MINDPATH SOLUTIONS INC
Psychiatry Service

PATIENT INFORMATION

PERSONAL INFORMATION

Full Name :
(PLEASE USE CAPITAL)

Date of Birth : _____ / _____ / _____ **Gender** : ☐ Male ☐ Female

Address : _____

Phone Number : _____ **E-Mail** : _____

Social Security Number : _____

Marital Status : ☐ Single ☐ Married ☐ Divorce ☐ Others

Preferred Contact Method : ☐ Phone ☐ Text ☐ Portal

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Home Number** : _____

Relationship : _____ **Mobile Number** : _____

OFFICE USE ONLY

Date : _____ **Membership Type** : _____

Membership Number : _____ **Payment Type** : _____

Staff Name : _____ **Staff Signature** : _____

Contact Information :
526 S Main St. Wildwood, FL 34785
352-322-2169 (Office)
www.mindpathsolutions.com

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MEDICAL HISTORY

Patient Name :

Date of Birth : _____ / _____ / _____

Medical History				
	Patient	Mother	Father	Sibling/ Grandparent
Thyroid				
Diabetes				
High Blood Pressure				
Heart Disease				
Stroke				
Kidney Disease				
Liver Disease				
Glaucoma				
Cataracts				
Epilepsy				
Osteoporosis				
Asthma				
COPD				
Migraine				
HIV/AIDS				
Cancer				
Mental Health				
Depression				
Anxiety				
Bipolar Disorder				
Schizophrenia				
Other				

ALLERGIES (list all known)
SURGERIES (list all known

RISK FACTORS
Tobacco use? YES NO NEVER
Alcohol use? YES NO NEVER
Caffeine use- how many cups/day?
Sleep- how many hours/day?
Medical Marijuana use? YES NO
Drug use? YES NO NEVER _____ _____ _____
Exercise- How many times per week?

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CONFIDENTIALITY

This session content and all relevant materials to your treatment will be held confidential unless you request, in writing, to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a patient threatens the act or attempts to commit suicide or otherwise conducts themselves in a manner where there is a substantial risk of incurring serious bodily harm.
2. If a patient threatens bodily harm or death to another person.
3. If the Psychiatric Nurse Practitioner (Kristie Murdock APRN, PMHNP-BC) has a reasonable suspicion that a patient or other named person is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subject to these abuses.
5. Suspected neglect of the parties named in items #3 and #4.
6. If a court of law issues a legitimate subpoena, signed by a judge for information stated on the subpoena.

Occasionally I may need to consult with other professionals in their areas of expertise to provide the best treatment for you. Information about you may be shared in this context without using your name.

By signing below, I am agreeing that I have read, understand, and agree to the items contained in this document:

Patient Name:_____ Date:_____

Signature:_____

Parent/Guardian Signature:_____

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HIPPA/CLIENT RIGHTS

This Notice of Privacy Practices provides information about how the practice may use or disclose protected health information. The notice contains a client's rights section describing your rights under the law. Your signature below indicates that you have reviewed the notice before signing this consent

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The client has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES/NO
May we leave a message on your voicemail on your phone? YES/NO

Patient Name: _____ Date: _____

Signature: _____

Parent/Guardian Signature: _____

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CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation/treatment by MindPath Solutions Inc. for myself and/or my family member(s).

Patient Name: _____

Signature: _____

Parent/Guardian Signature: _____

Date: _____

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PHARMACY INFORMATION

PHARMACY CONTACT		
Pharmacy Name:	Pharmacy Phone #:	Lab Preference:
INSURANCE AND GUARANTOR INFORMATION		
Primary Insurance:	Policy #:	Group #:
Subscriber Name:	Relationship to Patient:	
Subscriber Date of Birth:	Subscriber Social Security #:	
Secondary Insurance:	Policy #:	Group #:
Subscriber Name:	Relationship to Patient:	
Subscriber Date of Birth:	Subscriber Social Security #:	

** I, _____ consent for MindPath Solutions Inc. to obtain/view my external prescription history. YES NO

Patient Name: _____

Signature: _____

Parent/Guardian Signature: _____

Date: _____

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Cancellation Policy

A “no-show” or cancellation with less than 24 hours’ notice prior to your scheduled appointment date and time will result in a cancellation fee of $75. **There are no exceptions.**

I understand that if I am a self-pay client, any cancellation fees will be charged directly to my credit care on file.

Patient Name: _____ Date: _____

Signature: _____

Parent/Guardian Signature: _____

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Authorization for Release of Information

- Patient's Name: _____
- Patient's DOB: _____
- Information to be released:
  a. Reports: _____
  b. Labs: _____
  c. Documents: _____
  d. Treatment Plans: _____
  e. Other: _____
- Purpose of Disclosure: _____
  _____
- Persons authorized to make Disclosure: _____
  _____
- Persons authorized to receive Disclosure: _____
  _____
- Method of Disclosure:
  a. Written: _____
  b. Verbal: _____
  c. Electronic: _____
- Date of Authorization (Today): _____
- Authorization Expires: _____

I fully understand that my medical information is protected by law. I authorize MindPath Solutions Inc. for the release of my information as I have clarified above. I understand that my consent is voluntary and I may revoke permissions at anytime, except if my information has already been shared according to this authorization.

