthcare Information Organization ("BBRHIO") and Business Associates of the BBRHIO.

BBRHIO is a Florida nonprofit, public benefit corporation organized and federally recognized 501(c)(3) of the Internal Revenue Code. Unless you specifically opt out as provided below your personal health information will be provided to BBRHIO. Tallahassee Primary Care Associates and our physicians support this health information exchange as an important part of healthcare technology that facilitates communication and community coordination of your patient care.

A Regional Healthcare Information Organization ("RHIO") is a group of organizations and stakeholders that exchanges data electronically to improve the quality, safety, and efficiency of healthcare delivery. RHIOs are ordinarily geographically defined entities that arrange for the means to exchange information electronically. They also develop and maintain HIE standards. To successfully exchange information, RHIOs must build their data exchange on sound principles and processes.

BBRHIO is locally owned and managed, and consists of numerous well-established and respected local health care organizations and stakeholders. The Board of the BBRHIO is comprised of local health care providers, and is solely under the control of the local Board. www.BigBendHealth.com, which is the website of the BBRHIO, is a first-of-its-kind health resource that creates economic benefits, a connected workforce, improved medical care and a breakthrough in records management. The purpose of www.BigBendHealth.com is to be the essential communication resource and HIE for health care in the Capital region. Additionally, www.BigBendHealth.com is the largest active Health Information Exchange ("HIE") in Florida, containing millions of patient records processing numerous health care messages between providers in the community.

STATEMENT OF PURPOSE: BBRHIO seeks to reduce the cost and improve the quality and efficiency of health care provided by the Participants through the electronic management and exchange of health information acquired or generated by them in providing, paying for, and reporting on patient care items and services. The Participants anticipate that the electronic management and exchange of such information will simultaneously help eliminate unnecessary repeat testing, increase the accuracy of medical diagnoses, improve medical treatment, and improve outcomes for patients. BBRHIO and TPCA contract through Business Associate agreements with vendors who operate a Regional Health Information Network ("RHIN") to facilitate the electronic transmission, storage, and sharing of health information among participating providers of health care services, third-party payers for health care services, and other interested parties in their respective regions in a manner that complies with all applicable laws and regulations, including without limitation those protecting the privacy and security of health information. The intent for each of the organizations who participate in HIE with RHIN's and other HIE mechanisms, like TPCA, is to share information to improve efficiency, enhance communication, secure data, facilitate claims and provide valuable medical treatment information broadly to assist in your health care. These efforts, which are encouraged through specific efforts of the government entities, are intended to provide a collaborative framework through which the parties can securely share information more efficiently and effectively for your benefit.

Example information on this effort and participation, as well as general information related to the Tallahassee health care community, can be found at www.BigBendHealth.com. Example information on vendors/business associates of HIE for the Tallahassee health care community can be found at www.HIENetworks.com. Example information on HIE generally and the national efforts in that regard can be found at www.healthit.gov.

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Patient Authorization for Release of Protected Health Information and Medical Records

Patient's Name_____ **Date of Birth**_____
(Last, First, Middle/Maiden)
Address:_____ **City, State, Zip**_____
Phone #_____

I authorize my physician and/or administrative and clinical staff at Tallahassee Primary Care Associates or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Person or Entity to Receive Information:	**Person or Entity to Disclose Information:**
Name/Organization:_____	**Name/Organization:** TPCA-Behavioral Health Counseling Dept.
Address:_____	**Address:** 1803 Miccosukee Commons Dr.
City, State, Zip:_____	**City, State, Zip:** Tallahassee, FL 32308
Phone:_____ **Fax:**_____	**Phone:** 850-402-6202 **Fax:** 850-219-1045

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):
( ) Complete Medical Record ( ) Billing Records ( ) Office Notes ( ) Other:_____
DATES OF SERVICE:_____
PURPOSE: ( ) Changing Physicians ( ) Personal Copy to Patient ( ) Attorney ( ) Insurance
( ) Other:_____

This authorization will expire on:_____(If no date is specified, it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:
___**I DO I DO NOT** authorize the release of information pertaining to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, and all medical records and clinical information relating thereto.
Initials of individual giving authorization: _____
___**I DO I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for mental health or psychiatric conditions.
Initials of individual giving authorization: _____
___**I DO**___**I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for drug or alcohol abuse, drug-related and/or alcohol-related treatment.
Initials of individual giving authorization._____
I have read and understand the nature of this authorization and I have been provided a copy of TPCA's Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at Tallahassee Primary Care Associates, P.A., Administrative Offices 1803 Miccosukee Commons Drive, Tallahassee, Florida 32308, and Attn: Compliance Officer or email Compliance@TallahasseePrimaryCare.com. I understand that a revocation is not effective to the extent that my physician or Tallahassee Primary Care Associates has taken action in reliance upon this authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I also understand that such revocation does not affect TPCA's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

Signature or Patient's Representative:_____ **Date:**_____

Relationship to Patient:_____ **Witness:**_____

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Consent for Services of a Minor Child

In almost all cases, Tallahassee Primary Care Associates (TPCA) requires written consent from a parent(s) or legal guardian(s) in order to provide healthcare services in the Diagnostic Imaging Center, Lab, Clinical Services Departments, Behavioral Health Department, and/or primary physician's offices for a minor child under the age of 18.

All parent(s) or guardian(s) are encouraged to attend all medical appointments at Tallahassee Primary Care Associates, but we understand that isn't always possible. To avoid having to reschedule appointments when a parent(s) or guardian(s) is unable to attend, this consent form authorizing TPCA and its medical professional to provide medical care must be signed by the appropriate person.

If a minor child presents to our facility unaccompanied or in the company of an adult other than a parent or legal guardian, a TPCA professional(s) will not provide care or services.

I, (We) _____ and _____do hereby state that I am (we are) the parents or legal guardians of (child's name) _____ of minor age born on _____ .

We authorize and consent to the professional services provided at or arranged by TPCA or it's Behavioral Health Department(s) for (Childs's name) _____, including exam/services, and any additional treatment necessary in the professional's judgment to protect the health and safety of the minor.

Signature _____
(Parent or guardian)

Date _____

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Late Cancellations, Missed Appointments & Documentation Policy

Mental health care requires the collaborative effort of both you and your provider. When the patient does not keep his/her scheduled appointments, does not cancel within the required 48 hour (2 business days) notice, or has a late arrival of 15 minutes or more, it will be considered a NO SHOW. Not only do you miss an opportunity for treatment but you also deny someone else this opportunity.

Whenever possible a courtesy call will be made to remind our patients of their scheduled appointment; however, it is the responsibility of the patient to contact their care provider of any cancellations. Late cancellations, late arrivals or missed appointments will be charged a $50.00 fee (payment is expected on or before your next scheduled appointment).

***FMLA or any other documents requested by this office will be charged a fee of $ 20.00 for the first page and $ 10.00 per page thereafter. If a historic narrative of records is requested, there is a $ 50.00 fee.**

I HAVE READ THE ABOVE AND AGREE WITH THIS POLICY.

Signature of patient or legal guardian _____

Date of birth _____

Date_____

Revised 5.15.17