

NPI

PATIENT INFORMATION
(Child 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

NPI

Patient Name: _____

Date: _____

GUARDIAN INFORMATION

Name: Last : _____

First _____

Dob _____

Relation to Patient: _____

Gender: _____

Guardian Phone Number: _____

ADDITIONAL GUARDIAN INFORMATION

Name: Last : _____

First _____

Dob _____

Relation to Patient: _____

Gender: _____

Guardian Phone Number: _____

NPI

Patient Name: _____

Date: _____

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: _____

NPI

Patient Name: _____

Date: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

ID# : _____

Group# _____

Group policy-Employer Name: _____

Primary Insured Name: _____

Insured Date of Birth: _____

Patient's relationship to Insured: _____

SECONDARY INSURANCE

ID# : _____

Group# _____

Group policy-Employer Name: _____

Primary Insured Name: _____

Insured Date of Birth: _____

Patient's relationship to Insured: _____

Who complete this form? _____

Relationship to patient _____ Date form completed _____

NPI

Date: _____

MEDICAL HISTORY FORM

Patient Name: _____

DOB: _____

Appointment Date: _____

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? _____

Does patient have any of the behaviors listed below? Please check any that apply

- _____ None
- _____ Not able to develop healthy relationships
- _____ Not able to establish friendships
- _____ Aggression toward people and/or Animals
- _____ Argues with adults
- _____ Blurts out answers before done
- _____ Deceitfulness
- _____ Destruction of Property
- _____ Easily Distracted
- _____ Expressive language problems
- _____ Fails to follow through
- _____ Fidgets
- _____ Forgetful
- _____ Hostile and defiant
- _____ Hyperactivity
- _____ Impulsivity
- _____ Inattention
- _____ Interrupt or intrude
- _____ Leaves seat
- _____ Listening problems
- _____ Loses temper
- _____ Organizing problems
- _____ Poor math
- _____ Poor reading
- _____ Poor written expression
- _____ Problems with communication
- _____ Receptive problems
- _____ Refuses to comply
- _____ Reluctant to do academics
- _____ Runs around
- _____ Social Personal skills
- _____ Speech production poor
- _____ Spiteful/Vindictive
- _____ Talks excessively
- _____ Threatening behavior
- _____ Touchy
- _____ Trouble with Leisure games, quietly "on the go"
- _____ Violates all rules
- _____ Won't wait turn

GENERAL SYMPTOMS: CHILD

Name: _____ Date: _____

Appointment date: _____ Date of Birth: _____

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

		SEVERITY LEVEL	
<input type="checkbox"/>	None		
<input type="checkbox"/>	Agitation		
<input type="checkbox"/>	Anxious mood		
<input type="checkbox"/>	Avoidance of people		
<input type="checkbox"/>	Concentration		
<input type="checkbox"/>	Crying spells		
<input type="checkbox"/>	Delusions		
<input type="checkbox"/>	Depressed mood		
<input type="checkbox"/>	Distrustful		
<input type="checkbox"/>	Eating/Feeding problems		DESCRIBE <input type="text"/>
<input type="checkbox"/>	Feeling worthless		
<input type="checkbox"/>	Hallucinations		
<input type="checkbox"/>	Irritability		
<input type="checkbox"/>	Loss of interest In all or most activities		
<input type="checkbox"/>	Memory problems		
<input type="checkbox"/>	Panic Attacks		DESCRIBE <input type="text"/>
<input type="checkbox"/>	Phobias/Fears		DESCRIBE <input type="text"/>
<input type="checkbox"/>	Relationship problems		
<input type="checkbox"/>	Restlessness		
<input type="checkbox"/>	Shortness of breath		
<input type="checkbox"/>	Sleep - Cant sleep		
<input type="checkbox"/>	Sleep - interrupted sleep		
<input type="checkbox"/>	Suspicious of others		
<input type="checkbox"/>	Tired or easily fatigued		
<input type="checkbox"/>	Trouble getting along in public		
<input type="checkbox"/>	Upset easily		

