



Mental Health Center of Florida  
We Help You Be You. Improved.

**PATIENT INFORMATION (ADULT)**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City/State Zip

EMAIL: \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ MEDICAL DOCTOR: \_\_\_\_\_

DATE OF PREVIOUS COUNSELING: \_\_\_\_\_

MEDICATION PRESENTLY TAKING: \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City/State Zip

**SPOUSE/FAMILY INFORMATION**

SPOUSE'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

Email: \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City/State Zip

CHILDREN'S NAMES AND AGES \_\_\_\_\_

NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**MHCFlorida.com**

1848 SE 1<sup>st</sup> Ave. Fort Lauderdale, FL 33316 | T 954.885.9500 | F 954.885.9444  
184 Treemonte Drive Orange City, FL 32763 | T 407.479.3050 | F 407.479.3052  
Our Affiliates: VisitingMentalHealth.com • DrAnnMonis.com



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### INSURANCE INFORMATION

ChildNet

Information Below

Self-pay

INSURANCE CO. \_\_\_\_\_ POLICY# \_\_\_\_\_

ADDRESS \_\_\_\_\_

GROUP # \_\_\_\_\_ PHONE# \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

Fees for services are to be paid at the time services are rendered unless prior arrangements are made. If unable to keep your appointment, kindly give 48 hours notice; otherwise, you will be billed for the time reserved for you.

I authorize **MHC of Florida** to render necessary treatment. I authorize payment of medical benefits to **MHC of Florida** for service rendered unless prior approval has been arranged. I have read and understand the above and agree to pay for all treatment rendered, including, but not limited to, all office visits and tests expenses.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
PATIENT NAME (printed)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RESPONSIBLE PARTY  
SIGNATURE

\_\_\_\_\_  
RESPONSIBLE PARTY  
NAME (printed)

\_\_\_\_\_  
DATE

### CANCELLATION/ OFFICE NO SHOW POLICY

Fees for services are to be paid at the time services are rendered. If unable to keep your appointment kindly give 24 hours notice; otherwise, you will be billed \$15.00 for the time reserved for you.

\_\_\_\_\_  
Signature of Acknowledging Party

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## Authorization for Evaluation and/or Treatment

### ADULT

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Location: \_\_\_\_\_

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological, psychiatric and potential psychotropic medication management) evaluation and/or treatment by staff from Mental Health Center of Florida. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

- a. The benefits of the proposed treatment
- b. Alternative treatment modes and services
- c. The manner in which treatment will be administered
- d. Expected side effects from the treatment and/or the risks of side effects from medications, including psychotropic (when applicable).
- e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, an advanced registered nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Florida Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Mental Health Center of Florida, and I consent to disclosure for use by Mental Health Center of Florida staff for the purpose of continuity of my care. Per Florida mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

6. **Expiration of Consent:** This consent to treat will renew every 12 months unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Printed Name of Responsible Party

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

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### RELEASE OF INFORMATION

I \_\_\_\_\_, hereby give permission for Mental Health Center of Florida to share, receive, or exchange all pertinent information that will assist in my care, as indicated below:

**Check all that apply:**

Get from:	Give to:	Exchange with:	<b>How we handle your information</b> (Please provide name and contact information):
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Facility: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Treating Physician: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Supervising Physician: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attorney: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ChildNet: _____

Other (Please provide information and explain):

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## **AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION**

To: Any and All Treating Health Care Practitioners or Facilities:

This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Law) found at 45 CFR, Part 164.

This document authorizes any and all licensed health care practitioners, including but not limited to: physicians, nurses, therapists, social workers, counselors, dentists, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, medical attendants and other persons who have participated in providing any health care or service to me, to discuss any communication, whether confidential or privileged, and to provide full and complete patient reports and records justifying the course of treatment including but not limited to: patient histories, x-rays, examination and test results, HIV, mental health, drug abuse treatment, psychiatric and psychological records, reports or information prepared by other persons that may be in your possession and all financial records, to the Department of Health (or any official representative of the Department) pursuant to Section 456.057, Florida Statutes. This document provides full authorization to the Department of Health (or any official representative of the Department) to use any of the aforementioned reports and information for reproduction, investigation or other use for licensure or disciplinary actions and civil, criminal or administrative proceedings, as needed by the Department and may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws and regulation.

By signing below, the patient understands, acknowledges and authorizes the Department to release their identity and medical records to law enforcement and other regulatory agencies in appropriate circumstances at the Department's discretion.

**A photocopy of this document is as sufficient as the original.**

I understand that this authorization may be revoked upon my written request except to the extent that action has already been taken on this authorization.

Patient Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Authorized Person Other than Patient (Print): \_\_\_\_\_

Signature of Authorized Person Other than Patient: \_\_\_\_\_

Witness Name (Print): \_\_\_\_\_ Witness Signature: \_\_\_\_\_

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## NOTICE OF PRIVACY PRACTICES

### ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of Mental Health Center of Florida*. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

If you have any questions about our *Notice of Privacy Practices*, please contact our office at:

Mental Health Center of Florida  
1848 SE 1<sup>st</sup> Ave. Fort Lauderdale, Florida 33316  
1 (800) 771-2165 (toll free)

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at the above address.

I acknowledge receipt of the *Notice of Privacy Practices* of Mental Health Center of Florida

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient/parent/conservator/guardian)

I acknowledge receipt of the *Notice of Privacy Practices* of Mental Health Center of Florida

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient/parent/conservator/guardian)

### INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: \_\_\_\_\_ Date: \_\_\_\_\_

An acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:  
\_\_\_\_\_
- There was a medical emergency (the staff member will attempt to obtain acknowledgement at the next available opportunity).

Other reason(s): \_\_\_\_\_

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