NPI

PATIENT INFORMATION
(Adult Intake)

Date: _____

Appointment Date: _____ Referred by: _____

Last Name: _____

First Name: _____

Middle Name: _____ Generation: _____

Birth Name: (last, First, MI) _____

Cell#: _____ Home#: _____ Work#:Ext: _____

Email Address1: _____ Email Address2: _____

Address1: _____

Address2: _____ APT or Unit# _____

City: _____ ST: _____ Zip: _____

SS#: _____ Sex: _____

Date of Birth: _____ Preferred Language: _____

Race: _____ Ethnicity: _____

*Confidential communication method: (Required)

- ☐ Home phone, you can leave a message
- ☐ Work phone, you can leave a message
- ☐ Cell phone, text or verbal message
- ☐ Email
- ☐ US Postal Service
- ☐ Electronic Portal of the Patient

Patient Name: _____

NPI

Date: _____

GUARDIAN INFORMATION

Name: Last : _____

First _____

Dob _____

Relation to Patient: _____

Gender: _____

Guardian Phone Number: _____

EMERGENCY CONTACT DETAILS:

Emergency Contact: _____

Emergency Contact Phone: _____

Relationship: _____

GUARANTOR INFORMATION:

Is someone other than patient is responsible for payment? ☐Same as patient

Name: Last : _____ *First* _____

Relation to Patient: _____ *SS#:* _____

Billing Address: _____

Address Line 2: _____

City: _____ *State:* _____

Phone # Ext: _____ *Zip:* _____

DOB: _____ *Mobile number:* _____

Patient Name: _____

NPI

Date: _____

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
ID# :		
Group#		
Group policy-Employer Name:		
Primary Insured Name:		
Insured Date of Birth:		
Patient's relationship to Insured:		

CARE TEAM

Primary Care Physician Name: _____

Primary Care Physician Address: _____

Primary Care Physician Phone: _____

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Street or Intersection: _____

REASON FOR TODAY'S VISIT

What is the reason for today's appointment? _____

_____

_____

NPI

PRESENTING PROBLEMS: ADULT

Name:_____ Date_____

Appointment date:_____ Date of Birth:_____

Do you currently (now) have any of the symptoms listed below: Check all that apply

		SEVERITY LEVEL	
☐	None		
☐	Agitation		
☐	Anger		
☐	Anxious Mood		
☐	Argumentative		
☐	Attention poor		
☐	Avoidance of people		
☐	Concentration		
☐	Crying spells		
☐	Delusions		
☐	Depressed mood		
☐	Distracted		
☐	Distrustful		
☐	Do not socialize		
☐	Do not want to or feel like socializing		
☐	Failing to follow through		
☐	Feeding problems		DESCRIBE
☐	Feeling worthless		
☐	Hallucinations		
☐	Helpless		
☐	Hopeless		
☐	Impulsive		
☐	INDICISIVENESS		
☐	Irritability		
☐	Loses temper easily		
☐	Loss of interest in all or most activities		
☐	Memory Past		
☐	Memory Recent		
☐	Muscle cramping (not due to physical problem)		
☐	Muscle tension (not due to physical problem)		
☐	Nervousness		
☐	Panic attacks		
☐	Phobias/fears		DESCRIBE
☐	Poor Organization skills		
☐	Relationship problems		
☐	Restlessness		
☐	Shortness of breath		
☐	Sleep - Cant sleep		
☐	Sleep - interrupted sleep		
☐	Social personal problems		
☐	Speech problems		
☐	Suspicious of others		
☐	Thinking problems		
☐	Tired or easily fatigued		
☐	Trouble getting along in public		
☐	Trouble with work functions		
☐	Upset easily		
☐	Worrying that you cannot control (excessive)		

Patient Name: _____

Date: _____

NPI

TRAUMA AND ABUSE

Has patient been exposed to trauma or a traumatic event

☐ No exposure to trauma ☐ Exposed to trauma

Describe: _____

Has patient ever been exposed to any type of abuse, please check all that apply:

☐ No exposure to abuse ☐ Exposed to sexual abuse

☐ Exposed to emotional abuse ☐ Exposed to physical abuse

Describe: _____

If you answered YES to Trauma or Abuse, Continue, otherwise, skip this section,

Please check any that apply only with reference to trauma or abuse.

