OFFICE POLICY

Welcome to the Boys Town Central Florida Behavioral Health Clinic! The information in this packet is provided to ensure that you have a full understanding of our office policies. **Please read carefully, complete the enclosed documentation, and sign where indicated**. This first sheet will be yours for future reference. If you need assistance with completing this form, please request assistance from one of our staff members or by contacting 407-588-2170. The information must be complete before you can be seen in our clinic.

Please arrive at least 15 minutes early for your first scheduled appointment to review your completed paperwork.

FINANCIAL RESPONSIBILITY AND PAYMENT POLICY – You are responsible for payment of all charges for mental health services provided, including any co-payments or deductibles. You are also required to provide an insurance card – this is necessary to validate coverage of benefits. You are ultimately responsible for any service provided that is not covered by your policy.

INSURANCE – You are responsible for any charges due to your insurance company. Your account with this office is your responsibility. As a courtesy to our clients, we will file insurance. It is your responsibility to notify us of any changes in your insurance plan. Any co-payments, deductibles, or services not covered by insurance are your financial responsibility. Any service denied because of a change in benefits becomes your responsibility.

OFFICE HOURS – Office hours are 8:00 a.m. to 6:00 p.m., Monday through Thursday, and 8:00 a.m. to 5:00 p.m. on Friday. To schedule appointments, please contact 407-588-2170.

AFTER HOURS – In the case of an emergency, call 911 or go to the nearest hospital emergency room.

CANCELLATION – Cancellations must be made at least 24 hours prior to your appointment; otherwise, a fee may be assessed. All routine phone calls, including rescheduling appointments and routine questions, will be handled during normal business hours.

LATE APPOINTMENTS – You may need to reschedule appointments if you are 15 minutes late.

TERMINATION – Termination of services may occur when three appointments are missed without proper cancellation or when treatment recommendations are not accepted or followed.

FAMILY INVOLVEMENT – The primary responsibility of each mental health provider is to provide the most effective treatment for each client. Involvement of the family is viewed as essential in maximizing treatment success.

CLIENT RIGHTS – Please review the client rights and responsibilities information posted in the reception area. A copy of this information is included in this packet.

CONFIDENTIALITY – Law protects the confidentiality of all communication between a client and psychologist/therapist, and your provider can only release information about our work to others with your written permission.

BOYS TOWN CENTERAL FLORIDA BEHAVIORAL HEALTH CLINIC
STATEMENT OF UNDERSTANDING

Please read and review the following pages for an explanation of our office policies and keep them for your reference. By initialing, you indicate that you understand and/or were explained each policy outlined below.

Please Initial:

FINANCIAL RESPONSIBILITY AND PAYMENT POLICY

_____ I agree that I am responsible for payment of all charges for mental health services provided to me, including any copayments or deductibles. I understand that I am responsible for notification at the time of the visit of any benefit changes in my insurance plan. I further understand that I am responsible for any service provided to me that is not covered by my policy. I accept financial responsibility for the services provided to me by the Boys Town Central Florida Behavioral Health Clinic

NOTICE OF PRIVACY AND CLIENT RIGHTS

_____ I have received the Boys Town Notice of Privacy, which describes how confidential health information about the client may be used or disclosed and how to get access to this information. I have also received a copy of the Boys Town Central Florida Behavioral Health Clinic Client Rights & Responsibilities.

CONSENT TO TREATMENT

_____ The Boys Town Central Florida Behavioral Health Clinic works with children and their families to identify and treat such issues as depression, anxiety, school problems, and ADHD. The Clinic offers specialized services, including behavioral and psychological assessments as well as counseling. I, knowing that the client has a condition requiring diagnosis and treatment, do hereby voluntarily consent to such treatment by the Boys Town Central Florida Behavioral Health Clinic staff, assistants, or designees as is, in their judgment, necessary. I further acknowledge that no guarantees have been made to me as to the results of treatment. I authorize you to provide reasonable and proper care by today's standards. If applicable, I have informed my treating provider of my mental health advance directives and have provided a copy for mental health decision-making that will become part of my treatment record.