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

Patient name : _____

Date: _____

MEDICAL HISTORY FORM-CHILD

BIRTH HISTORY

During pregnancy, biological mother's complications

- | | |
|---|---|
| <input type="checkbox"/> No complication during biological mother's pregnancy | <input type="checkbox"/> amniocentesis |
| <input type="checkbox"/> Unknown complications during biological mother's pregnancy | <input type="checkbox"/> anemia |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> emotional problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> high fever |
| <input type="checkbox"/> placenta previa | <input type="checkbox"/> vaginal infection |
| <input type="checkbox"/> OTHER complication during biological mother's pregnancy | |

During pregnancy did biological mother do any of the following

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> No tobacco, alcohol or drug use | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Alcohol consumption | <input type="checkbox"/> Drug use |

Were there any problems during labor or delivery

- | | |
|--|---|
| <input type="checkbox"/> No problems with labor and delivery | <input type="checkbox"/> Unknown problems with labor and delivery |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Jaundiced child |
| <input type="checkbox"/> Child with breathing problems | <input type="checkbox"/> Child Premature at 5 months |
| <input type="checkbox"/> Child Premature at 6 months | <input type="checkbox"/> Child Premature at 7 months |
| <input type="checkbox"/> Child Premature at 8 months | |

DEVELOPMENTAL:

Did child have any Developmental abnormalities

- Unknown developmental abnormalities No developmental abnormalities
 There were developmental Abnormalities

If yes, please explain: _____

For children over 5 years old, did child have any of the following?

- Encopresis (passes feces in inappropriate places) and not due to physical problem or medication
 Enuresis (repeated voiding urine in bed or clothes intentional or unintentional),
and not due to physical problem or medication

If enuresis, Please select from the below

- At night
 During the day
 Both day and night

At what age did the child Walk?

At what age did the child Talk?

At what age did the child toilet train?

EDUCATION AND SCHOOL:

Child's current grade level

- | | | | |
|---------------------------------------|------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Kindergarten | <input type="checkbox"/> 1st grade | <input type="checkbox"/> 2nd grade | <input type="checkbox"/> 3rd grade |
| <input type="checkbox"/> 4th grade | <input type="checkbox"/> 5th grade | <input type="checkbox"/> 6th grade | <input type="checkbox"/> 7th grade |
| <input type="checkbox"/> 8th grade | <input type="checkbox"/> 9th grade | <input type="checkbox"/> 10th grade | <input type="checkbox"/> 11th grade |
| <input type="checkbox"/> 12th grade | | | |

Name of School? _____

Type of school that child attends

-
- Private
-
- Public
-
- Home schooled

Child's current average grades in school subjects

-
- A's
-
- B's
-
- C's
-
- D's
-
- F's

Has there been a change noted in child's performance in school

-
- No change in performance
-
- Yes change in performance

If Yes, Describe _____

Has there been a change noted in child's behaviour in school

-
- Behavioral problems at school noted
-
- No behavioral problems at school

If Yes, Describe _____

Indicate if child has been tested for an IEP (Individualized Education Plan)

-
- Tested for IEP (Individualized Education Plan)
-
- Not tested for IEP (Individualized Education Plan)

If Yes, Describe _____

Is child's placement in IEP due to

-
- IEP due to learning problems
-
- IEP due to behavior problems

If child was placed in IEP indicate the number of hours of placement

-
- 1 hour
-
- 2 hours
-
- 3 hours
-
- 4 hours or more

History of school suspension?

-
- No prior history of school suspension
-
- There is a prior history of school suspension

Explain _____

Other education related problems _____

PERSONAL OR SOCIAL HISTORY: Child:

Where was patient born? _____

Marital Status: single, never married Married 1 time

Name and Age of spouse or partner _____

Who does patient live with? Check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> alone | <input type="checkbox"/> sibling(s) | <input type="checkbox"/> foster parents |
| <input type="checkbox"/> mother | <input type="checkbox"/> maternal grandmother | <input type="checkbox"/> Group home |
| <input type="checkbox"/> father | <input type="checkbox"/> maternal grandfather | <input type="checkbox"/> Homeless |
| <input type="checkbox"/> adoptive mother | <input type="checkbox"/> paternal grandmother | <input type="checkbox"/> Other person or situation |
| <input type="checkbox"/> adoptive father | <input type="checkbox"/> paternal grandfather | |

