4700 Millenia Blvd
Suite 175
Orlando, FL 32839

Telephone: 407-704-1461
Fax: 407-987-2354
www.happymindcompany.com

PLEASE COMPLETE IN FULL / PRINT CLEARLY

Patient's Full Name (Last, First, Middle Initial):________________, ________________, ______

Address: ____________________________ City/State/Zip: ________________________________

Home Phone: ________________ Work Phone: ________________ Cell: ________________

Where May We Contact You? Home • Work • Cell •

Patient's Date of Birth: ______________ Age:_____ Social Security #:__________________

Marital Status (circle one): single / married / widowed / separated / divorced Sex: Male / Female

Driver's License Number:__________________________ Patient here before? Yes No

Employer:______________________ Full Part time Occupation:______________________

Spouse's Employer:____________________________ Occupation:______________________

Email:____

Person Responsible for Account:______________________ Relationship to Patient:______________

Address (if different):____________________________ City/State/Zip________________________

Home Phone (if different): ________________________ Work Phone: ________________________

Name and Phone Number of closest relative/friend NOT living with you:_________________________

Emergency Contact:_________________________ Relationship to patient_____________________

Emergency Contact Phone #_____________________

How Were You Referred To This Office?____

In the unfortunate event that this account is assigned to any attorney for collection and/or suit, the prevailing party shall be entitled to any and all attorney's fees and costs of collection. Also, an additional fee of 40% of the amount owed will be added for collection charges.

Please be sure to review and acknowledge The Happy Mind Company's *Financial*, *Medication* and *Practice Policies*, found at the end of this packet.

IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE GIVE 48 HOURS NOTICE
A $75.00 CHARGE WILL BE IMPOSED FOR THE TIME RESERVED.

I certify that all information on this page is true. I have read and understand and agree to the above.

Signature:__________________________________ Printed Name:__________________________

Relationship to Patient:____________________________ Date:__________________________

***If legal guardian, please present guardianship paper to receptionist**

Health History
(Confidential)

Name: ______________________________ Today's Date: ______________________

Age: __________ DOB: ____________ Date of Last Physical Examination ____________________

What is your reason for visit? ____

SYMPTOMS: Circle symptoms you currently have or have had in the past year:

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, Weakness, Numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Loss of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

MEN ONLY
- ☐ Breast lump
- ☐ Erectile difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discourse
- ☐ Other

Date of last menstrual period: ___________

Date of last pap smear ______________

Have you had a mammogram? __________

Are you pregnant? __________

Number of children _________

CONDITIONS: Circle symptoms you currently have or have had in the past:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS: List medications you are currently taking	ALLERGIES: To medications or substances

Pharmacy Name: ____________________ Pharmacy Phone: ____________________

(All information is strictly confidential)

CONDITIONS: Check symptoms you currently have or have had in the past:

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives have had any of the following

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes No
If yes, please give approximate dates ______________________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

YEAR OF BIRTH	SEX OF BIRTH	Complications, if any

HEALTH HABITS: Check which substances you use and describe how much you use

	Caffeine	
	Tobacco	
	Drugs	
	Other _________	
	Other _________	
	Other _________	

OCCUPATIONAL CONCERNS

Check if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

X ______________________________ ______________
PATIENT/GUARDIAN SIGNATURE DATE

X ______________________________ ______________
REVIEWED BY DATE

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TREATMENT CONSENT FORM

*This form must be completed by ALL PATIENTS- ADULTS and MINORS and signed by **both parents** if a minor is being seen and parents are divorced or separated prior to meeting with the professional staff at The Happy Mind company!*

Name:______________________________________ Date:________________

Date of Birth:________________ Social Security Number:_________________

Explanation of Consent Form:
This treatment consent form covers all procedures and testing that are not of a nature to require a special consent, and it provides protection for the procedures and testing performed by the professional staff of The Happy Mind Company. This form documents that the patient has consented to treatment at The Happy Mind Company, including but not limited to medicine management, psychotherapy, psychological testing, counseling and coaching. This allows the professional staff at The Happy Mind Company to provide services to you.

