Submit

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New Patient Registration Form

Patient Information

Last Name	Middle Initial	First Name
Birth Date	SSN	Email
Address		Apt #
City	State	Zip
Preferred Contact Number		Alternate Contact Number

Appointment Confirmation: Text ☐ Email ☐ None ☐

Gender ☐ M ☐ F | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Other: _____

Race/Ethnicity ☐ Caucasian ☐ African American ☐ Hispanic ☐ Native American ☐ Asian ☐ Other: _____

Emergency Contact Name	Emergency Contact Number

Are you on or applying for any type of disability or worker's compensation? If yes, explain:

Have you ever been convicted of a crime or involved in any legal proceedings? If yes, explain:

If patient is under 18, please complete the responsible party's information below

(Also complete this section if the patient has a Legal Guardian)

Last Name	First Name	
Birth Date	Phone	Relationship to Patient:
Address *(if different from above)*		Apt #
City	State	Zip

Primary Insurance Information

Insurance Provider:	Insurance Policy Holder:
Insurance Number:	Group Number:
Relationship to Policy Holder:	Policy Holder DOB & SSN:

Secondary Insurance Information

Insurance Provider:	Insurance Policy Holder:
Insurance Number:	Group Number:
Relationship to Policy Holder:	Policy Holder DOB & SSN:

Account # _____

Current Medications

List ALL the medications currently prescribed to you by any doctor. Please include any vitamins and/or herbal supplements.

Medication Name *Example: Pristiq*	Strength *Example: 20 mg*	Times Taken Per Day *Example: 2 times daily*

Past Psychiatric Medications

Please list all past psychiatric medications taken, dosage, length of time you took the medication and why you stopped taking it.

Medication Name *Example: Pristiq*	Dosage *Example: 20 mg*	Length of Time Taken *Example: 3 months*	Why You Stopped Taking the Medication *Example: It made me too drowsy*

Allergies

Please list any medication allergies below or check the space below if you have no known allergies.

_____ I have no known drug allergies.

Medication	Reaction

Account # _____

Medical History

Please circle any condition below that applies to your personal medical history and briefly explain in space provided.

Diabetes ☐	Hypertension ☐	High Cholesterol ☐
Migraines ☐	Chronic Pain ☐	Gastro Esophageal Reflux (GERD) ☐
Fibromyalgia ☐	IBS ☐	Thyroid Disease (Hyper/Hypo) ☐
Heart Disease ☐	Head Injury ☐	Cancer ☐
Seizures ☐	Sleep Apnea ☐	Stroke ☐
Anxiety ☐	Depression ☐	ADHD ☐
Alzheimer's ☐	Parkinson's ☐	Alcoholism/Drug Abuse ☐
Other: ☐	Other:	Other:

Have you had any recent changes in any of the following areas?

Weight	Energy Level	Ability to Sleep

Please list all of your prescribing physicians and their specialty: _____

_____

Please list your most recent blood work tests and results: _____

_____

Please list the date of any Psychiatric Inpatient Hospitalizations, name of the hospital, and reason for admission below.

Please list the problems or concerns you'd like to discuss with your doctor below.

Account # _____

Family History

Place a check to indicate any family members that have or have had any conditions below:	Father	Mother	Sons	Daughters	Brothers	Sisters	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inherited/Genetic Disease (i.e. Alzheimer's, Parkison's, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism/Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:												
Other:												
Other:												

Please complete the information below for each family member notated above.

Living or Deceased (L/D)												
If deceased, age at death												

Please provide any additional details: _____

_____

_____

Account # _____

Social History

Current Employment	**Highest Level of Education Completed**
If any, please describe your military background.	
Living Situation ☐ With Spouse/Partner ☐ With Parent(s) ☐ With Children ☐ Other: _____	
Exercise Habits (Describe the type and amount of exercise you do regularly and how often.)	
Caffeine Intake (Indicate the number of cups of each caffeine drink below you consume each week or indicate if not applicable.) Coffee: ☐ Tea: ☐ Cola: ☐ Energy Drinks: ☐ Other: ☐	
Are you currently sexually active?	**If yes, are you trying for pregnancy?**
Do you use alcohol?	**If yes, please indicate type and amount consumed per week.**
Do you use tobacco?	**If yes, please indicate type and amount used per week.**
Do you, or have you ever taken drugs, legal or illegal, other than over-the-counter medications that were not prescribed for you? **If yes, please describe.**	

Please use this space to provide any additional information for your provider to review regarding your medications, medical history, or concerns you'd like to address.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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INFORMED CONSENT FOR MENTAL HEALTH EVALUATION/TREATMENT

Initials

_____ I hereby voluntarily consent to a **mental health evaluation including psychological testing.** I understand that these are primarily non-invasive, pencil-and-paper tests given for my benefit to better understand my health care condition. I know that the results and issues discussed are private and cannot be communicated to anyone else without my consent.

_____ I hereby voluntarily consent to **mental health treatment.** I understand that this includes **psychotherapy** (talk therapy), either individually or with my family as well as **medication management.** I know that the issues I discuss are private and cannot be communicated to anyone else without my consent.