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

PHYSICAL AND RECREATIONAL ACTIVITY

Please check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> No physical activity | <input type="checkbox"/> Likes to walk | <input type="checkbox"/> Crafts |
| <input type="checkbox"/> PE at school | <input type="checkbox"/> Involved in sports | <input type="checkbox"/> Video games |
| <input type="checkbox"/> Goes to the Gym | <input type="checkbox"/> Swimming | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Rides a bicycle | <input type="checkbox"/> Fishing | <input type="checkbox"/> Other activity |

If other, Please specify

MILITARY

Does either parent have Military history? Yes No

Adult Patient: Please check any that apply: **Child Patient:** Please check any that apply:

- | | |
|---|--|
| <input type="checkbox"/> Active military | |
| <input type="checkbox"/> Retired military | <input type="checkbox"/> Active duty parent in the U.S. military |
| <input type="checkbox"/> Administrative discharge | <input type="checkbox"/> Parent retired or discharged from U.S. military service |
| <input type="checkbox"/> Dishonorable discharge | |
| <input type="checkbox"/> Medical discharge | |

LEGAL PROBLEMS OR ISSUES

- | | | |
|---|--|--|
| <input type="checkbox"/> No history of legal problems, arrests or convictions | | |
| <input type="checkbox"/> Gangs | <input type="checkbox"/> Detention | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> DUI/DWI | <input type="checkbox"/> Jail or Juvi | <input type="checkbox"/> Custody |
| <input type="checkbox"/> Arrested | <input type="checkbox"/> Probation | <input type="checkbox"/> Other legal problem |
| <input type="checkbox"/> Convicted | <input type="checkbox"/> Current civi law suit | |

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 _____

IMMUNIZATIONS - ChildAre Immunization up to date? Yes No**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

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: _____

Hospitalizations (Other than Psychiatric)

Has the patient had any previous Hospitalizations? Yes No

Location/Facility	Reason for Hospitalization	Approximate Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: _____

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 NEUROPSYCHIATRIC 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 healthcare 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: _____



**NOTICE OF PRIVACY PRACTICES
FOR
PROTECTED HEALTH INFORMATION (HIPAA)**

Neuropsychiatric Institute
4107 W Spruce Street Suite 100
Tampa / FL / 33607
Phone: (813) 636 8811
Fax: (813) 636 8855

Or visit us at: <http://neuropsychiatric.net>
Effective Date: 1/1/2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your care is created. Typically, this record contains medical information such as your symptoms, examination, test results, diagnoses, treatment and/or treatment plan and billing related information. This information is considered protected health information (PHI).

This Notice is intended to advise you about the ways we may use and disclose medical information about you. It also describes

your rights and certain obligations with regard to your medical information and applies to all of the records of your care generated by your healthcare provider(s) for our organization.

Our Responsibilities

Our Practice is required to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information that we collect and maintain.

We are required by law to abide by the terms of this Notice and notify you if changes are made. We reserve the right to make changes to the Notice and make the new provisions effective for all protected health information we maintain.

Copies of our Notice are available in our main reception area(s) and on our website.

How We May Use and Disclose Medical Information About You.

The following describes examples of the way we may use and disclose medical information:

For Treatment:We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other healthcare professionals such as physicians, nurses, technicians, clinical laboratories, imaging centers, medical students, or other personnel who are involved in your care. We may communicate your information using various methods, orally, written, facsimile and electronic communications.

We may also provide other healthcare professionals who contribute to your care with copies of various reports and information to assist him/her and ensure that they have appropriate information regarding your condition/treatment plan and diagnosis.

NPI

For Payment:We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. Examples may include contacting your insurance company for referrals, verification or preapproval of covered services.

For Health Care Operations:We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessments, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities such as lab or radiology interfaces within the EHR. We may contact you to remind you of your appointment by telephone or reminder card unless requested otherwise.