This form provides evidence that no guarantee is made by any professional at The Happy Mind Company concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at The Happy Mind Company. If you have any questions concerning this or any other matters, it is your responsibility to ask your psychiatrist, psychologist, or therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment:

I, ______________________________________, for ______________________________________,
(Print Your Name as a Consenting Adult) *(Print Name of Patient)*

Do hereby voluntarily consent to care and treatment by The Happy Mind Company, assistants and/or designees. I am aware that the practice of medicine psychiatry, clinical psychology, clinical social work and therapy is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the counseling process and that I share responsibility for my treatment. My responsibilities in treatment include informing the psychiatrist, coach or therapist of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

______________________________________ ______________________________
Signature *Date*

______________________________________ ______________________________
Witness Signature *Date*

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TELEMENTAL HEALTH INFORMED CONSENT

I (name of self or parent/guardian), ____, hereby consent to participate, or allow my minor child ________________________________ to participate in telemental health services with providers at The Happy Mind Company as part of psychiatry and psychotherapy services. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different geographic areas.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2. I understand that there are benefits (including but not limited to easier access to care and the convenience of meeting from a location of my choosing), risks, and consequences (including but not limited to disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized person(s), and/or limited ability to respond to emergencies) associated with telemental health. I understand that my health care provider or I can discontinue the telehealth visit if it is felt that the videoconferencing connections are not adequate for the situation. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits have been addressed.

3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to the confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding; an insurance audit mandates disclosure of progress notes).

5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call the office at 407-704-1461 to discuss, since we may have to reschedule. If you are unable to reach the office, please know that we will make every effort to reach you by phone as soon as possible.

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7. I understand that my therapist or doctor may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

EMERGENCY PROTOCOLS

Your therapist or doctor needs to know your location in case of an emergency. You agree to provide the address where you are at the beginning of each session. An emergency contact person is also required to be listed, and only contacted on your behalf when your safety is called into question, and/or during a life-threatening emergency. I authorize providers at The Happy Mind Company to contact this person in an emergency situation. My emergency contact person's name, address and phone number are:

____
____
____

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Signature of Client/Parent/Legal Guardian ________________________

Date __________________

Effective 12/03/20

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Patient Name: ______________________________ Date of Birth: ______________________

Primary Insurance: __________________________ Employer: ________________________

Name of Policy Holder: ____

SS# of Policy Holder: ______________________ Relationship to Patient: _________________

Date of Birth of Policy Holder: ________________

***Please present insurance card to receptionist to copy for our records**

Please remember that insurance is considered a possible source of reimbursement for the fees you pay to the Provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. ***If the insurance company doesn't pay within 60 days, the patient is responsible for any balance.***

Please be advised some insurance companies require preauthorization for mental health benefits. It is the member's responsibility to ensure that preauthorization has been obtained before services are performed. I understand by signing below any claims denied due to a preauthorization requirement will be the full responsibility of the member.

I understand that if my insurer or the company which manages my mental health benefits requires reports from my therapist, these reports will likely include a treatment plan and periodic updates of the treatment plan. The purpose of these reports is to monitor progress, assure quality and to insure appropriate utilization of services. These reports may require verbal and written summaries which include a statement of the problem, history, diagnosis, a formulation of the problem and the dynamics as well as a plan of treatment. If I am a member of a PPO/HMO this may require reporting to my primary care physician.

I hereby authorize payment directly to The Happy Mind Company of any insurance benefits otherwise payable to me and all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans. Any non-assignable benefits are to be made payable jointly to the above named group and myself. I also give the above named group authorization to file any and all claims on my behalf to the insurance commissioner regarding my insurance company.

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. ***I understand that I am financially responsible for all charges whether or not paid by said insurance.*** I hereby authorize assignee to release all information necessary to secure payment.

I certify that all information on this page is true. I have read, understand and agree to the above.

Signed: ______________________________ Printed Name: ______________________________

Date: ______________________________

Responsible Party Signature (if different from patient): ______________________________

Printed Name of Responsible Party: __________________________ Date: ________________

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: ______________________ DATE OF BIRTH: ______________________

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company **to Receive** PHI

____
____
____

Name and Address of Individual/Facility **to Disclose** PHI

____
____
____

Information authorized for use or disclosure, or to be obtained ***(Please circle items that should be disclosed)***:

History & Physical   Discharge Summary   Operative Report   ER Record   Consultation   Lab reports

Progress Notes   X-ray reports   Other______________________

Medical information between ______________________ to ______________________

The information will be obtained, used, or disclosed for the **following purpose** only ***(Please circle appropriate item(s) below)***:

Insurance   Continued treatment   Legal   At the request of the patient or patient's representative

Other (specify) ______________________

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be eighteen (18) months from date of signature or upon occurrence of the following event: ______________________.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released, unless prohibited by law and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

______________________ ______________________
SIGNATURE OF PATIENT DATE

______________________ ______________________
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

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ACKNOWLEDGEMENTS

Patient or Client Name: ______________________________ **Date:** ________________

By initialing each of the following and then signing below, I am acknowledging that I have read and understand as well as agree to adhere to the following, and have received copies of each to keep in my possession:

NAME OF POLICY	INITIALS
Financial Policy - The Happy Mind Company	_________
Practice Policy - The Happy Mind Company	_________
Medication Policy - The Happy Mind Company	_________

* A copy of each policy is available to read/review on our website*

https://happymindcompany.com/forms-policies/