_____ I have been requested to participate in a **court-ordered psychological evaluation/treatment** program. The results of the evaluation or treatment progress will be reported to:

_____

_____ I voluntarily consent to the following Testing/Treatment:

_____

_____ I voluntarily consent for my child to receive the following Testing/Treatment:

_____

_____ I voluntarily consent for my records (or my child's records) to be reviewed by the clinic regarding potential eligibility for participation in clinical research trials. I also give consent to be contacted regarding optional participation in clinical research trials.

Name of Client/Patient: _____ **SSN:** ___/___/_____ **DOB:**___/___/_____

Date service is to begin: _____/___/_____

_____ _____

Signature of Client/Patient Date

Client/Patient is a minor ☐ or is unable to consent because_____.

My relationship to the client/patient is _____ and I have signed this Consent on his/her behalf.

_____ _____

Parent/Guardian Signature Date

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Financial Policy

Thank you for choosing The Anchor Clinic. We are committed to your successful treatment. The following is our financial policy which we request that you read, understand, and sign prior to treatment.

Payments

All payments (i.e., co-pays, co-insurance, deductibles) are due at the time of service. Payments are accepted in the form of cash, check, money order, and credit card (Visa, Mastercard, Discover, Amex).

Appointment Cancellation Policy

If you are unable to make your scheduled appointment, we must be notified at least 24 hours in advance. If our staff does not receive proper notification, the time scheduled with your clinician becomes a missed opportunity and delay for another client to be seen. Therefore, if an appointment is missed or not cancelled with proper notification, a fee will be applied to your account and with your permission, your credit card will be charged. A fee of $180.00 is applied for any new patient or testing appointments. The fee for missing follow-up appointments is $110.00. This fee is not billed to insurance, it is the patient's responsibility and must be paid prior to rescheduling any future appointments. If more than two sessions are missed without proper notification, continued services can be discontinued.

Please note: Appointment confirmations are a courtesy ONLY. You are responsible for keeping track of your appointment date and time.

Forms completed by our providers:

Health insurance does not cover form fees (e.g., ESA, FMLA, accommodation letters). An $80/$160 form fee must be paid prior to completion of forms.

Billing

Balances are due upon receipt of account statements. In most cases, management can set up a payment arrangement with clients having trouble paying their balances in full to avoid it being turned over to a collection agency. Accounts must remain in good standing to continue receiving treatment at The Anchor Clinic.

Returned Checks

A $30.00 service fee will be added to your account for each returned check from your bank. Only cash payments will be accepted if two NSF checks are received.

My signature below acknowledges that I have read, fully understand, and agree to all parts of this financial policy. I also understand that my account may be turned over to a collection agency if it becomes delinquent.

Patient's Name_____ Patient's DOB _____

Signature of Client/Guardian_____ Date _____

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NOTICE TO PATIENTS REGARDING PRIVACY OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Federal regulations developed under the ***Health Insurance Portability and Accountability Act (HIPAA)*** require that this Practice provide you with this notice regarding ***Personal Health Information (PHI)***. Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record serves as a:

- basis for planning your care and treatment
- means of communications among other health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third party payer can verify that services billed were actually provided
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Protected Health Information (PHI) is any health information created or received by your health care provider that contains information that may be used to identify you, such as name, address, telephone numbers, and account numbers, or your condition. It includes written or oral health information that relates to your past, present, or future mental health; the provision of health care to you; your past, present, or future payment for health care.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practice upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations

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CONTROLLED SUBSTANCE AGREEMENT

The purpose of this Agreement is to prevent any misunderstandings about certain medicines you may be prescribed by the physicians or nurse practitioners at this clinic. This is to help both you and your provider to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor patient relationship and that my provider undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my provider may stop prescribing me certain medications and/or release me from the practice. In this case, my doctor will taper me off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my provider about the character and intensity of my symptoms, the effect of the symptoms on my daily life, and how well the medicine is helping to relieve my symptoms.

I will not use any illegal controlled substances, including marijuana, cocaine, etc. I will not share, sell, or trade my medication with anyone. I will not attempt to obtain any controlled medicines, including benzodiazepines, controlled stimulants, or anti-anxiety medicines to treat the same symptoms from any other doctor.

I will safeguard my medication from loss or theft. I understand that lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for controlled medication will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use _____ (Pharmacy), located at _____ (Address), to fill all of my prescriptions written by my provider at Anchor Clinic.

I agree to notify my doctor and/or his staff if I change my pharmacy and I agree to use the same pharmacy for fulfilling all of my prescriptions.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with prescribed treatment.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding this agreement have been adequately answered. A copy of this document has been given to me.

Patient Name:_____ **DOB:**_____ **Signature:**_____

Witness Name:_____ **Signature:**_____ **Date:**_____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form will allow the Anchor Clinic to correspond with others about your care.
Please complete for any person or healthcare provider with whom we may discuss your care. A separate form is required for each party.

