Neuropsychiatric Institute
(813) 636-8811

PATIENT INFORMATION

4107 W Spruce St Ste 100
Tampa, FL 33602

Date:_____ Account Number:_____

Last Name:_____ Phone #1:_____ ☐Home ☐Work ☐Cell

First:_____ MI:_____ Phone #2:_____ ☐Home ☐Work ☐Cell

Address:_____ Email:_____

_____ Date of Birth:_____ SS#:_____

City:_____ Marital Status: (S)ingle (M)arried (O)ther:_____

ST:_____Zip:_____Sex:_____ *Emergency Contact:*_____

Employer/School:_____ *Emergency Phone:*_____

☐Full Time Student ☐Part Time Student

If patient is a minor or someone other than the patient is responsible for payment, please complete the following section:

*Name:*_____ *Relation to Patient:*_____

*Address:*_____ *DOB:*_____ *SS#:*_____

*City:*_____ *Employer:*_____

*ST:*_____ *Zip:*_____ *Sex:*_____ *Phone:*_____ *Ext:*_____

Insurance #1:

_____

ID#/CLM#:_____

GRP/PLCY/Emloyer:_____

Insured Name:_____

Insured DOB:____/____/_____; How related?_____

Insurance #2:

_____

ID#/CLM#:_____

GRP/PLCY/Employer:_____

Insured name:_____

Insured DOB:_____ How related?_____

RELEASE OF RECORDS:
I authorize the release of general medical, as well as psychological/psychiatric, substance abuse, or other information pertinent to my treatment, to any insurance company, adjuster, case manager, attorney, or any other party as may be necessary to process health insurance claims, receive authorization for services or medications (including representing patient in requesting Appeal for coverage of services or medications), or to facilitate collection of any balance due for services rendered. I understand that this authorization releases Neuropsychiatric Institute LLC from all legal liability that may arise from the release of the information.

ASSIGNMENT OF BENEFITS/PROCEEDS;FINANCIAL RESPONSIBILITY:
I hereby authorize and direct any Payor on my behalf (including health insurance, disability insurance, worker's compensation, liability insurance, Medicare, Medicaid, a government entity, or attorney) to pay any medical and/or government benefits, or from the proceeds of any settlement, judgment or verdict, due to me directly to Neuropsychiatric Institute, LLC (Provider) for services rendered, both by reason of illness or injury, and by reason of any other bills that are due Provider. This is to act as an assignment of my rights and benefits to the full extent allowable under the law and/or to the extent I am obligated to pay Provider for services rendered. I understand that I am and remain personally responsible for deductibles, co-payments, and any professional services not covered and/or not paid by Payor(s). If it becomes necessary to turn my account over for collection, I will be responsible for collection and/or attorney fees. I also understand that Provider may perform a 'Trace" or search to verify my name, social security number and/or mailing address.

- *A fee will be assessed on returned checks ($40 fee or the amount charged by Provider's bank, whichever is higher).*
- *A fee may be charged for appointment not kept, or cancelled, without notification at least 24 hours prior to scheduled appointment.*

A photocopy or digital copy of this document shall be considered as valid and enforceable as the original.

Signature: _____ Witness(Office):_____

Insured/Responsible Party

The doctors and staff at Neuropsychiatric Institute would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

FINANCIAL POLICY

- *It is your responsibility to inform our office of any address or telephone number changes.*
- *Your account is to be kept current - accordingly, all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable by cash, check, or Debit/Credit card.*
- *A returned check will result in all future payments being required in the form of cash or debit/credit card.*
- *If you do not have your payment(s), additional appointments may not be scheduled until balance is paid.*
- *You may be asked to schedule another appointment for issues other than the reason for your original appointment.*
- *There is a charge for the completion of forms or letters (ex: disability, FMLA, etc.). Charge is set by provider based on complexity and volume of paperwork to be completed.*
- *A fee of $50 may be charged for appointment not kept without notification at least 24 hours prior to scheduled appointment.*
- *Medication Refill fee: We reserve the right to charge an administrative fee for prescriptions requested outside of a visit. Patient must make follow up appointments within the time requested by provider following each visit. Failure to timely schedule appointments will result in a refill fee, per prescription written/sent.*
- *You will only be sent a statement if your balance exceeds $5 and you will only receive a refund if the credit amount is over $10. Refunds will be issued within 4-6 weeks from the date requested, and only if there are no pending insurance claims.*
- *If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.*

IF YOU HAVE HEALTH INSURANCE COVERAGE:

We will submit your claims, however we must emphasize that **as medical providers, our relationship is with you, not your insurance company**. Although we verify your benefits with your insurance company, we can only provide an estimate of your coverage based on the information given to us at the time of the inquiry.

