Behavioral Collaborative Care Solutions
9010 SW 137 Ave. STE 111 Miami, FL 33186 Office: 305-671-3503 Fax: 305-671-3505
www.behavioralccs.com Info@doctorsccs.com

Patient Information Form

Date:_____

Patient Name: _____ **DOB:** ___/____/_____

If patient is underage of **18 yrs** old, **responsible party must complete remainder of this section.**

Name of Responsible **Party:** _____

Home Phone #_____ **Cell Phone #**_____ **Work Phone #**_____

Email Address:_____ Social Security#_____

Home Address: _____ Apt#_____

City: _____ State: _____ Zip Code: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Emergency Contact:_____Phone#_____

Relation to Patient:_____

Primary Care Physician_____Phone#_____

INSURANCE INFORMATION / FINANCIAL RESPONSIBILITY (**PLEASE ATTACH PHOTOCOPY)**

Primary Payer:_____ **Member ID#**_____

Subscriber's Full Name: ☐ **Same as patient** ☐ **Other Name:**_____ **DOB**_____

Medicare ID#_____ **Medicaid** ID#_____

INSURANCE ASSIGNMENT AND SELF PAY AGREEMENT
AUTHORIZATION TO RELEASE

I certify that I have insurance cove rage with the primary insurance company, if applicable; and the secondary insurance payer, if applicable, listed above. I assign directly to "Behavioral Collaborative Care Solutions, LLC (BCCS) (including Hernan Pabon M.D, Oscar Pozo M.D., Octavio Alfonso APRN, Albert Garcia APRN, Adriana Aristizabal, APRPN , Steven Krywinski, PhD, or any clinician with the BCCS group), all insurance payment s, if any, otherwise payable to me for services rendered. I understand I am financially responsible for deductible, co-payments, co-insurance, missed appointment fees, non-covered charges, and any and all balances not covered under a contractual agreement between " Behavioral Collaborative Care Solutions, LLC" and my insurance or other third party payer. I authorized the use of my signature for all insurance submissions. I request that payment of authorized Medic are benefits and, if applicable, Medigap benefits, be made on my behalf to "Behavioral Collaborative Care Solution s, LLC" for any services furnished to me by that provider.

If Self Pay, I understand it is my responsibility to pay for services rendered at time of visit.

I understand and agree that "Behavioral Collaborative Care Solutions LLC" may use my health care information to the above named insurance payer(s) and their agents for the purpose of obtaining payment for services and determining insurance benefit s or the benefits payable for related services. I understand that if an authorization is needed from my insurance plan, it is my responsibility to obtain such authorization on and provide this to BCCS.

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

X_____

Print Name of Patient, Parent, Guardian or Personal Representative

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The following information is provided by: ☐ Patient (self) ☐ Parent ☐ Family member:_____ ☐ Other:_____

Birthplace (City and State): _____

Current Housing Situation: ☐ Living alone ☐ Living with spouse ☐ Living with partner ☐ Living with roommate(s)
☐ Living with parents ☐ Living with brother/sister ☐ Living with aunt/uncle ☐ Living with grandparent·

How many in household, including yourself? _____

Advanced Directives:
☐ None ☐ Do Not Resuscitate ☐ Living Will ☐ Durable Power of Attorney (provide copy) ☐ Healthcare Proxy (provide copy)

1. Chief Complaint: What is the reason for your visit?

☐ Addiction
☐ ADHD
☐ Anger/Temper
☐ Anxiety
☐ Bipolar
☐ Binge Eating
☐ Concentration is poor
☐ Confusion
☐ Depression
☐ Energy level decreased
☐ Grief
☐ Guilt
☐ Hallucinations
☐ Other, please explain: _
☐ Helpless
☐ Hopeless
☐ impulsivity
☐ Irritability
☐ Isolation
☐ Mania
☐ Medication Effects
☐ Memory problem
☐ Obsession/ OCD
☐ Panic Attacks
☐ Paranoia
☐ Parkinson's
☐ Phobia
☐ Self-injury
☐ Suicidal Thoughts
☐ Tearfulness
☐ Worthlessness