CONFIRMATION PHONE CALLS

_____ Boys Town will attempt to confirm appointments prior to each scheduled appointment. It is ultimately my responsibility to attend scheduled appointments. You may contact me by phone. _____ Yes _____ No
You may leave a message. ___ Yes ___ No You may contact me at this phone number: _______________

PERMISSION TO FURNISH INFORMATION FROM RECORDS

_____ I understand that certain medical information regarding the client many need to be released by the Clinic to third-party payers in order to obtain payment for the services provided. I hereby authorize and request the Boys Town Central Florida Behavioral Health Clinic staff to furnish medical information requested by the health insurance carrier or any other third-party payer. I authorize contact with my insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy, and I authorize my insurance company or health plan administrator to release information to the Boys Town Central Florida Behavioral Health Clinic

COORDINATION OF CARE

_____ In order to provide the highest level of care, we may request permission to discuss relevant aspects of care with other providers serving the client. Such providers may include but are not limited to: physicians, school personnel, and previous mental health providers. When contact with other providers is requested, a separate Consent for the Release of Information will be completed and signed for each provider. If your clinician may communicate with the client's primary care provider (physician) about today's appointment, please sign the attached Consent for the Release of Information form and return it with this form.

STATEMENT OF UNDERSTANDING

Signing below indicates that I have read or have had read to me the contents of this document and have received pertinent information regarding Office Polices, Client Rights & Responsibilities, and Notice of Privacy. I agree to abide by the stated terms and conditions of service provision. I agree that these provisions will remain in effect until I provide written revocation to the Clinic. If I am signing for someone other than myself, I represent that I have legal authority to do so.

______________________	______________________	________
Printed Name of Client	**Signature of Client (IF NOT A MINOR)**	**Date**
______________________	______________________	________
Printed Name of Legal Guardian	**Signature of Legal Guardian**	**Date**

Behavioral Health Clinic
Client Rights & Responsibilities

CLIENT RIGHTS TO SERVICES

You have a right to:

- reasonable access to services regardless of race, religion, gender, sexual orientation, or ethnicity.
- be informed about the qualifications of the Clinical staff who are responsible for the client's care, treatment, and services.
- receive services in the Clinic during Clinic business hours.
- receive individualized treatment.
- refuse care, treatment, and services and to be informed about what will happen if this occurs.

RESPONSIBILITIES OF CLIENTS

It is your responsibility to:

- provide the Clinic with your current contact information and to notify the Clinic staff of any changes.
- keep scheduled appointments and, when necessary, cancel them at least 24 hours in advance.
- participate in an informed way in the decision-making and treatment planning process and have family members participate in such planning.
- follow treatment recommendations.

COMPLAINTS OR GRIEVANCES

If you have a complaint or grievance:

- you have the right to file a complaint or grievance without interference or retaliation.
- about the quality of services, you have the right to contact the Department Director, or you can call the Boys Town Hotline at **1-800-218-8032** (24 hours a day/7 days a week).
- you also have the right to file a grievance with:
  - Health and Human Services
  - Council on Accreditation

NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review carefully.

At Boys Town we are committed to protecting the personal information we obtain about you while providing services through our continuum of child and family services. We are required by law to follow the privacy practices described in this Notice. We may change our privacy practices at any time. The revised privacy practices will be set forth in a revised Notice and will be effective for all health information that we maintain at that time. Upon your request, we will provide you with a copy of the most recent Notice. A current copy of our Notice of Privacy Practices will be posted in a visible location at all times in our National Headquarters' office at 378 Bucher Drive, Boys Town, NE 68010. A current copy will also be available on the website **www.boystown.org**.

WHO WILL FOLLOW THIS NOTICE

- Any health care professional authorized to enter information into your record.
- All Boys Town staff members, including volunteer groups we allow to help while care is being provided.
- All the above entities, sites and other locations will follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for purposes of treatment.

1. Uses and Disclosures. Your health information may be used and disclosed by Boys Town in order to provide services to you. Other uses or disclosures will be made only with your authorization and at any time you have the right to revoke such authorization. The following are examples of such uses and disclosures:

a. Treatment. We will use or disclose your health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with third parties that have already obtained your permission to have access to your health information. In addition we may disclose your health information to another entity or health care provider who becomes involved in your care by providing assistance with your health care or treatment. Information obtained by Boys Town employees will be included in your record and used to determine the course of your treatment. Employees involved in your care will communicate with one another personally about your treatment.

b. Payment. Your health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services that we recommend such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We may use and disclose treatment information about you so that the treatment and services you receive may be billed to and payment may be collected.

c. Healthcare Operations. We may use or disclose, as needed, your health information in order to support the business activities of Boys Town. These activities include, but are not limited to, quality assessment and improvement activities, employee review activities, training of students (interns), licensing, marketing, and fundraising, and conducting or arranging for other business activities. We may use or disclose your health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use or disclose your health information for other marketing activities. We may use or disclose your demographic information and the dates that you receive treatment from Boys Town. Boys Town may use your treatment information for performance improvement activities, record review activities, etc.