Business Associates, BA:Provide services for our organization through written contracts and/or service agreements. Examples of these services include billing and collection and software support. We may disclose your health information to a BA so they can perform the services we have asked them to do such as billing your third party payer for services rendered. The BA is also required by law to protect and safeguard your health information which is clearly defined through our Business Associate Agreement and written contracts/service agreements.

Breach Notification:In the event that there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a BA you will be notified within 45 days of the breach. In addition to your individual notification we may be required to meet further reporting requirements set forth by state and federal agencies.

Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object:We will not use and disclose information without your written authorization, except as described in this Notice or as required by applicable laws. Written authorization is required for, most uses and disclosures of psychotherapy notes; PHI for marketing purposes unless we speak with you and disclosures that constitute a sale of PHI. If you provide an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your authorization.

Individuals Involved in Your Care or Payment for Your Care:Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

NPI

Future Communications: We may communicate with you via newsletters, mailings or other means regarding treatment options and information on health related benefits or services; to remind you that you have an appointment; or other community based initiatives or activities to include limited marketing or fundraising initiatives in which our facility is participating. You have the right to opt out at any time if you are not interested in receiving initiatives in which our facility is participating. You have the right to opt out at any time if you are not interested in receiving these communications, please contact our receiving these communications, please contact our Privacy Officer. Privacy Officer. Marketing and Fundraising initiatives, if applicable are limited and may require a separate authorization.

Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to

Object: We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law, We may use and disclose health information to the following types of entities, including but not limited to:

Authorities: If you are not present, able to agree or object to the use or disclosure (such as in an emergency situation), then your healthcare present, able to agree or object to the use or disclosure (such as in an emergency situation), then your healthcare provider may, using professional der may, using professional judgment will judgment will determine whether the disclosure is in your best interest. In this case, only the information In this case, only the information that is relevant to your health care will be disclosed.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

State Specific Requirements: Many states have reporting requirements which may include population based activities relating to improving health or reducing health based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries and others.

Your Health Information Rights: Although your health record is the physical property of the practice that compiled it, you have the right to the record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy: You and/or your personal representative have the right to inspect, review and receive a copy of your medical information. Electronic copies are electronic copies are available and may include various electronic means such as a patient portal or other reasonable accommodations requested. We available and may include various electronic means such as a patient portal or other reasonable accommodations requested. We may deny your request to inspect and deny your request to inspect and copy in limited circumstances to include release of psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed administrative action or proceeding.

Requests to copy and/or a review must be submitted in writing to OUR PRACTICE : There will be a fee charged for all applicable copying and producing copy of portable media (CD, USB) up to the maximum amount as prescribed by governing law.

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Amend: If you feel that the medical information we have is incomplete or incorrect, you may ask us to amend the information by submitting a request in writing.

We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosed. You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosures to carry out treatment, payment and health care operations. OUR PRACTICE will provide the first accounting to carry out treatment, payment and health care operations. OUR PRACTICE will provide the first accounting to you in any 12 month period without charge, upon month period without charge, upon receipt of your written request. The cost for subsequent requests for an accounting within the 12 month period will be up to the maximum amount prescribed by governing law.

Request Restrictions: You have the right to request a restriction or limitation of your medical information we use or disclose about you for treatment, payment or healthcare operations.

Restrictions from your health plan (insurance company): You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket covered services, provided the disclosure is not required by other laws.

Other Restrictions, Limiting Information: You also have the right to request and limit any medical information we disclose about you to someone who may be involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests in writing.

We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternate phone number or address. We ask alternate phone number or address. We ask that you submit these requests in writing that you submit these requests in writing.

If your rights, please submit your request in writing to the practice's privacy officer indicated below.

For More Information or to Report a Problem: If you have questions and would like additional information please contact the Privacy Officer. If you believe that your (or someone else's) privacy rights may have been violated, you may file a complaint with the Privacy Officer at the contact number below or with the Secretary of Health and Human Services. All complaints must be submitted in writing within 180 days of when you knew that the act or omission occurred and there will be no retaliation for filing a complaint.

Privacy Officer: Juanita Provenzano

Address: 4107 W Spruce Street

Suite 100

Tampa FL 33607

Telephone:(813) 636 8811

Date: _____

Signature: _____ Patient Name: _____

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: _____