SEASIDE WELLNESS
OF NAVARRE

1931 Ortega St., Navarre, FL. 32566
Telephone: (850) 684-1410 Fax: (833) 989-0937

New Patient Registration

Patient name: ______________________________

Street address: ______________________________

City: ____________________ State: __________ Zip code: __________

Date of birth: ______________ Email address: ____________________

Home phone: ______________ Cell: ______________ Work: ______________

Driver's license: ____________________ Social sec. number: ______________

Martial status: _________ single _________ married _________ divorced _________widowed

Employer: ____________________ Job title: ______________

Primary care provider: ______________________________

Referring provider: ______________________________

Preferred pharmacy: ______________________________

Pharmacy phone: ______________________________

Emergency contact name: ______________________________

Emergency contact phone: ______________________________

Emergency contact relation to patient: ______________________________

Payment information: ____ Credit card (MC/Visa/Amex/Discover) ____ Debit card ____Cash
____Check ____ Cashier's check ____ Apple Pay

Card number: ____________________ Exp. Date:__________ Sec. code ________

Signature of patient/responsible party: ______________________________

Printed name of patient/responsible party: ______________________________

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Informed Consent for Services

Introduction

Seaside Wellness of Navarre is a multispecialty group practice of primary care and psychiatric care professionals providing therapy, medication management, and other services. Our providers are committed to ensuring that each and every individual receives the highest quality of care and services possible. This legal document establishes guidelines for your participation in services with us. Please read it carefully and discuss any questions or concerns with office staff and/or the health professional before signing.

Consent to Treatment

Your signing of this document provides Informed Consent for examination, diagnostic procedures, and treatment, including therapy. Medical care, including psychiatric services, is not an exact science and no guarantees are made as to the result of such examinations, treatment, and/or diagnostic procedures. While the course of treatment is designed to be helpful, it still can be difficult or uncomfortable.

Health Insurance Benefits and Authorization to Disclose Protected Health Information

Our providers are preferred network providers with most health insurance plans and employee assistance programs (EAP). Copayments and deductibles are paid at the time of service as part of the insurance provider contract. Payment in full is required when your benefits are not able to be verified. Service claims sent to your insurance provider require disclosure of Protected Health Information including, but not limited to, identifying information, diagnosis, service dates, service type, and fees. In some instances, your insurance provider may require documentation such as the treatment plan and clinical notes. Your signing of this document provides specific authorization for the release of this information. Your insurance provider may need you to supply certain information directly. It is your responsibility to comply with these requests. Please notify us of insurance changes before your next visit. Knowing your insurance benefits is your responsibility. **You are responsible for any balance not covered by or paid by your insurance company for any reason.**

Non-Discrimination

Seaside Wellness of Navarre does not discriminate in the provision of services to an individual based upon race, color, sex, national origin, disability, religion, or sexual orientation.

Appointment Reminders and Patient Portal

We provide appointment reminders by text message, voice, and/or email using the contact information you provide during registration. This service is a courtesy. Please do not rely upon electronic reminders as the sole reminders for your appointment. To opt out of this feature for security and confidentiality purposes, inform the office staff or your provider. You will be registered with our Patient Portal for electronic document sharing and more. You signing this document authorizes the use of your contact information for the purposes of appointment notifications and Patient Portal features.

Confidentiality

We are committed to the confidentiality of your Protected Health Information by the ethical guidelines and legal requirements of our profession. Information will not be released without your written consent except under certain circumstances as required by law. Known or suspected abuse, abandonment, or

neglect of a child or vulnerable adult must be reported to the appropriate state or county agency (Fla. Stat. § 415.504 and 415.1034); A provider may have a legal obligation to take protective action if there is reason to believe that there is clear and immediate probability of physical harm to the patient, to other individuals, or to society (Fla. Stat. § 491.0147); and, In certain cases, a judge may issue a court order for the release of Protected Health Information. When participating in couples or family therapy, that treatment unit is considered to be the patient. Requests for treatment records require authorization from all participants before releasing information. The provider may share information from an individual with all participants when clinical judgment determines it is in the interest of helping the treatment unit. This no-secrets policy is intended to mitigate risk of a conflict of interest between the individual and the treatment unit. If an individual has a prevailing interest of confidentiality, the provider may need to refer the individual to another provider or recommend termination of treatment. Confidentiality is encouraged amongst couples, family, and group therapy members but is cannot be enforced by the facilitator or Seaside Wellness of Navarre.