d. Incidental Uses and Disclosures. There may also be incidental uses or disclosures of your health information as a result of otherwise allowed uses and disclosures. Such uses and disclosures may occur because they cannot reasonably be prevented. For example, when we correspond with you by mail, we cannot reasonably prevent others from viewing your name on the package.

e. Business Associates. _We may disclose health information to other persons or organizations, known as business associates, who provide services on our behalf under contract. To protect your health information, we require our business associates to appropriately safeguard the information we disclose to them.

f. Some Examples. Limited information may be used in the census report if you are receiving services and residing at Boys Town. We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. We may use or disclose health information to tell you about or recommend possible treatment options or alternatives of interest.

2. Uses and Disclosures Allowed or Required by Law. We may use or disclose your health information in the following situations as allowed or required by law:

a. Required by Law. We may use or disclose your health information if we are legally required to do so. We will limit the use of disclosure to that required by such law.

b. Public Health. We may use or disclose health information to a public health authority for purposes of controlling disease, injury or disability. We may also disclose your health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

c. Communicable Diseases. We may disclose your health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

d. Health Oversight. We may disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include, but are not limited to, government agencies that oversee the health care system, government benefit programs, other government regulatory programs and entities subject to civil rights laws.

e. Abuse or Neglect. We may disclose your health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information to the governmental entity or agency authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

f. Food and Drug Administration. We may disclose your health information to a person or company required by the Food and Drug Administration (FDA) for purposes relating to the quality, safety or effectiveness of FDA regulated products or activities.

g. Legal Proceedings._We may disclose health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions, in response to a subpoena, discovery request or other lawful process.

h. Law Enforcement. We may disclose health information, so long as applicable legal requirements are met, for law enforcement purposes.

i. Coroner, Funeral Directors, and Organ Donation._ We may disclose health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner of medical examiner to perform other duties authorized by law. We may also disclose health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. Health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

j. Research. We may disclose your health information to researchers when their research has been approved by a privacy board or an institutional review board.

k. Criminal Activity. Consistent with applicable federal and state laws, we may disclose your health information, if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

l. Military Activity and National Security. When the appropriate conditions apply, we may use or disclose health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your health information to authorized federal officials for conducting national security and intelligence activities, including providing protective services to the President of the United States or others.

m. Correctional Institutions. If you are an inmate or in legal custody, we may disclose to the correctional institution or law enforcement official having legal custody of you, certain health information if necessary for health and safety purposes.

n. Compliance. Under the law, we must make disclosures of health information to the Secretary of the Department of Health and Human Services to enable it to investigate or determine our compliance with the requirements of the privacy laws.

o. Workers' Compensation. We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

p. Additional Situations. Other uses or disclosures of your health information not covered by this notice or the laws that apply to Boys Town, may be made only with your written permission. If you provide Boys Town with this permission you may revoke that permission at any time.

3. Your Rights. Following is a statement of your legal rights with respect to your health information and a brief description of how you may exercise these rights.

a. Access. You have the right to look at or get copies of your medical information, with limited exceptions: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civic, criminal, or administrative action or proceeding; and certain laboratory information restricted by federal law. Our office may charge you a reasonable fee for copying, mailing, labor and supplies associated with your request. Any request for access to or copies of your health information must be in writing and provided to our Privacy Officer. If your request for access to or copies of your health information is denied, you may, depending on the circumstances, have a right to have a decision to deny access reviewed. We will provide you, in writing, with our reasons for denial of access and, if, by law, you are allowed to have such denial reviewed, we will provide you with instructions for having a denial of access reviewed.

b. Restrictions. You may ask us to restrict the use or disclosure of any part of your health information to carry out treatment, payment, or healthcare operations. You may also request that any part of your health information not be disclosed to family, relatives or friends who may be involved in your care or to notify them of your location, general condition or death.