Section A: (*Must be completed for all authorizations*)
I hereby authorize the use or disclosure of my individual identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may no longer be protected by the federal privacy regulations. I give my permission to release confidential/sensitive mental health treatment records including HIV test results, alcohol and drug therapy, and lab reports.

Patient Name: _____ DOB: ___/___/___ ID#/SSN#_____

Person and/or Organization providing the information: _____

Person and/or Organization receiving the information: _____

☐ Allow two-way communication ☐ Include all records ☐ Include only specific records

If you chose specific records, please describe: _____

Section B: (*Must be completed only if a health care provider or health plan has requested authorization*)
The health plan or health care provider must complete the following:
What is the purpose of the use or disclosure? _____

Will the health plan or health care provider requesting the authorization receive in-kind compensation in exchange for using or disclosing the health information described above? ☐ Yes ☐ No

The patient or the patient's representative must read and initial the following statements:

I understand that my health care and the payment of my health care will not be affected if I do not sign this form.
Initials_____

I understand that I may see a copy of the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Initials_____

Section C: (*Must be completed for all authorizations*)
The patient or patient's representative must read and initial the following statements:
I understand that this authorization will expire on ___/___/___ Initials _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any affect on my actions they took before they received the revocation.
Initials _____

Signature of patient or patient's representative: Date:

_____ _____/_____/_____
(Form must be complete before signing)

Printed name of patient's representative: _____Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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AUTHORIZATION FOR RELEASE OF INFORMATION TO ANOTHER PERSON

Patient's First & Last Name (Printed): _____ DOB: _____

Provider(s) Name: _____

Please list the family members, spouse, or other person(s), if any, to whom we may release your personal medical information.

If authorized, Anchor Clinic may release your information to any authorized person(s) in person or via telephone regarding your general medical condition and/or your diagnosis (including treatment, payment, and health care operations).

Authorized Person's Name: _____ Relationship to Patient: _____

Authorized Person's Name: _____ Relationship to Patient: _____

Authorized Person's Name: _____ Relationship to Patient: _____

☐ I do NOT authorize Anchor Clinic to release my information to anyone

NOTICE: This authorization is for full disclosure of pertinent mental health treatment records, including HIV test results, alcohol and drug therapy, and lab reports. If there is any information that you do not want disclosed to the named party, please indicate below what portions of the record you would like excluded.

Exclusions: _____

I hereby grant Anchor Clinic the approval to discuss my medical history as outlined above. Any exclusions have been noted. I understand that this authorization is voluntary and will remain in effect until _____ /_____ /_____ or until rescinded by myself in writing.

Patient (or Representative) Signature: _____ Date: _____

Witness Name (Printed): _____ Witness Signature: _____

These records are confidential and not for re-release by any facility other than Anchor Clinic.

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NOTICE TO PATIENTS REGARDING PRIVACY OF HEALTH INFORMATION PRACTICES (CONT'D)

OUR RESPONSIBILITIES

The Practice is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practice and to make the new provisions effective for all protected health information we maintain. Should our information practice change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

USE AND DISCLOSURE OF PHI IN TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS

Your Protected Health Information (PHI) may be used and disclosed by this Practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be in writing, electronically, by facsimile, or orally. Additionally, this Practice may also use your PHI to remind you of an appointment, inform you of potential treatment alternatives, and inform you of health-related benefits or services that may be of interest to you.

OTHER USES OR DISCLOSURES PERMITTED WITHOUT AUTHORIZATION

In addition to treatment, payment, and health care operations, our Practice may use or disclose your PHI without your permission or authorization in certain circumstances including:

- when legally required to comply with any federal, state, or local laws that involve disclosure of your PHI
- when there are risks to public health as permitted or required by law
- to report abuse, neglect, or domestic violence if it is believed that the patient is a victim
- to conduct health oversight activities such as audits, or civil, administrative, or criminal investigations, proceedings, or actions
- for judicial and administrative proceedings authorized by an order of a court or administrative tribunal
- for law enforcement purposes
- to coroners, funeral directors, and for organ donation in such cases as identification, determination of cause of death, and/or performance in the medical examiner's duties authorized by law
- for research purposes if such use has been approved by an institutional review board or privacy board
- for specified government functions as authorized by HIPAA privacy regulations
- in correctional institution situations when information is necessary for your health, and the health and safety of other individuals

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NOTICE TO PATIENTS REGARDING PRIVACY OF HEALTH INFORMATION PRACTICES (CONT'D)

If you have questions or would like additional information, you may contact the Privacy Officer at the following address:

The Anchor Clinic
Attn: Privacy Officer
890 South Palafox Street
Suite 300
Pensacola, FL 32502

If you believe your privacy rights have been violated, you can file a complaint with the Director of Health Information Management or with the Secretary of Health Services. There will be no retaliation for filing a complaint.

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

_____ _____

Signature of Patient or Legal Representative Date

If signed Legal Representative, relationship to Patient: _____

Distribution: original maintained in patient record
copy provided to patient