CHECK ANY THAT APPLY

		SEVERITY LEVEL
	None	
	Avoidance related to the trauma	
	Avoids activities or places connected with event	
	Difficulty relaxing	
	Easily Startled	
	Efforts to avoid thoughts or feelings related to traumatic event	
	Feeling detached or estranged related to trauma	
	Flashbacks	
	Helpless	
	Horror	
	Hypervigilant or overconcerned	
	Pessimism	
	Physical reaction after exposure to traumatic event	
	Recurring Dreams of the traumatic event	
	Significant distress in life as a result of trauma	
	Sleep difficulty as a result of trauma	
	Unable to recall or remember important aspect of the traumatic event	
	Uncontrollable intrusive or distressing thoughts	

NPI

Patient name : _____

Date : _____

PERSONAL AND SOCIAL HISTORY: Adult:

Where was patient born? _____

Marital Status:

- ☐ single, never married
- ☐ Married 1 time
- ☐ Married 2 times
- ☐ Married 3 times
- ☐ Married 4 or more times
- ☐ Divorced 1 time
- ☐ Divorced 2 times
- ☐ Divorced 3 or more times
- ☐ Widowed
- ☐ Legally separated
- ☐ Annulled
- ☐ Domestic Partner

Name and Age of spouse or partner _____

Who does patient live with? Check all that apply

- ☐ alone
- ☐ mother
- ☐ father
- ☐ adoptive mother
- ☐ adoptive father
- ☐ sibling(s)
- ☐ maternal grandmother
- ☐ maternal grandfather
- ☐ paternal grandmother
- ☐ paternal grandfather
- ☐ foster parents
- ☐ Group home
- ☐ Homeless
- ☐ Spouse
- ☐ Children
- ☐ Other person or situation

If, Other person or situation _____

Is patient currently employed?

- ☐ Has a job
- ☐ Does not have a job

Employer Name: _____

Occupation: _____

Do you enjoy your work?

- ☐ Patient enjoys their work
- ☐ Patient does not enjoy their work

Education Level:

- ☐ Level than High School
- ☐ High School Diploma
- ☐ GED (General Educatin Degree)
- ☐ Technical school degree/title
- ☐ Some College
- ☐ College degree 4 or 5 year
- ☐ Doctorial Degree
- ☐ Master Degree

If Education Level is less than high school, Highest Grade Completed: Choose an item below

- ☐ Elementary 1-5
- ☐ Middle school 6-8
- ☐ 9th grade
- ☐ 10th grade
- ☐ 11th grade

NPI

Patient Name: _____

Date: _____

PHYSICAL AND RECREATIONAL ACTIVITY

Please check all that apply:

- ☐ No physical activity
- ☐ PE at school
- ☐ Goes to the Gym
- ☐ Rides a bicycle
- ☐ Likes to walk
- ☐ Involved in sports
- ☐ Swimming
- ☐ Fishing
- ☐ Crafts
- ☐ Video games
- ☐ Watching TV
- ☐ Other activity

If other, Please specify

MILITARY

Does either parent have Military history? ☐ Yes ☐ No

Adult Patient: Please check any that apply:

- ☐ Active military
- ☐ Retired military
- ☐ Administrative discharge
- ☐ Dishonorable discharge
- ☐ Medical discharge

Child Patient: Please check any that apply:

- ☐ Active duty parent in the U.S. military
- ☐ Parent retired or discharged from U.S. military service

LEGAL PROBLEMS OR ISSUES

- ☐ No history of legal problems, arrests or convictions
- ☐ Gangs
- ☐ DUI/DWI
- ☐ Arrested
- ☐ Convicted
- ☐ Detention
- ☐ Jail or Juvi
- ☐ Probation
- ☐ Current civi law suit
- ☐ Divorce
- ☐ Custody
- ☐ Other legal problem

If yes to any of the above, please explain: _____

_____

DISABILITY

Check any that apply:

- ☐ Not disabled by social security
- ☐ Disabled by social security

If disabled, how long/explain _____

NPI

Patient name : _____

Date: _____

RISK FACTORS

Has patient had any "recent" suicidal thoughts

- [ ] No recent suicidal thoughts
- [ ] There have been recent suicidal thoughts

If yes, When?