In addition, you may request that we restrict the use and disclosure of your health information for disaster relief efforts. Your request must be in writing addressed to our Privacy Officer and state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit the use and disclosure of your health information, your health information will not be restricted. If we do agree to the requested restriction, we may not use or disclose your health information in violation of that restriction unless there is an emergency. We may terminate our agreement to restrict uses and disclosures of your health information by providing you with written notice of such; provided, however, that our termination shall only be effective with respect to health information created or received after we have given you notice of termination of the restriction.

c. **Confidential Communication.** You have the right to request that we send your health information to you by alternative means or to an alternative location. We will accommodate reasonable requests. We may condition this accommodation by having you sign an authorization, asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must be in writing, addressed to our Privacy Officer, and state the accommodations you are requesting.

d. **Amendments.** You may request an amendment of your health information that we maintain. Such request must be in writing and provided to our Privacy Officer. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement that will become part of your health information. If you file a statement of disagreement, we reserve the right to respond to your statement. You will receive a copy of any response we make and any such response will become part of your health information.

e. **Accounting of Disclosures.** You have the right to request an accounting of certain disclosures we have made, if any, of your health information. This right applies to disclosures made on and after April 14, 2003 for purposes other than (i) treatment, payment or healthcare operations as described in this Notice; (ii) disclosures made to you; (iii) disclosures to a facility directory; (iv) disclosures to family members or friends involved in your care or for notification purposes; or (v) disclosures pursuant to an authorization. The right to receive this information is subject to certain exceptions, restrictions and limitations. Your request for an accounting must be in writing, addressed to our Privacy Officer. The right to receive this information is subject to certain exceptions, restrictions and limitations. Your request for an accounting must be in writing, addressed to our Privacy Officer.

f. **Electronic Notice.** If you receive a copy of this Notice on our website or by e-mail, you have the right to obtain a paper copy from us upon request.

4. **Written Authorization.** Any uses and disclosures of your health information for purposes other than treatment, payment and health care operations, or as otherwise allowed or required by law as described above will be made only with written authorization. Any authorization you provide to us is effective for the period specified in the authorization (which cannot exceed one year) unless you revoke the authorization in writing. You may revoke any written authorization, at any time. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to your authorization prior to the time we received your written revocation.

5. **Others Involved in Your Healthcare.** We may disclose to a member of your family, a relative, a close friend or any other person you identify, your health information that directly relates to that person's involvement in your health care or who has responsibility for payment of your health care. We may also use or disclose your health information to notify or assist in notifying a relative or any person responsible for your care, of your location, general condition or death. In addition, we may use or disclose your health information to a public or private entity, authorized by law or by its charter to assist in disaster relief efforts, for the purposes of coordinating the above uses and disclosures to your family or other individuals involved in your health care.

6. **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. To complain to us, you may send our Privacy Officer a letter describing your concerns to the address found below. We respect your privacy and support any efforts to protect the privacy of your health information. We will not retaliate against you for filing a complaint.

7. **Contact Information.** If you have any questions about this Notice, you may contact our Chief Compliance Officer for Youth Care by telephone, e-mail, facsimile, or mail at the address set forth below. If, however, you want to exercise any of your rights pursuant to this Notice of Privacy Practices or have a complaint, such action must be in writing and faxed or mailed to our Chief Compliance Officer for Youth Care at the address set forth below.

Boys Town
Attention: Chief Compliance Officer Youth Care
13603 Flanagan Boulevard
Boys Town, NE 68010
Phone: 402-498-1935
Facsimile: 402-498-3113
Email: **ChiefComplianceOfficerYouthCare@boystown.org**

BOYS TOWN CENTRAL FLORIDA BEHAVIORAL HEALTH CLINIC
CLIENT INFORMATION SHEET

Client Information

Last Name:	First:	MI:	Birth Date:
Address:	City:	State:	Zip:
Home Phone: Work Phone:	Marital Status: M D S W	Gender: ❑ M ❑ F	Is Client Currently a Student? ❑ Yes ❑ No
Primary Care Physician:	Referring Physician:		

Person to Notify in Case of Emergency (friend or relative not living with you):

Name	*Relationship*	*Phone*

Race: ❑ Asian ❑ Black ❑ White ❑ Native Hawaiian ❑ Sudanese ❑ American Indian/Alaskan National ❑ Other ❑ Decline to Answer

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Decline to Answer

Responsible Party (Legal Guardian)		Spouse/Other Parent	
Last Name: First: M.I.:	Birth Date:	Last Name: First: M.I.:	Birth Date:
Address:		Address:	
City: State: Zip:		City: State: Zip:	
Home Phone: Work Phone: Cell Phone:		Home Phone: Work Phone: Cell Phone:	
E-mail Address:	Relationship to Client:	E-mail Address:	Relationship to Client:
Circle One: Employed Unemployed Disabled Retired		Circle One: Employed Unemployed Disabled Retired	
Employer Name:		Employer Name:	
Employer Address: Phone:		Employer Address: Phone:	