_____

_____

_____

STRESSORS:

☐ Disability
☐ Divorce
☐ Education Problems
☐ Other: _____
☐ Family
☐ Financial Problems
☐ Health Problems
☐ Housing Problems
☐ Limited Resources
☐ Marriage
☐ Peer/ Friendship
☐ Support System
☐ Work Issues

Personal Strengths, Abilities, Skills, Motivation (list all that apply to the patient's current state):

_____
_____
_____

2. Psychiatric History:

Have you ever been treated for mental health/psychiatric conditions/ psychotherapy? ☐ YES, ☐ NO Next question #3

If YES, then answer the Inpatient and/ or Outpatient Treatment History tables below.

If NO, t hen skip to next question #3.

INPATIENT Psychiatric TREATMENT HISTORY IN HOSPITAL or PARTIAL Hospitalization

Facility Name	Dates of Treatment	Reason or Explanation of this treatment
Name: City, State Phone ( ) - Fax ( ) -		
Name: City, State Phone ( ) - Fax ( ) -		
Name: City, State Phone ( ) - Fax ( ) -		

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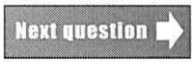
OUTPATIENT Psychiatric/ Mental Health/ Psychotherapy TREATMENT HISTORY·

Psychiatrist/ APRN / Therapist / Other Mental Health	Dates of Treatment	Reason or Explanation of this treatment
Name: City, State Phone ( ) - Fax ( ) -		o Medication Management to treat _____ o Psychological Testing o Therapy (_Individual _ Family _Group) o Additional Explanation:
Name: City, State Phone ( ) - Fax ( )		o Medication Management to treat _____ o Psychological Testing o Therapy (__Individual _ Family _Group) o Additional Explanation:
Name: City, State Phone ( ) - Fax ( ) -		o Medication Management to treat _____ o Psychological Testing o Therapy (__Individual _ Family _Group) o Additional Explanation:

3. Substance Abuse History:

Have you ever been treated for alcohol or drug use and/or ab use? □ YES, □ NO 

#3a

If YES, then complete the Treatment History table below.

INPATIENT and/or OUTPATIENT SUBSTANCE ABUSE TREATMENT HISTORY:

Facility Name	Dates of Treatment	Reason or Explanation of this treatment
Name: City, State Phone ( ) - Fax ( ) -		
Name: City, State Phone ( ) - Fax ( ) -		

3a. Complete the table below regarding the following substances:

Substance	Have you ever tried before?	Age Started	Last used on this approx. date	Frequency of use	Lost Control?	Comments
Caffeine (coffee, tea. cola's)	☐ Yes ☐ No					
Cigarettes, cigars or tobacco	☐ Yes ☐ No					If you quit smoking, when did you quit?
Cocaine	☐ Yes ☐ No					
Hallucinogens (LCD, mushrooms, Mescaline)	☐ Yes ☐ No					
Heroin	☐ Yes ☐ No					
IV Drug use	☐ Yes ☐ No					
Marijuana	☐ Yes o No					
Medical Marijuana	☐ Yes o No				If currently using medical marijuana, what doctor or facility do you go for treatment?	
Pain Pills	☐ Yes o No					
Other :	☐ Yes ☐ No					

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3b.) Alcohol Use: Have you ever tried before?

□ Yes (See additional questions below) □ No (then continue to next Section- 3c)

What age did you start alcohol use?_____ When did you last drink alcohol? _____

How often do you have a drink containing alcohol?

□ Never □ Monthly or less □ 2-4 times a month □ 2-3 times a week □ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

□ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more

How often do you have six or more drinks on one occasion?

□ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

Periods of Abstinence:_ _

Comment s or more information about your alcohol history that you want to share?