Requests for Disability

Seaside Wellness of Navarre does not accept patients seeking treatment for the sole purpose of obtaining disability benefits or patients seeking long-term disability benefits. It is possible that after evaluating you your provider may be willing to complete short-term disability paperwork on your behalf; however, your provider is not required to do so and may decline to assist with such a request. Your provider may also require you to schedule a separate follow-up appointment for this purpose. Additional fees are assessed for these services.

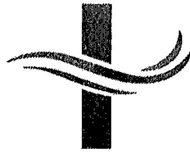
Medication Management

To ensure the best reaction to any prescribed medications, please observe the following procedures:

- Always notify your provider of any side effects or problems with medications you are experiencing.
- Never stop or change the dose of a medication without first discussing it with your provider.
- Suddenly stopping medication can cause medical problems. For this reason, do not allow yourself to run out of medication.
- Keep your scheduled appointments. Although your provider will prescribe you adequate medication until your next visit, cancelled or missed visits can prevent you from having sufficient amounts of medication and make it difficult for your provider to monitor your progress and any complications.
- If you do cancel or miss a visit, be sure to reschedule your next visit before you run out of medication. In general, we will insist that you see your provider before refilling your medication.

Providers and Staff

Your care will be managed by your personal provider or other providers who are not employed by Seaside Wellness of Navarre, but have privileges to care for patients at this center. Your provider's care is supported by a variety of individuals employed by Seaside Wellness Center of Navarre, including secretarial and billing staff. Your provider may also decide to call in consultants who practice in other specialties and may be involved in your care. Like your provider, those consultants have privileges to provide services for patients at this center but are not employed by Seaside Wellness Center of Navarre. Seaside Wellness Center supports several graduate programs by providing on-site training and precept opportunities to students.



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Emergency
In the event of a mental health emergency and you are unable to contact our office, please contact your physician, emergency phone number 911, or go to the nearest emergency room. The National Suicide Prevention Hotline at 1-800-273-8255 is available 24/7.

Informed Consent Attestation
I attest that I have read this document completely, fully understand it, and agree to all described herein. I have had the opportunity to discuss any questions regarding this document.

____

Patient Name Signature Date

If you are signing this document as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

____

Name Relationship Signature Date

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Adolescent Consent Form & Parent Agreement to Respect Privacy

Adolescent therapy client:
Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _______________________________________ Date__________

* * *

Parent/Guardian:
Initial boxes and sign below indicating your agreement to respect your adolescent's privacy:

/____/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

/____/ Although I know that in this state I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

/____/ I understand that I will be informed immediately about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature ____ Date__________

Parent Signature ____ Date__________

Provider Signature ______________________________________ Date__________

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Financial Policy

Thank you for choosing Seaside Primary Care and Psychiatry, LLC DBA Seaside Wellness as your healthcare provider. This policy is designed to answer the most frequently asked questions our patients have regarding payment for services. A copy will be provided to you upon your signature.

Insurance: If you are not insured by one of our participating insurance plans, we will provide you with a superbill to file your claim with your insurance provider. However, payment in full is expected at the time of service. A current copy of your driver's license and a valid insurance card is required for timely processing. Your insurance company may need certain information from you directly; it is your responsibility to comply with their requests. If you change carriers or policies, please notify us so we can make the changes and help you receive your maximum benefits.

Co-payment, Co-insurance, & Deductibles: All co-payments, co-insurance, and deductibles **are due at the time of service.** These arrangements are part of your insurance contract. Failure on your part to collect co-payments, co-insurance, and deductibles from patients can be considered fraud.

Non-covered Services: Be aware that some or all of the services you receive will be considered non-covered or not considered necessary by your insurance company. These services **must be paid in full** at the time of service.

Self-pay: **All payments** are due at the time of service unless PRIOR arrangements have been made with our financial counselor. Cash discounts will be given only if payment is made in full at the time of service.

Non-payment: If your account is over ninety (90) days past due, it may be turned over to a 3rd party collection agency.
___(Initials) I understand, that if my account should go to a 3rd party collection agency, that I will be charged an additional 50% of my outstanding balance, to pay for the collection agencies fees.

Refunds: Refunds are not issued until all charges have been posted and processed. If you are expecting a refund and have not received it after at least sixty (60) days from your last visit, please call our office so we can research your account.

No Show/Cancellation Policy: No show appointments will be charged/billed $65 fee. If cancellations or reschedules are not made prior to 24 hours a fee of $65 will be billed to the patient.