_____

If yes, Explain

_____

Has patient had any suicidal thoughts that lead to hospitalization:

- [ ] No suicidal thoughts leading to hospitalization
- [ ] Yes, suicidal thoughts leading to hospitalization

If yes, explain (list approx date, name of facilitie(s))_____

Has patient attempted suicide in the past?

- [ ] There has never been a suicide attempt
- [ ] There has been a suicide attempt in the past

How many times?

- [ ] 1 time
- [ ] 2 times
- [ ] 3 times
- [ ] 4 times or more

Date, facility, means _____

Has patient had any recent homicidal thoughts?

- [ ] No recent homicidal thoughts
- [ ] Recently there have been homicidal thoughts

If yes, explain _____

Patient Name: _____

Date: _____

NPI

Vitals

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

Weight One year ago: _____

5 years ago: _____

HABITS

***USE OF ALCOHOL** Social ☐ Excessive ☐ Dependent ☐ None ☐

Indicate how much and how often _____

***Tobacco Smoking?(check one)**

☐Never Smoker

☐Current Some Day Tobacco smoker

☐Current Every Day Tobacco smoker

☐Former Tobacco Smoker

Tobacco, how much and how often (example: 1 pack per day) _____

Indicate how long ago you quit smoking _____

***Other Smoking?** ☐Vape ☐Marijuana ☐None

***Current OR Past use of ILLEGAL DRUGS? ___ No ___ Yes If yes, explain**

TYPE	PAST	CURRENT	HOW OFTEN

NPI

Medical History Form

Patient Name: _____

Date: _____

Review of Systems

Has the patient ever had any of the following? **(If so, please place a checkmark and indicate when)**

DESCRIPTION	Now ✓
SKIN	
Dryness/ itching/ rash	
Suspicious moles or lumps	
Hair and Nail changes	
HEENT	
Head injury	
Vision Problems	
Blurred/double Vision	
Flashing lights or specks	
Glaucoma or Cataract	
Decreased hearing	
Ringing in ears (tinnitus)	
Ear ache/ drainage	
Nose Bleeds	
Sore Throat	
Loss of voice/hoarseness	
Non-healing sores in mouth	
Bleeding gums	
RESPIRATORY	
Chronic shortness of breath	
Painful breathing	
Chronic cough	
Coughing up blood	
CARDIOVASCULAR	
Chest pain	
Palpitations	
Fainting spells	
Swollen ankles (edema)	
GASTROINTESTINAL	
Trouble swallowing	
Persistent nausea/vomiting	
Diarrhea	
Constipation	
Heartburn/ Indigestion	
Change in appetite	
Change in appearance of stool	
Vomiting blood	
Rectal bleeding	
Regular use of laxatives	
Jaundice	
Gall Bladder problems	

DESCRIPTION	Now ✓
URINARY	
Frequent or urgent urination	
Pain or burning on urination	
Incontinence	
Blood in urine	
GENITAL	
Pain during sex	
Sexual Dysfunction	
Penile/vaginal discharge	
Method of contraception	
Woman: Date of last menses	
MUSCULOSKELETAL	
Muscles or Joints Pain	
Muscle weakness	
Muscle stiffness or cramping	
Arthritis	
Chronic pain: Location	
NEUROLOGIC	
Dizziness and/or Fainting	
Seizures/convulsions	
Numbness and/or tingling	
Tremor/hand shaking	
Headaches	
ENDOCRINE	
Heat or Cold intolerance	
Excessive appetite	
Excessive thirst and urination	
Significant weight change	
Excessive sweating	
HEMATOLOGIC	
Easy bruising or bleeding	
Swollen glands	
INFECTIOUS DISEASE	
Hepatitis	
HIV OR AIDS	
STD: Specify	
Frequent infections	
PSYCHIATRIC ROS	
Anxiety	
Depression	
Mania	
Hallucinations	
Delusions	
Eating Disorder	

