PRISAT, PA
3685 Crown Point Court
Satyen P. Madkaiker, M.D. & Staff Jacksonville, FL 32257-5967

PATIENT INFORMATION

Today's date					
Patient's full name	Nickname?				
Date of birth		Sex	___ Male ___ Female		
Social Security #					
Marital status	___ Single ___ Married ___ Divorced ___ Widow/ Widower				
Student information	___ Not student ___ Student/part-time ___ Student/full-time				
Home address					
(cont … city, state, zip)		County			
Day phone number		OK to leave message?	___ Yes ___ No		
Evening phone number		OK to leave message?	___ Yes ___ No		
Cell phone number		OK to leave message?	___ Yes ___ No		
Driver's license #		State issuing license			
Language(s) spoken:		Religion			

EMERGENCY CONTACT INFORMATION

Emergency contact	
Emergency contact's phone	
Emergency contact's relationship to you	

EMPLOYMENT INFORMATION

Employer	
Occupation	
Business phone	Ext:
Employer's address	

(city, state, zip)	

PATIENT GENDER INFORMATION

Please check one of the following:

_____ Male
_____ Female
_____ Transgender Male / Transgender Man / Female-to-Male
_____ Transgender Female / Transgender Female / Male-to-Female
_____ Genderqueer, neither exclusively Male nor Female
_____ Additional Gender Category / Other
_____ Decline to answer

PATIENT SEXUAL ORIENTATION

Please check one of the following:

_____ Straight / Heterosexual
_____ Lesbian / Gay / Homosexual
_____ Bisexual
_____ Something else
_____ Don’s know
_____ Decline to answer

INSURANCE INFORMATION

Are you self-pay or insured?	___ Self-pay. Please continue to next page. ___ Insured. Please complete the next section(s).

PRIMARY INSURANCE

Does your insurance require referral or pre-authorization PRIOR to your visits?
If Yes, check here____ If No, skip this section
Authorization #_____ #of sessions_____
Authorized services through _____(date)

It is **YOUR** responsibility to check with your insurance regarding pre-authorization or referral **BEFORE** your appointment begins. If your insurance does not pay because **YOU** did not obtain pre-authorization or referral, **you** will be responsible for the full amount due.

Relationship to insured	___ Self ___ Spouse/Partner ___ Child ___Other:		
Insurance name			
Policy/contract/ID #		Group #	

SECONDARY INSURANCE

Relationship to insured	___ Self ___ Spouse/Partner ___ Child ___Other:		
Insurance name			
Policy/contract/ID #		Group #	

AUTHORIZATIONS / AGREEMENTS

Please read the following, initial each line, and sign below:

_____ I understand that for all medication refills, I am expected to make an appointment to be seen by my provider. I understand that medications will not be called in to a pharmacy or approved by fax without being seen. I understand that for certain medications, I have the choice of being discharged from the care of PRISAT, PA into the care of my PCP ("Primary Care Physician").

_____I understand that payment in full is due at time of service for all copays / coinsurance / deductibles that are my responsibility and that if I arrive without full payment, I will not be seen and my appointment will be rescheduled. I understand that if my insurance company fails to pay my balance in full, or there is no payment within 90 days, it is my responsibility to pay the bill directly to PRISAT, PA.

_____I authorize PRISAT, PA to bill my insurance company(ies) directly for services provided. I authorize payment of any insurance benefits payable to me to be paid directly to PRISAT, PA. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to PRISAT, PA. I authorize PRISAT, PA to release or receive any information necessary to expedite insurance claims. I understand that I am directly and fully financially responsible to PRISAT, PA for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover THR fee.

_____I understand that a consultant report may be forwarded to my PCP ("Primary Care Physician") and/or my referral source for my medical record. If I have been referred by an EAP ("Employee Assistance Program"), communication may be given to my EAP, if requested by them.

_____I understand that if I fail to keep my appointment, or do not cancel 24 hours prior my appointment, I shall be charged a $25 no show/late cancellation fee for the medical doctors and $55 no show/late cancellation fee for the therapists.

_____I understand that there will be a $35 charge on all returned checks and that if a check is returned, I will lose check writing privileges at PRISAT, PA.

_____I understand that if I am on the Suboxone (Buprenorphine) Treatment Program, that NO CHECKS will be accepted. (Forms of payment accepted will be: cash, credit, or money order).

_____I understand that I will be charged for non-emergency calls answered by the answering service. The charge is $5.00 per call for calls received Monday through Friday and the charge is $15.00 per call for calls received on Saturday, Sundays, and holidays.

_____I understand that the charge for having paperwork completed is $15.00 for the first page and $10.00 for each page thereafter.

_____I have received a copy of the "Notice of Privacy Practices" and I have been provided an opportunity to review it.

_____I understand that a photocopy of these authorizations / agreements shall be as valid as the original.

Patient Signature _____ Date _____

Parent / Guardian Signature _____

NOTICE OF PRIVACY PRACTICES

PATIENTS – PLEASE RETAIN THESE TWO PAGES FOR YOUR RECORDS.

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.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us To:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is not in effect.

We Have the Right To:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assistant in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting accreditation, certificates, licenses, and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name, your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing of information that describes you in general, not personal, terms and dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposed in limited circumstances where the

research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, or Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety of the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers' Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations of proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the forms you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $1.00 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations, and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the changes and to include the changed in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at this office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or think that we may have violated your privacy rights, please contact us at: Privacy Office; PRISAT, PA; PO Box 24331; Jacksonville, FL 32241-4330. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PATIENT MEDICAL INFORMATION

Patient's name		Today's date	
Primary Care Physician		Phone	
Who referred you to us?		Phone	
Pharmacy name		Phone	

Previous Psychiatric Treatment? If yes, list doctors and/or facilities	

Please list any illnesses for which you have received treatment in the past 5 years	

Please list any medications you are currently taking	

If additional room is needed, please use back side of this page!

Intake Questionnaire – Adults

Name: _____ Date: _____

Put a check next to any of the following that have been a significant problem for you during the past month:

_____ Difficulty with getting things organized
_____ Frequency procrastination of important tasks
_____ Forgetting important things
_____ Being easily distracted by noise or activity around you
_____ Feeling restless or fidgety
_____ Feeling easily bored
_____ Irritability or impatience
_____ Worrying too much
_____ Muscle tension
_____ Feeling overwhelmed
_____ Feeling sad or down
_____ Lack of pleasure in activities
_____ Fatigue and/or low energy
_____ Difficulty falling asleep
_____ Guilt
_____ Difficulty staying asleep
_____ Low self worth
_____ Anxiety attacks and/or panic attacks
_____ Feeling that your mind is moving too fast
_____ Acting impulsively
_____ Intrusive thoughts about traumatic experiences
_____ Feeling embarrassed too easily
_____ Substance abuse
_____ Alcoholism
_____ Other problems (describe): _____
_____
_____

Describe the problem(s) you most want to help you with: _____
_____
_____
_____

List any allergies you may have:: _____
_____
_____
_____

PATIENT CONTACT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS:

___ VOICE MESSAGE: (_____) _____ - _____

___ TEXT MESSAGE: (_____) _____ - _____

___ EMAIL ADDRESS: _____

I CONSENT TO BE CONTACTED FOR MY APPOINTMENTS VIA THE ABOVE CONTACT METHOD.

_____

_____

PATIENT SIGNATURE DATE