Primary Insurance Information	Secondary Insurance Information
Insurance Co. Name:	Insurance Co. Name:
Insured's Name:	Insured's Name:
Relationship to Client:	Relationship to Client:
Policy #: Group #:	Policy #: Group #:
Effective Date: Insurance Phone #:	Effective Date: Insurance Phone #:

Your signature indicates that the above information is accurate and reflective of your current insurance information. You understand that you are responsible for any copayments or deductibles at each appointment. By signing below, you also understand that the benefit information that our office staff obtained is a courtesy and is NOT a guarantee that insurance will pay for the services provided. Further, you understand that you are responsible for any amount due that is not covered by your insurance provider, and you understand that the Clinic will bill you for any outstanding amounts owed. **You are responsible for reporting any insurance changes to the front desk staff at the time of your appointment.**

NAME OF RESPONSIBLE PARTY   SIGNATURE OF RESPONSIBLE PARTY   DATE

Pretreatment Questionnaire

Client Name: ____________________ **DOB:** ____________ **Date:** ______ **Gender:** ☐ **M** ☐ **F**

Form completed by: _____________________________ ☐ **Self** ☐ **Parent** ☐ **Legal Guardian**

Referred by: ___________________________ ☐ **Physician** ☐ **Employer** ☐ **Relative** ☐ **Friend** ☐ **Website** ☐ **Other:**____________________

Primary concern(s) for which treatment is sought: __________________________________

____

1. **Please rate yourself/your child on each of the areas below AND whether it has been a problem during the last month:**

	Extremely Poor			OK			Extremely Well	Is this a problem?	
Getting along with family	1	2	3	4	5	6	7	Yes	No
Getting along with other peers/children outside of the home	1	2	3	4	5	6	7	Yes	No
Getting along with other adults outside of the home	1	2	3	4	5	6	7	Yes	No
Performance at school/work	1	2	3	4	5	6	7	Yes	No

2. **Please rate yourself/your child on each of the areas below AND whether it has been a problem during the last month:**

	Never			Sometimes			Always	Is this a problem?	
Overactive, acts without thinking	1	2	3	4	5	6	7	Yes	No
Sad, unhappy, down, or depressed	1	2	3	4	5	6	7	Yes	No
Worried, nervous, and/or anxious	1	2	3	4	5	6	7	Yes	No
Difficulties with school (academics and/or behavior)	1	2	3	4	5	6	7	Yes	No
Sleeping problems	1	2	3	4	5	6	7	Yes	No
Problems with temper, having a 'short fuse'	1	2	3	4	5	6	7	Yes	No
Difficulty tolerating frustration/change	1	2	3	4	5	6	7	Yes	No
Problems with peers	1	2	3	4	5	6	7	Yes	No
Other: __________________	1	2	3	4	5	6	7	Yes	No
Other: __________________	1	2	3	4	5	6	7	Yes	No

Clinician Use: ____Int ____Ext ____Comb ____Oth;

Individuals living with you/your child:

Name_________________________________ Age_____ Relationship_________________________

Name _________________________________ Age_____ Relationship_________________________

Name _________________________________ Age_____ Relationship_________________________

Name _________________________________ Age_____ Relationship_________________________

Developmental history:

Complications at birth or in early childhood? ☐ Yes ☐ No If yes, please explain:__________________

____

Educational history:

Current school: ____ Current grade: _____

Has your child ever been retained? ☐ Yes ☐ No If yes, in what grade(s)? _________________________

Special education placement? ☐ Yes ☐ No If yes, in what area? _______________________________

Has the school performed psychological testing? ☐ Yes ☐ No If so, when? _______________________

Is there an IEP (Individual Educational Plan)? ☐ Yes ☐ No ☐ Don't know

How would you describe your child's overall academic performance?