Pain Questionnaire:

Is patient in pain now? ___No ___ Yes ___ N/A

location?_____

If yes, please rate pain on scale of 1-10 (with 10 being most severe) _____

Is patient receiving care for pain? ___No ___ Yes ___ N/A

If yes, please indicate treating Facility or Doctor: _____

Patient Name: _____

Date: _____

NPI

MEDICAL HISTORY

Medication ALLERGIES? specify drug name and reaction:

Name	ReactionName	SeverityName

Additional Health History

_____

_____

_____

Please list ALL CURRENT medication.

Are you currently on any medication? ☐ **Yes** ☐ **No**

Please include any over-the-counter (non-prescription) and herbal medications taken regularly.

Name of Medication	Dose (amount)	How often Taken	Started Date	Prescriber

Patient Name: _____

date: _____

NPI

Past Psychiatric Medications

Medication Name	When taken	Doctor's Name

List all Previous psychiatric, counseling, and/or psychiatric hospitalizations:

Has the patient had previous Psychiatric treatment or counseling ☐ **Yes** ☐ **No**

Location/Facility/Provider	Reason for Treatment	Approximate Date

Past Medical History

_____

_____

_____

_____

_____

_____

Hospitalizations (Other than Psychiatric)

Has the patient had any previous Hospitalizations? ☐ Yes ☐ No

Location/Facility	Reason for Hospitalization	Approximate Date

NPI

Patient Name _____

Date: _____

Medical History Form

Surgeries

Additional Health History

FAMILY HISTORY

Please give the following information about the health of patient's immediate family:

Additional Health History

NPI

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.

Signature:_____ Patient Name: _____

Date:_____

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.

Signature: _____ Patient Name: _____

Date: _____

NPI

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

NPI

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: _____ Patient Name: _____

Date: _____

NPI

Informed Consent/Advanced Directives:

- I have been notified of the availability of information on Advanced Directives
- 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.

Do you wish to name a surrogate decision maker? ○ Yes ○ No

Signature: _____ Patient Name: _____

Date: _____

NPI

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, THE NEUROPSYCIATRIC INSTITUTE originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment
A means of communication among the many health professionals who contribute to my care
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third party payer can verify that services billed were actually provided
And a tool for routine hea1thcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

Please share informatoin with: _____

_____

I request the following restrictions to the use or disclosure of my health information

_____

_____

Signature: _____ Patient Name: _____

Date: _____

NPI Neuropsychiatric Institute

Account#_____

Patient Name:_____ Date of Birth:_____

Notice of Artificial Intelligence (AI) Use in Documentation

Neuropsychiatric Institute, LLC may use secure, HIPAA-compliant Artificial Intelligence (AI) tools to assist in generating clinical documentation and enhancing our records' accuracy and efficiency. Please be assured that AI is used as a supplementary tool, and all documentation is reviewed by your clinician to ensure accuracy and alignment with your care plan. Your privacy and confidentiality remain a top priority, and all AI-assisted documentation adheres to strict security protocols in compliance with federal and state regulations.

By signing below, you acknowledge understanding of our use of AI in documentation as outlined above. If you have any questions or concerns about this process, please feel free to discuss them with your provider.

_____ _____

Signature of Patient or Legal Representative Date

NPI

NEUROPSYCHIATRIC INSTITUTE:

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 to the Primary Care Provider listed.

The 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.

Primary Care Provider Name:_____

PCP Phone: _____

Signature: _____ Patient Name: _____

Date: _____