We accept cash, checks, cashier's checks, money orders, Visa, AMEX, MasterCard, Discover, Apple Pay, and Debit cards. Our charges are considered usual and customary for this area.

I have read and understand this policy and have received a signed copy and agree to abide by these guidelines.

______________________________ ______________________________
Patient Signature or Responsible Party | Date

______________________________ ______________________________
Printed Name of Patient or Responsible Party | Patient Date of Birth

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Release of Patient Information

I, ______________________________, authorize Seaside Primary Care and Psychiatry, LLC DBA Seaside Wellness to use and disclose my Protected Health Information to carry out treatment, payment, and other care operations. I understand that Seaside Wellness works hard to protect my privacy and preserves the confidentiality of my Protected Health Information.

Your Protected Health Information is any information as it relates to your past, present, or future physical or mental health condition or payment of your healthcare.

This information can include spoken or written facts used for the purpose of treatment, payment, or healthcare operations as their terms are defined in the federal HIPAA privacy rules. This consent also gives permission for any listed person(s) you designate below, to have access to your Protected Health Information.

Seaside Wellness may refuse treatment if you (or an authorized representative) do not sign the consent form. You may revoke your consent in writing, except to the extent the practice has already made disclosure and reliance upon your prior consent. If you do not consent to the Protected Health Information, or later revoke, Seaside Wellness may refuse to provide treatment.

I HAVE READ AND UNDERSTAND THE INFORMATION PRESENTED TO ME AND I HAVE RECEIVED A SIGNED COPY OF THIS FORM.

____

Patient Signature or Authorized Representative   Date of Birth   Date

______________________________   ______________________________

Printed Name   Relation to Patient (if applicable)

THE NAMES LISTED BELOW ARE AUTHORIZED TO HAVE ACCESS TO MY PROTECTED HEALTH INFORMATION

Name: ______________________ Relation: ______________ Phone: ____________________

Name: ______________________ Relation: ______________ Phone: ____________________

Name: ______________________ Relation: ______________ Phone: ____________________

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Authorization for Release of Medical Information

I, ______________________________, authorize Seaside Primary Care and Psychiatry, LLC dba Seaside Wellness to release or obtain confidential information about me by releasing/requesting a copy of my medical records, summary or narrative of my personal health information to/from physical/person/facility below/disclose the following protected healthcare information.

Records requested from:

Facility: ____

Address: ____

Phone: __________________________ Fax: ________________________

Release records to:

Facility: ____

Address: ____

Phone: __________________________ Fax: ________________________

___ Entire Record ___ Radiology reports ___ Progress notes ___ H&P
___ Lab reports ___ Other

This authorization shall be valid for one year from the date signed at which time this authorization to use or disclose protected health information expires. I understand that I have to right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that the facility has taken action in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclose by the recipient and may no longer be protected by federal or state law. The facility will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested service.

____

Patient Signature or Authorized Representative Date of Birth Today's Date

______________________________ ______________________________

Printed Name Relation to Patient

Patient SS#: ______________________ Received by: ______________________

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Notice of Privacy and Practice Policies

I acknowledge that I have read and agree with Seaside Primary Care and Psychiatry, LLC DBA Seaside Wellness notice of Privacy and Practice Policies as it pertains to Privacy of Individualized Consent and Authorization.

Print Name: ____

Signature: ______________________________ Date: ________________

PATIENT HISTORY FORM

Date: ______/________/________

NAME: ______________________________________ Birthdate: _____/_____/_____
Last First M. I.

Age:__________ Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Physician initials _______

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) ____________
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ☐High school ☐Some college ☐College graduate ☐Advanced degree

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ☐ Yes ☐ No Hours/week ______ If not, are you ☐ retired ☐ disabled ☐ sick leave?

Do you receive disability or SSI? ☐ Yes ☐ No If yes, for what disability & how long?____________

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

Physician initials ______

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

Physician initials _______

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes ☐ No ☐
CANNABIS: Marijuana, hashish, hash oil					Yes ☐ No ☐
STIMULANTS: Cocaine, crack					Yes ☐ No ☐
STIMULANTS: Methamphetamine—speed, ice, crank					Yes ☐ No ☐
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes ☐ No ☐
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes ☐ No ☐
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes ☐ No ☐
HEROIN					Yes ☐ No ☐
STREET OR ILLICIT METHADONE					Yes ☐ No ☐
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes ☐ No ☐
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes ☐ No ☐
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes ☐ No ☐
OTHER: specify)________					Yes ☐ No ☐

Physician initials _______