Patient Intake Packet

Date: ______/________/______

Please fill out this packet to the best of your ability.

Personal Information:

Name: ____
Last First Middle

Preferred name (if different from above): ______________________________________

Social Security Number: ______-_____-___________

Sex assigned at birth: ____________
O Male
O Female
O Non-Binary
O Not designated on birth certificate
O Decline to answer

Gender Identity: ____________________ Pronouns: ______________ [ ] Decline to answer

Sexual Orientation: ___________________________ [ ] Decline to answer

Date of Birth:___ ___ /___ ___ /___ ___ Age: _________

Month Day Year

Veteran: [ ] Yes [ ] No
If yes:
Do you have a military related disability? ____________

Branch: ____________________

Service start date: ________/________/________

Service end date: ________/________/________

Demographic Information:

Ethnicity: Hispanic _____ Non-Hispanic _____ Other (*please specify*): __________________

Race: White _____

Black/African American _____

Asian _____

Native American/Alaskan Native _____

Native Hawaiian/Pacific Islander _____

Other (*please specify*) ____

Contact Information:

Primary Phone: ______________________________ Secondary Phone: ___________________________

E-mail: ____

Mailing Address: ____

____

Communication Preference: _______________________________

Emergency Contact

Name:____

Relationship to client: _________________

Does emergency contact live with client? ____ Yes ____ No

If “No,” please provide the following:

Emergency Contact Street Address: ____

Emergency Contact Apartment/Suite/Unit: ________________ Emergency Contact Zip Code: _________

Emergency Contact City: _______________________________ Emergency Contact State: _________

Primary Phone: _____________________________ Secondary Phone: __________________________

Information that may be disclosed to Emergency Contact:
____

____

____

Parent/Guardian Information (if applicable):

Name: ____

Relationship: _______________________

Parent/Guardian Marital Status: ____________________________________

Parent/Guardian Date of Birth: _____________________________________

Parent/Guardian Living with Client?: [ ] Yes [ ] No

If “No,” Parent/Guardian Address:

____

____

Parent/Guardian Contact:

Home Phone: __________________

Cell Phone: ____________________

Work Phone: ___________________

Other: _________________________

Social History

Marital Status:

_____ Single

_____ Married time(s) on date(s) ____________________

_____ Divorced time(s) on date(s) ____________________

_____ Widowed time(s) on date(s) ____________________

______ Domestic Partner

______ Significant other

Children: _______ No _______ Yes _______ Number

Ages ____________________

Siblings (brothers/sisters): _____ No _____ Yes

Ages ____________________

Education:

Years of Schooling________(e.g., graduated high school = 12 years)

Degrees Obtained ____________________

Current Occupation:

Position Date Started

____

____

Previous Occupations:

Position Date Started Date Stopped Reason Stopped

____

____

____

____

Current Living Situation: ____________________

Weapons in the Home?______No _____ Yes (type) ____________________

____

____

____

____

Medical Conditions:

Current:

[ ] None
[ ] Asthma/Breathing Problems
[ ] Anemia
[ ] Cancer
[ ] COPD
[ ] Cirrhosis / Liver Disease
[ ] Diabetes
[ ] Epilepsy/ Seizures
[ ] Eye Disease / Difficulties
[ ] Heart Trouble/ Stroke
[ ] Hepatitis C
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Kidney / Bladder Problems
[ ] Metabolic Syndrome
[ ] Obesity
[ ] STDs / STIs
[ ] Thyroid Condition
[ ] Tuberculosis
[ ] Ulcers
[ ] Other *(please specify)*:

Past:

[ ] None
[ ] Asthma/Breathing Problems
[ ] Anemia
[ ] Cancer
[ ] COPD
[ ] Cirrhosis / Liver Disease
[ ] Diabetes
[ ] Epilepsy/ Seizures
[ ] Eye Disease / Difficulties
[ ] Heart Trouble/ Stroke
[ ] Hepatitis C
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Kidney / Bladder Problems
[ ] Metabolic Syndrome
[ ] Obesity
[ ] STDs / STIs
[ ] Thyroid Condition
[ ] Tuberculosis
[ ] Ulcers
[ ] Other *(please specify)*:

