Patient Information Facesheet

Name: _____

First Middle Last

Address: _____

Street Apartment #

_____

City State Zip

Date of Birth: ___/___/_____ **Age:** ____ **M**__ **F**__ **Social Security Number:** _____-_____-_____

Phone: ( ) _____ **Work** ( ) _____ **Cell** ( ) _____

Email: _____

Marital Status: _____ **Employment Status:** Y___ **N**___ **Disabled** ____**Student**____

Employer Name: _____

Responsible Party: _____

Name Address

_____

Relationship Employer Phone

Primary Insurance: _____**ID Number:** _____

Group Number: _____ **Name of Insured:** _____

DOB: _____ **Insured Social Security Number:** _____-_____-_____

Secondary Insurance: _____ **ID Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

MAY WE CONTACT YOUR PCP REGARDING YOUR CARE OR ANY CONCERNS WE MAY HAVE? Y__ **N**__

Emergency Contact: _____

Name Address Phone Number

Pharmacy Name/ Phone Number: _____

Medical History:

_____

_____

_____

Please List Any Allergies: _____

Please list previous psychiatric/psychological treatment, physicians or hospitals:

_____

_____

_____

All Medical information pertaining to the patient is strictly confidential. If you would like us to disclose any medical information to a family member or other physician, you must complete an Authorization to release Medical Information Form.

Financial Responsibility:

I, undersigned, understand that I am responsible for payments for any service rendered, regardless of whether this service is covered by an insurance policy. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. Which may include: AIDS, HIV, and SEXUALLY TRANSMITTED DISEASES AND SUBSTANCE ABUSE.

Consent to Treatment:

I hereby consent to examination and treatment by The Center For A Healthy Mind And Wellbeing, and Marcus De Carvalho, M.D. I affirm that I am of legal age and otherwise competent to consent to medical treatment. If not, the person signing below is the parent, legal guardian or person otherwise allowed by law to consent to the treatment of the patient. Their signature represents consent for treatment by The Center For A Healthy Mind And Wellbeing, and Marcus De Carvalho M.D.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature _____ **Date**_____

Printed Name_____

The Center For A Healthy Mind And Wellbeing Policies

1. **All co-pays, deductibles and co-insurance and balances are due at the time of services (accepted payment) CASH /CREDIT CARD/CHECK/MONEY ORDER. If you have a balance, you will be required to pay it in full prior to being treated in the office.**
2. Cancellations and No-Shows with less than 24 hours' notice are subject to the full charge of $50.00 for this service. (Subject to change according to each appointment).
3. In event I receive direct payment from my insurance provider; I agree to endorse payment to The Center For A Healthy Mind And Wellbeing.
4. I understand that I am financially responsible for all charges regardless of insurance coverage.
5. A charge will be assessed for preparation of all FORMS and LETTERS ATTORNEY FEES or COLLECTION AGENCY FEES applied to your account balance.
6. I agree to provide The Center For A Healthy Mind And Wellbeing with a release of information to access previous medical, psychiatric, and psychological records so that he/she can make informed decisions regarding my care.
7. I understand that at our first visit with the Center For A Healthy Mind And Wellbeing is acting as a consulting physician and reserves the right to direct me to more appropriate treatment if he/she feels that he/she is unable to provide me with the care I require.
8. I agree to participate in the information of the treatment plan and to the best of my abilities follow the treatment plan. I will consult The Center For A Healthy Mind And Wellbeing for making any changes in the treatment plan e.g. discounting medications or changing doses. I will obtain requested labs and studies in a timely fashion as they are meant for my safety.
9. **I will treat The Center For A Healthy Mind And Wellbeing, the office staff and other patients with respect. I will refrain from yelling or using obscene language while at The Center For A Healthy Mind And Wellbeing.**
10. Normal business hours are from 9:00 a.m. to 4:30 p.m. The office will be available during these hours to return phone calls. In non-emergent cases The Center For A Healthy Mind And Wellbeing will make their best effort to return your phone call within 24 hours.
11. After hours and on holidays Dr. De Carvalho will be available by telephone on an emergent basis only. Emergencies include but are not limited to adverse reactions to medications, threat of harm to self/other, acute change in behavior or mental status.
12. If you believe you have a life-threatening emergency it is imperative that you access emergency care in a timely fashion. Please call 911 and initiate access to emergency treatment prior to attempting to contact Dr. De Carvalho.
13. As a general rule, Dr. De Carvalho **DOES NOT CALL-IN PRESCRIPTIONS TO PHARMACIES**. It is the patient's responsibility to make sure that they have enough medication to last until their next appointment. You may have your pharmacy fax a refill request for approval for mediation and refills. Please allow 48/72 hours for refills.

