



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: _____ Parent's Work Phone: _____ Cell: _____

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

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

School: _____ Grade: _____ 504 or IEP in place? Yes / No

Email: _____

Do Both Parents Live in the Same House? Yes / No

Parent's or Legal Guardian's Name: (Must Be Completed) _____

Parent/Legal Guardian Employer: _____ Occupation: _____

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.

IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE GIVE 48 HOURS NOTICE; OTHERWISE, 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

GASTROINTESTINAL

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

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

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 discource
- Other

MUSCLE/JOINT/BONE

Pain, Weakness, Numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

CARDIOVASCULAR

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

SKIN

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

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:

- | | | | |
|---|---|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts | <ul style="list-style-type: none"> <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes | <ul style="list-style-type: none"> <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio | <ul style="list-style-type: none"> <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> 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	Check if your blood relatives have had any of the following	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and Outcome	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 _____

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

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

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.

Effective 12/03/20

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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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INSURANCE WAIVER AGREEMENT

I, _____,
(Printed name of patient or parent/guardian)

understand that I am responsible for any charges for psychiatric, psychological or psychotherapy services provided by The Happy Mind Company according to the financial policy.

I further acclaim that I do NOT have mental health insurance coverage, **OR** if I do, have chosen NOT to disclose this to The Happy Mind Company of my own accord. If the latter is true, then I understand that my insurance company may not reimburse me for any or all of my fees, and The Happy Mind Company would NOT be responsible for any charges that are not reimbursed by my insurance company.

Name of Patient

Patient Date of Birth

Signature of Patient or Parent/Guardian

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:

<u>NAME OF POLICY</u>	<u>INITIALS</u>
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/>