PATIENT INFORMATION FACESHEET

6817 Southpoint Parkway Suite 2402, Jacksonville, FL 32216
1677 Wells Road Suite A, Orange Park, FL 32073
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Orangepark@healthymindmd.com
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Dr. Marcus De Carvalho, M.D.

PERSONAL INFORMATION

First Name: _____ MiddleName: _____ Last Name: _____

Address: _____ APT/UNIT # _____

City: _____ State: _____ Zip: _____

Gender ☐ Male ☐ Female Date of Birth: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y) Age: ☐☐

Email: _____ Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Phone: ☐☐☐-☐☐☐-☐☐☐☐ Work: ☐☐☐-☐☐☐-☐☐☐☐ Cell: ☐☐☐-☐☐☐-☐☐☐☐

Marital Status: _____ Employment Status: ☐ Yes ☐ No ☐ Disabled ☐ Student

Employer Name: _____

Resposible Party Name: _____ Relationship: _____

Address: _____ Employer: _____ Phone: ☐☐☐-☐☐☐-☐☐☐☐

Primary Insurance: _____ ID Number: _____

Group Number: _____ Name of Insured: _____

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

Secondary Insurance: _____ ID Number: _____

Primary Care Physician: _____ Phone: ☐☐☐-☐☐☐-☐☐☐☐

MAY WE CONTACT YOUR PCP REGARDING YOUR CARE OR ANY CONCERNS WE MAY HAVE? ☐ Yes ☐ No

Emergency Contact: _____ (NAME) _____ (ADDRESS) _____ (PHONE NUMBER)

Pharmacy Name/Phone Number:

Medical History:

Please List Any Allergies:

Please list any previous psychiatric/psychological treatment, physicians, or

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 company. I authorized the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. Which may include: AIDS, HIV, and SEXUAL 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. No-Shows and Cancellations with less than 24 hours' notice are subject to the full charge of $85.00 for Medication Management and $85.00 for Therapy services. (Subject to change according to each appointment).
3. In the event that 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 and 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. PLEASE INITIAL HERE** _____
10. Normal Business hours are Monday-Thursday from 9:00 a.m. to 4:30 p.m. and Friday 10:00 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.

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 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 doctor's 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.

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:

2020 Treatment Consent and Policies

Prescriptions

Dr. De Carvalho and Associates provides refills and renews prescriptions only during appointments. Plan your visits to be on a **monthly** basis unless otherwise arranged. He does not approve refill requests from pharmacies outside of an appointment. **Do not ask your pharmacy to send a request.** This policy reduces prescription errors, improves patient safety, encourages appropriate follow-up and also improves compliance with new state laws governing controlled substances. You will receive enough medication or refills to last until your next recommended follow-up appointment.

A fee of $25.00 per prescription will be applied to your balance when you request between-visit refills or loss prescription refills. After your request has been approved by Dr. De Carvalho and or Associates and payment has been made, then refills are sent to the pharmacy. If refills are requested between appointments you will not receive a call back by the office. Trust that your message was received and check with your pharmacy 24 hours after request but allow up to 72 hours before phoning the office.

Medication refills will only be addressed during business hours Mon-Thurs (9am-4:30pm) Friday (10am- 3pm) No prescriptions will be refilled on Saturday, Sunday or Holidays. Approval of your refill may take up to three business days.

It is important to keep your scheduled appointments. Repeated no shows, cancellations, or late arrivals will result in denial of refills and put you at risk for termination.

Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The provider and the pharmacies are familiar with this process and will handle it as quickly as possible. Only the pharmacy is notified of approval status. Please check with your pharmacy or insurance company for updates.

New symptoms or events require a clinic appointment. Dr. De Carvalho and Associates do not diagnose or treat over the phone unless it is a pre-arranged phone visit.

Dr. De Carvalho and Associates only treats within the purview of psychiatric medicine. Please seek help from your primary care or urgent care providers for other health care needs.

Your healthcare is your responsibility. Please be proactive in your care and track how much medication you have and how many refills remain on the prescription. It is recommended that you make a follow-up appointment **Before** leaving so that your time is secured. A $50.00 fee will be applied to your balance for emergency appointments due to running out of medication.

_____**(initial)**

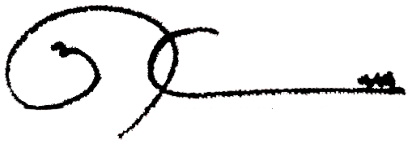
THE CENTER FOR A HEALTHY MIND AND WELLBEING

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/Gurdian/LegalRepresentative 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 talking,
  ✓ What food and/or drug allergies the client has,
  ✓ What medical conditions the client has.

All patients on ADD or ADHD medication must be rechecked in our office every 1 to 3 months to ensure proper symptom management on the medication. 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.

OUR OFFICES
1677 Wells Road Suite A Orange Park, FL. 32073 - (904) 272-0043 Fax(904) 269-4978
6817 Southpoint Parkway Suite 2402 Jacksonville, FL. 32216 - (904) 527-8777 Fax(904) 379-5744