- It is your responsibility to be aware of the service(s) being rendered, and whether your insurance policy covers those services.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy and agree to meet all financial obligations.
(A photocopy or digital copy of this document shall be as valid and enforceable as the original.)

_____	_____	_____
Responsible Party Signature	*Patient Name (Please Print).*	*Date signed*

4107 West Spruce Street, Suite 100, Tampa, FL 33602 - (813) 636-8811 - Fax (813) 636-8855

NPI Neuropsychiatric Institute

Print Patient Name _____ Patient DOB _____ Acct#_____

PATIENT CONSENT FORM

ePrescribe Program

The Providers at Neuropsychiatric Institute (NPI) use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (DrFirst) which improves the timely and accurate transmission of your medication information. The ePrescribe Program also includes:

- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

To optimize the use of this electronic capability, and coordinate your care between us and other health care providers involved in your care, we require that patients allow us to access their medication history through DrFirst. The medication history information may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information*.**

Consent

By signing this consent form you are agreeing that your provider at NPI may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

_____Signature of Patient or Guardian _____Today's Date

Informed Consent/Advanced Directives

(to be completed while with clinician)

- I have been notified of the availability of information on Advanced Directives
  - Do you wish to name a surrogate decision maker? ☐ No ☐ Yes
- I understand that as part of my Evaluation, my health care provider has established a treatment plan that I am to follow in order to obtain a satisfactory outcome and progress.
- I understand that if I do not follow the treatment plan outlined by the clinician, my treatment at Neuropsychiatric Institute may be discontinued for non-compliance.
- I further understand that I have the right to refuse treatment. If I refuse treatment, I release Neuropsychiatric Institute and any affiliated health care provider(s) connected to my care from any and all liability, claims, suit, cause of action, which may arise or could arise out of the aforesaid parties respecting and following my express will and direction.

Signature of Patient or Guardian:_____ Date:_____

NPI Established 1970
The Neuropsychiatric Institute
4107 W Spruce St Ste 100, Tampa, FL 33607 Phone (813) 636-8811 Fax (813) 636-8855

CONSENT FOR TELEHEALTH SERVICES

By using Telehealth for my appointment, I certify:

- That I have read, or had this form read, and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of telemedicine
- That I agree to terms and conditions as described herein.

I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services via telehealth over secure video conferencing platform.

I understand that the laws that protect privacy and the confidentiality of my medical information also apply to telehealth or teletherapy.

I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation. If other people are in the room, my provider shall be made aware and must agree to their presence.

I understand that there are potential risks involving technology, including but not limited to: Internet interruptions and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected. The Neuropsychiatric Institute will make all reasonable efforts to safeguard the transmission from potential computer virus or other involuntary intrusions and it is my responsibility to do the same. I will not hold the Neuropsychiatric Institute liable for any such intrusions.

I understand that while telehealth or teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.

I understand that my health care provider or I can discontinue the telehealth/teletherapy services if it is felt that this type of service delivery does not benefit my needs.

I understand that at no time will any audio-video recording of the Telehealth session be permitted without the expressed written consent in advance by both parties involved.

I have read and understand the information provided above regarding telehealth/teletherapy. I consent to the use of telehealth/teletherapy in my care.

PATIENT NAME:_____DOB:_____

_____ _____
Signature of Patient or Guardian Date Signed

PCP RECORDS RELEASE FORM

Patient Name: _____ DOB: _____

This will authorize NEUROPSYCHIATRIC INSTITUTE to release general medical, as well as psychiatric/psychological information from my health record in accordance with Florida Statutes 394.459, 480.32, and/or 90.503 the Primary Care Provider listed below.

- -

PCP Name&Phone:

- -

The above named Primary Care Provider is authorized to release general medical, as well as psychiatric/psychological information from my health record in accordance with Florida Statutes 394.459, 480.32, and/or 90.503 to Neuropsychiatric Institute. PCP, please send any relevant records or labs to:

NEUROPSYCHIATRIC INSTITUTE
4107 W. SPRUCE STREET
SUITE 100
TAMPA, FL 33607
Phone: (813) 282-0941
Fax: (813) 636-8855

I understand that I have the right to refuse this authorization and that the facility named above is released from all legal liability that may arise from the release of this information.

_____ _____

DATE AUTHORIZED SIGNATURE

_____

Print Name and Relation to patient (If signed by someone other than patient)