_____
_____
_____

Withdrawal Symptom	Have you experienced?	What Substance(s)?
Anxiety	☐ Yes ☐ No	
D.T's (delirium tremens)	☐ Yes ☐ No	
Seizures	☐ Yes ☐ No	
Sweating	☐Yes o No	
Tremors	☐Ye s ☐ No	
Tachycardia	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	

3c.) Have you experienced any withdrawal symptoms and on what substance(s)? Please explain

_____
_____
_____
_____

SMOKING STATUS:

□ Current every-day smoker
□ Current smoker
□ Current some day smoker
□ Former smoker
☐ Never Smoker
☐ Unknown, if current smoker
☐ Unknown, if ever smoker

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4. Medical History:

Please check beside any illness/ medical condition you have now or have had in the past:

□ Arthritis	□ Chronic Pain	□ Liver Disease	□ Stomach Problems
□ Blood Disorders	□ Diabetes	□ Lung Disease/Breathing problems	□ Stroke
□ Bowel Problems	□ Glaucome/ Vision Problems	□ Migraines	□ Thyroid Disease
□ Cancer	□ Heart Attack	□ Seizures/ Epilepsy	□ Ulcer
□ Chest Pain	□ Hepatitis	□ Other, Please explain: _____	

High Blood Pressure:

□ Yes □ No

Are you currently on medication for your high blood pressure?

_____

_____

_____

High Cholesterol:

□ Yes □ No

Are you currently on medication for your high cholesterol?

_____

_____

_____

Date of your most recent blood work?_____

*** Where?** □ LabCorp □ Millennium Physlab □ Quest Diagnostics

**** We kindly ask that you provide a copy of your most recent blood work lab results with this document or have them fax it to us.***

Have you ever had an EKG? □ No □ Yes, When: _____

Was the EKG: □ Normal □ Abnormal □ Unknown

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SURGICAL PROCEDURES: **Type of Injury/Accident** **Date Occurred**

SERIOUS INJURIES OR ACCIDENTS: **Type of Injury/Accident** **Date Occurred**

ALLERGIES:

Food / Medication Allergy	Type of Reaction

PAST PSYCHIATRIC ONLY MEDICATIONS YOU HAVE TRIED AND ARE NO LONGER TAKING:

Past Psychiatric Medications you have tried	Dose (mg: Tablets or Capsules or other dose type)	Frequency	Date Started	Date Stopped	Reason for Stopping
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed			
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed			
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed			
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed			
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed			
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed			
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed			
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed			
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed			

CURRENT PSYCHIATRIC MEDICATIONS: COMPLETE LIST OF ALL CURRENT MEDICATIONS

Current Medications	Dose (mg: Tablets or Capsules or other dose type)	Frequency	Last dose taken
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed	
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐ PM ☐ As needed	
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐PM ☐ As needed	
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐PM ☐ As needed	
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐PM ☐ As needed	
	☐ mg (_ TAB _ CAP)	x day ☐ AM ☐PM ☐ As needed	

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5. Family History

Has anyone in your family ever been treated for any of the following? Place and 'X' where appropriate.

Illness	Fat her	Mother	Brother	Sister	Children	Aunt		Uncle		Grandparent	
						Father's side	Mother's side	Father's side	Mother's side	Father's side	Mother's side
ADHD											
Alzheimer's Disease											
Anxiety/ Panic Attacks											
Bipolar Disorder											
Depression											
Heart Disease											
Schizophrenia											
Seizures											
Stroke											
Substance Abuse											
Suicide Attempts											

NUTRITIONALASSESSMENT: Height: _____ Current Weight:_____

Without wanting to, have you lost / gained more than 10 pounds within the last 6 months? o YES o NO

If YES,

Amount Weight Lost:_____ Amount Weight Gained:_____

Sleep Patterns: Hours each night:_____ o Awakens Frequently o Difficulty returning to sleep o Difficulty falling asleep

FUNCTIONAL ASSESSMENT:

Have you experienced a recent loss of independence in caring for yourself? o YES o No

If YES, please explain:_____

FOR WOMEN ONLY:

Date of last menstrual period:_____

Are you currently pregnant? o YES o NO Are you planning to get pregnant in the near future? o YES o NO

Birth control method:_ _

Comments - In your own words, please describe why you have sought services with us?

_____

_____

_____

Do you have any history of Trauma (i.e. sexual, verbal, physical abuse)?