☐ Poor ☐ Below Average ☐ Average ☐ Good ☐ Excellent

Your/your child's interests/activities: ____

____

What are your/your child's strengths? ____

____

Previous mental health treatment: ☐ None ☐ Yes (please detail below)

Mo/Yr ________ Provider _________ Treatment ______________ Outcome ____________________

Mo/Yr ________ Provider _________ Treatment _______________Outcome _____________________

Current legal concerns: ☐ Yes ☐ No If yes, please explain: ______________________________

____

Past history of abuse: ☐ Yes ☐ No If yes, please explain: _______________________________

____

Religious/spiritual affiliation(s): _____________________________ ☐ None ☐ Prefer not to answer

Medical diagnoses and conditions: ☐ None ☐ Other:_________________________________

____

Significant operations/invasive procedures: ☐ None ☐ Other: ____________________________

____

Serious injuries/chronic illnesses/hospitalizations: ☐ None ☐ Other: ____________________
____

Last visit to doctor/well-check date: __________ **Doctor's name**: ______________________

Allergies: ☐ None ☐ Other: ____

Immunizations current? ☐ Yes ☐ No If no, please explain: ____________________________

Medications (prescribed and over-the-counter): ☐ None

Medication ____________ Dosage _______ Prescribing Physician ___________ Started _______
Medication ____________ Dosage _______ Prescribing Physician ___________ Started _______
Medication ____________ Dosage _______ Prescribing Physician ___________ Started _______

Date of last medication check?____

Adverse drug reactions: ☐ None ☐ Other: ____

Substance use:

Alcohol use: ☐ None ☐ Suspected ☐ Known to use currently ☐ Recovering
Type: __________________________ Amount: __________ How often? __________

Drug use: ☐ None ☐ Suspected ☐ Known to use currently ☐ Recovering
Type: __________________________ Amount: __________ How often? __________

Harm to self or others

Are you concerned that your child may be in danger of harming themselves or others? ☐ Yes ☐ No
If yes, please explain:
____
____

Parent/Client Signature: _____________________________________ **Date**: _____________

Behavioral Health Clinic
975 Oklahoma Street
Oviedo, Florida 32765
Phone: 407-588-2170; Fax: 407-588-2171

Authorization to Release Information to Primary Care Provider

Client Name: ___________________________________ Date of Birth: __________________

☐ I do **NOT** authorize Behavioral Health Clinic Staff to:
contact/communicate with my child's/my Primary Care Provider.

I hereby authorize Behavioral Health Clinic staff to:
☐ release and/or ☐ request information from the record of the above-named client.

To/From: ____
Name of Primary Care Provider, Clinic, and Address

Phone: _______________________________ Fax: _____________________________

Purpose for Disclosure:

☐ To permit coordination and collaboration of care ☐ Other: _________________________

Information to be Released:	Information Requested:
☐ Psychological Evaluation	☐ Medical Evaluation/Diagnosis
☐ Treatment Summaries	☐ Prescribed Medications
☐ Other: ____________________________	☐ History/Physical
	☐ Other: ____________________________

At any time, I may revoke this consent in writing. I understand that the revocation will not be effective retroactively for information exchanges that have already occurred. Unless otherwise noted, this consent expires 6 months from the date of my signature below.

NOTICE TO RECIPIENTS: You are prohibited from disclosing the information to any other party and are required to destroy the information after the stated need has been fulfilled. This information has been disclosed to you from records which may be protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Father Flanagan's Boys' Home, its employees, and its officers are hereby released from any legal liability for disclosure of the above information to the extent indicated and authorized herein.

____ ________________
Signature of client (if not a minor, unless receiving substance use services) Date

____ ________________
Signature of parent or legal guardian (if client is a minor) Date

BOYS TOWN
Central Florida

PAYMENT POLICY

Thank you for choosing us to assist you and your family. We are committed to providing you with the best care possible. As one of our clients, we want to ensure that you have a clear understanding of our payment policy. Please read this carefully and ask any questions that you may have.

1. **Insurance** – We participate in most insurance plans. You are responsible for any charges due to your insurance company. Your account with this office is your responsibility. As a courtesy to our clients, we will file insurance. Please present a copy of your insurance card at each visit. It is your responsibility to notify us of any changes in your insurance plan. Any service denied because of a change in benefits becomes your responsibility. Services not covered by your insurance are your financial responsibility.

2. **Co-payments, coinsurance, and deductibles** – All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. We are contractually obliged to collect the co-payment at the time of service. Coinsurance and deductible amounts may vary. A deposit of $50 as a down payment that will be applied toward your coinsurance or deductible is expected at each visit until your coinsurance or deductible has been met. We accept cash, check, Visa, MasterCard, Discover, and American Express.

3. **Self-Pay** – Payment is expected at the time of service if we will not be submitting charges to insurance. We accept cash, check, Visa, MasterCard, Discover, and American Express.

4. **Claim Submission** – We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

5. **Coverage changes** – If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits.

Please call if you have questions about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.

Our practice is committed to providing the best treatment to our clients. Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.