I HAVE READ AND AGREE TO ABIDE BY DR. DE CARVALHO OFFICE POLICIES

_____ _____

Signature **Date**

_____

Printed Name

**** If you have anyone you would like to add to your consent list please request a form from the front desk.**

Patients' Rights

I have the right

A. To receive medical care with respect for cultural ethnic identity, religion, gender, age, marital status, disability, source of payment and sexual preference.
B. To have my treatment and personal information kept private.
C. My records may not be released without member permission, unless required by law.
D. To a physical environment that is safe, sanitary and conducive to effective treatment, which appropriately safeguards the privacy and confidentially of doctor/patient program.
E. To easy access to care in a timely fashion, treatment choices with regard to cost or coverage by my insurance plan.
F. To participate in the development of my plan of care with regards to my needs.
G. To information pertaining to my insurance and their role in the treatment process.
H. To information regarding clinical guidelines used in providing and managing my care.
I. To obtain my doctors medical training and work history.
J. To knowledge about advocacy and community groups and prevention services
K. To resources available for communicating to make concerns/questions and or resolving disputes, conflicts or grievances.
L. To knowledge about the laws that relate to my rights and responsibilities in the treatment process.
M. To resources available for communication to make concerns/questions and or resolving disputes, conflicts or grievances.
N. To knowledge about the laws that relate to my rights and responsibilities in the treatment process.

Family History

Please indicate if any of the following family members have a current or past problem with the following conditions:

	Mother	Father	Maternal Grandparents	Paternal Grandparents	Other
Alcoholism					
Drug Addiction					
Depression					
Anxiety					
Thyroid Disease					
Diabetes					
Asthma					
Seizures					
Mental Illness					
Other					

Please list any other pertinent information about yourself: _____

_____

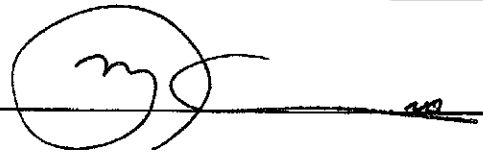
THE CENTER FOR A HEALTHY MIND AND WELLBEING

Marcus De Carvalho, M.D. has educated me regarding the medication that has been prescribed for me. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that could occur and the possible effects of this medication if the person taking it becomes pregnant. I have also been informed of the reason this medication has been prescribed.

If the person for whom the medication has been prescribed is under the age of eighteen (18) or is unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or am legally authorized to initiate and consent to treatment on behalf of this person.

Client Name: _____

Client/Guardian/Legal Representative Signature: _____

Provider Signature: _____ 

Date: _____

- It is recommended that women who are or may become pregnant, or are breast-feeding, discuss this with their doctor **before** taking **any** medication.
- It is recommended that clients be educated on reporting all side effects they experience, including but not limited to, which side effects to report **immediately** to a health care provider.
- It is recommended that any provider prescribing medication obtain a thorough client history, including but not limited to:
  - ✓ What medication, included prescribed and over –the-counter medications, the client is or has been taking,
  - ✓ What food and/or drug allergies the client has,
  - ✓ What medical conditions the client has.

All patients on ADD or ADHD medications must be rechecked in our office every 1 to 3 months to ensure proper symptom management on the mediation. The medications used to treat this diagnosis are most often controlled substances. So we ask that you abide by the office policies and keep your scheduled appointment.

1677 Wells Road Suite A Orange Park, Fl. 32073 P(904)272-0043 F(904)269-4978

6817 Southpoint Parkway Suite 2402 Jacksonville, Fl. 32216 P(904)527-8777 F(904)379-5744