_____

_____

_____

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Welcome to Behavioral Collaborative Care Solutions, LLC (BCCS). This document contains important information about our professional services and business policies. Please read it carefully and note any questions you may have for them be discussed at our next meeting.

This consent packet constitutes a binding agreement between us.

The philosophy of our practice it to combine psychiatry (medication management) and psychotherapy *to* teach the client how to identify the thinking that leads to feelings and behaviors that may be unhealthy and/or self-defeating. Psychotherapy has been shown *to* have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. However, there are no guarantees about what will happen.

Late cancellations and no shows

This policy has been established in order to provide the highest-level Service to all our patients. It has been proven that consistent attendance provides for the greatest opportunity for success. By providing us notice of a cancellation, we may be able to accommodate other patients with your appointment slot.

- Patients must call at least 24-hours prior to their scheduled time, when they knowingly are unable to make their appointment. Cancellations within 24-hours of appointment will be considered a late cancellation.
- A patient will be allowed to continue with their therapy after one no-show/ late cancellation, provided an explanation is supplied to the Therapist.
- After two (2) no shows/ late cancellations, the patient will be discharged from treatment.
- Patients will receive telephone/text reminders of appointment dates/times the workday prior to scheduled appointment (unless patient chooses not to be called).
- We apply a $25 no-show or late cancellation fee.

Contacting Us

Our main office number is 305.671.3503. If we are unavailable to take your call, please feel free to leave a message. Your therapist will provide a contact number for you to reach them directly. *If you experience a life-threatening emergency, call 911 or go to the nearest hospital emergency room and request to be seen by a mental health professional.*

Insurance

If you have health insurance that covers mental health benefits, you will be quoted your deductible, if it applies, as well as any co-insurance or co- payment that may apply per session. In addition to sessions, we must charge these amounts on a prorated basis for other professional services you may require, such as report writing or consultations with other professionals (primary care physician, psychologist, psychiatrist, etc.). We will alert you to any billable time before charging your account and will require your written permission before consulting additional providers outside of BCCS.

If you would like insurance imbursement, you are required to present your health insurance information and allow proper verification by our office, prior to being seen. You are fully responsible for non-sliding scale rate, paying either the entire amount per session or you are in-network co-pay. The office will discuss this with you in detail before scheduling a follow-up session. Please also note that in order to qualify for insurance reimbursement, we are required to give you a mental health assessment (diagnosis)which may prevent you from being covered for similar services in the future.

MD/ ARNP /Ph.D./ LMHC / RMHC / Students in training rotation

BCCS is a private group practice for Mental Health. Clinicians who provide services as part of our mental health team are current Licensed/Registered or In Rotation under Florida Medical good standing certifications. Providers are required to collaborate/extend or be under direct supervision per Florida regulations, providers requiring are under the direct collaboration/supervision of Dr. Hernan Pabón and/or Steven Krywinski, Ph.D. These are requirements regulated by the State of Florida in order to fulfill their full independent licenses. Our clinicians are sometimes asked to shadow each other, provide conjoint therapy (where there are two clinicians working with the client/s), record a session, observe a specific session or course of therapy, or co-facilitate e a group. Our Collective Mental Health is a team of clinicians all working together to increase access to menta l wellness. We consider each clinician to be working as part of this team. You have the right to request services to be rendered by a Psychiatric MD or a fully Licensed LMHC. Current staff : (H ernan Pabon, MD, Oscar Pozo, MD, Steven Krywinski, Ph.D, Albert Garcia, ARNP, Octavio Alfonso, ARNP/Extender, Francisco Brenes, ARNP, Adriana Arisitizabal ARNP, Xenia Cabrera LMHC, Claudia Quintanilla, MS, R·IMH, Carol Pulido, MS, R-IMH.. At any given time, current staff may change, as well as, current licensing status.

Initials: _____

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If you become involved or are currently involved in litigation that requires your therapist participation,

we do not testify or attend any court hearing under any circumstance. You are expected to inform us immediately if you are involved in any child-support, custody, disability and or civil criminal case.