Patient Name: _____ Date: _____

Signature: _____

Parent/Guardian Signature: _____

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TELEHEATH CONSENT

Telehealth will be used for videoconferencing appointments. Please follow instructions provided by your provider to access your online appointment.

By signing this document, I (print name) _____ acknowledge:

1. Telehealth is NOT and emergency service and in the event of an emergency, I will use a phone to call 911 or other emergency resource previously listed.
2. My location must be given to the provider at the start of the telehealth session. I am responsible for ensuring I am in private location where others cannot see or overhear any aspects of my session.
3. If at any time the provider suspects I am not in a private location, they reserve the right to end the session even if there is time remaining. This is in the interest of preserving my confidentiality.
4. My provider and I will be in direct, virtual contact through the telehealth service and my camera will remain turned on for the duration of my session.
5. To maintain confidentiality I will not share my telehealth platform link with anyone not authorized to participate in my appointment.
6. MindPath Solutions Inc. is not responsible for connectivity issues associated with use of the telehealth sessions.

By signing this form, I acknowledge that I have read and understand the form and its contents including the risks and benefits of the procedures. I acknowledge that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Name: _____ Date: _____

Signature: _____

Parent/Guardian Signature: _____

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COMMUNICATION CONSENT

This consent form allows Kristie Murdock APRN PMHNP-BC to communicate my Protected Health Information (PHI) through the following unsecure means.

I, (Print Name)_____, hereby consent and authorize MindPath Solutions Inc. to communicate my PHI through the following unsecure transmissions (please initial next to all of your choices):

_____ Cellular/Mobile Phone. This includes voicemails: _____
_____ Unsecured email: _____
_____ Appointment/Scheduling/Billing Reminder System
_____ Other Media (Please Describe): _____
_____ **I do not** wish to have my protected health information transmitted electronically. This means I agree to communicate with MindPath Solutions Inc. via telephone or face to face only and not through electronic means.

Should we agree to communicate by the approved communications listed above, i.e. voicemail, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, MindPath Solutions Inc. cannot guarantee that those communications will remain confidential. While MindPath Solutions Inc. may utilize encryption methods, firewalls, and/or back-up systems to help secure our communications, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. **There is no guarantee that information transmitted electronically will remain confidential.**

I, (Print Name)_____, consent to MindPath Solutions Inc. transmitting the following PHI by using the electronic means indicated above:
_____ Information related to scheduling/appointments
_____ Information related to billing and payments
_____ Information related to your mental health treatment
_____ Information related to practice operations
_____ Other Information (Please Describe) _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to ament this consent form so that my provider may communicate with me via that method.

Patient Name: _____ Date:_____

Signature:_____

Parent/Guardian Signature: _____

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EMERGENCY AGREEMENT

If you need immediate help for an emergency please call 911 or go to your nearest emergency room. You can also call the following hotlines to receive 24/7 live support if you experience a crisis:

Local Crisis Center: 1-866-355-9394 (www.lsbc.net)
National Lifeline: 988
Crisis Text Line: 741741 text “hello”

If an emergency occurs during psychiatry services where I become concerned about any of the following, I will do whatever I can within the limits of the law to prevent harm to you or anyone else:

- Threats to your personal safety
- Threats to someone else’s safety
- Other concerns that I feel require immediate action or attention

For this purpose we may also contact the person you’ve named as your Emergency Contact.

Acknowledgment

By signing below, I acknowledge that I understand and agree to the Communication and Emergencies Policies stated above. I understand that MindPath Solutions Inc., may not be immediately available and should not be contacted in the event of an emergency. I acknowledge that I have been provided with alternative resources which can offer immediate support and assistance during a crisis. MindPath Solutions Inc. is not responsible for any harm, injury or death that may be imposed as a result of failure to utilize the resources provided for assistance during a crisis.

Patient Name: _____ Date: _____

Signature: _____

Parent/Guardian Signature: _____

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AUTHORIZATION OF RELEASE

In the event of a medical or clinical emergency this authorization grants permission for MindPath Solutions Inc. to contact the person you have specified below for notification and assistance.

Will release to/from:

Person/Agency Name: _____

Relationship: _____

Address: _____

Phone: _____

*NOTICE TO RECEPIENT REGARDING DISCLOSURE OF CONFIDENTIAL INFORMATION: This information has been disclosed to you from confidential records that are protected by state and federal law. These laws prohibit you from any further disclosure of this information without specific written consent from the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state and federal law may result in a fine, jail sentence, or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

I understand that my records are protected under Federal Confidentiality Regulations (or other state and/or local statutes/regulations) and cannot be given out to anyone without my written authorization. I also understand that I may revoke this authorization in writing at any time - except to the extent that some or all information originally authorized to be released has already been disclosed. I further understand that eligibility, enrollment, treatment, and payment is not conditional upon authorizing release of Protected Health Information (PHI). The potential exists that information be disclosed pursuant to this authorization be subject to redisclosure by the recipient and no longer protected by the privacy rule.

Patient Name: _____ Date: _____

Signature: _____

Parent/Guardian Signature: _____

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