Professional Records

Both law and the standards of my profession require that we keep appropriate treatment records. You are entitled to receive a copy of the records at your written request unless we believe that seeing them would be emotionally harmful to you. Because these are professional records written in technical language, they can be misinterpreted or can be upsetting, so if you request your records, then we recommend that
you and your clinician review them together to discuss what they contain. Any notes the clinician may take for academic purposes contain no identifying information and are *not* part of your protected health information (outlined in more detailed in the accompanying HIPAA document).

Random Drug Screen: Please be advised that we can request random drug screen for Insurance and Patient safety. If your random screening indicates positive to any illegal substance, you will be discharge immediately from our office without any continuation of medication.

Authorization for Consent to Treat

By signing below, I hereby authorize BCCS LLC (including but not limited to all providers on staff) to carry out such assessment and treatment procedures as may be necessary for my care. This authorization includes Psychiatric Evaluations, Psychiatric Medication Management, Group therapy, and Individual Psychotherapy.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Name (Printed)_____

Client Signature: _____ **Date:** _____

Parent/Guardian Consent for Minors

I certify that I am the parent or legal guardian of: _____

I hereby authorize BCCS, LLC to carry out such assessment and treatment procedures as may be necessary for my child's mental health care.

Minor's Name (Printed):_____ **Minor's Date of Birth:** _____

Parent/ Guardian' s Name Signature:_____

Parent/ Guardian (Printed name):_____ **Date:**_____

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Authorization for Consent to Treat thru Telemedicine

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and sub-specialists. The information may be used for initial diagnosis, therapy, follow-up, and/or education, and may include the following:

- Patient Medical Records
- Medical Images
- Live two-way audio and video
- Output data from medical devices (including sound and video files)

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will Include measures to safe guard the data and to ensure its Integrity against intentional or unintentional corruption.

Expected Benefits:

Improved access to medical care by enabling a patient to remain in his/her office or at remote site while the physician obtains test results and consults from healthcare practitioners at distant/other sites.

More efficient medical evaluation and management

Obtaining expertise of a distant specialist

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases information transmitted may not be sufficient (e.g. poor resolution of Images) to allow for appropriate medical decision making by the physician and consultant(s)
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment
- In very rare instance, security protocols could fail, causing a breach of privacy of personal medical information
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other Judgment errors.

By signing this form, I understand the following:

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine and that no information obtained in the use of telemedicine which Identifies me will be disclosed to researchers or other entities without consent.

1. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time. My psychiatrist/therapist has explained the alternatives to my satisfaction.
2. I understand that I have the right to inspect all Information obtained and recorded during the telemedicine interaction and may receive copies of this information for a reasonable fee.
3. I understand that a variety of alternative methods of medical care may be available *to* me, and that I may choose one or more of these at anytime. My psychiatrist has explained the alternatives to my satisfaction .
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state providers.
5. I understand that it is my duty to inform my psychiatrist of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to Treat thru Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. **I hereby authorized <u>Behavioral Collaborative Care Solutions</u> to use telemedicine in the course of my diagnosis and treatment**.

Signature of Patient (or person authorized to sign for patient): _____ **Date:** _____

IF*, authorized signer, relationship to patient: _____

*An ID photo must be submitted of authorized person signing on behalf of patient.

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PRACTICE NOTICE

Please be advised,

If you are seeking any of the following forms, please talk to the administrative staff before scheduling your appointment. Medical provider (MD, ARNP, and/or Therapist) will not address these issues during your consultation.

FMLA (Family Medical Leave of Absences)

Emotional Support Mascot

Disability (Short or Long Term)

N-648 (Citizenship Disability form)

Public School forms

Jury Duty

In addition, if you are prescribed any psychotropic medication treatment, the medical provider issuing the prescription will indicate on the actual prescription if any refills will be provided. No refills are ever given on psychotropic controlled substances (ie: Adderall, Vyvanse, Concerta, Focalin).

We do not provided refills via fax or called into the pharmacy; some exceptions may apply. If you feel this may be an issue with your compliance with your medication treatment plan, please speak with your provider directly or the office manager.

Initials: _____