Family Members:

[ ] None
[ ] Asthma/Breathing Problems
[ ] Anemia
[ ] Cancer
[ ] COPD
[ ] Cirrhosis / Liver Disease
[ ] Diabetes
[ ] Epilepsy/ Seizures
[ ] Eye Disease / Difficulties
[ ] Heart Trouble/ Stroke
[ ] Hepatitis C
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Kidney / Bladder Problems
[ ] Metabolic Syndrome
[ ] Obesity
[ ] STDs / STIs
[ ] Thyroid Condition
[ ] Tuberculosis
[ ] Ulcers
[ ] Other *(please specify)*:

Explain (include date(s) and treatment(s) received:

____

____

____

Ability to self-manage medical conditions: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Explain self-management techniques:

____

____

Are you currently experiencing any physical symptoms which are not being treated by a physician?

☐ Yes, explain:

____

____

☐ No

Short-Term Physical Health Care Goals:

Long-Term Physical Health Care Goals:

Past Medical Hospitalizations/Surgeries:

[ ] Yes (complete the Hospitalizations / Surgeries section)
[ ] No (proceed to allergies and examinations sections)

Hospital	Dates Inpatient	Reason for Admission	Outcome

Procedure	Date	Hospital	Outcome

Past Psychiatric Hospitalizations:

Hospital	Dates Inpatient	Reason for Admission	Outcome

Allergies *(to include medications and foods):*
[ ] No [ ] Yes (explain allergen, reaction, and severity):

Immunizations:

Has the individual had or been immunized for the following diseases? (Check all that apply):

[ ] None
[ ] Unknown
[ ] Diphtheria
[ ] Chicken Pox
[ ] HPV
[ ] Meningitis
[ ] Pneumococcal
[ ] Small Pox
[ ] German Measles
[ ] Influenza
[ ] MMR
[ ] Polio
[ ] Tetanus
[ ] Hepatitis B
[ ] Measles
[ ] Mumps
[ ] Shingles
[ ] COVID-19
[ ] Other *(explain)*

All immunizations up to date? [ ] Yes [ ] No

Explain: ____

Family Psychiatric History:

Diagnosis **List Relationship**

Depression:____________________

Bipolar Disorder: ____________________

Schizophrenia:____________________

Anxiety Disorder: ____________________

Social Phobia: ____________________

Posttraumatic Stress Disorder: ____________________

Panic Disorder: ____________________

Eating Disorder (Anorexia or Bulimia): ____________________

Attention Deficit/Hyperactivity Disorder: ____________________

Dementia/Alzheimer’s Disease: ____________________

Alcohol Dependence: ____________________

Drug Dependence: ____________________

Impulse Control Disorder: ____________________

Personality Disorder (e.g., Paranoid, Borderline, Antisocial, Avoidant): ____________________

____

Completed Suicide: ____________________

Seizure Disorder: ____________________

Cerebrovascular Disease (e.g., stroke): ____________________

Multiple Sclerosis: ____________________

Brain Tumor: ____________________

Other Neurologic Conditions (list): ____________________

____

Endocrine Disorders (list): ____________________

____

Pain Rating:

Current Pain: No ___ Yes ___

Location on body: _____________

Intensity 0-10 (0 =none to 10 = most severe imaginable) ______

Interferes with daily function (0=no interference to 10=completely disabled) ____

Traumatic Brain Injuries: No ___ Yes ___ **Number** _____

Date _____ Duration of Loss of Consciousness _____ minutes Hospitalization: No ___ Yes ___

Date _____ Duration of Loss of Consciousness _____ minutes Hospitalization: No ___ Yes ___

For Persons Assigned Female at Birth:

Date of Last Menstrual Cycle: _______________________

Chance of Being Pregnant: None_____ Possible_____ Definite ______

Expected Delivery Date: ____________

Form of Birth Control: ____

Pregnancies: Number_____ Dates (MM/YY) ____

Breast Feeding: Yes ____ No ____

Receiving prenatal care? Yes ____ No ____

Name of prenatal provider: _____________________________________

Comments:

____

____

____

____

Height: ______________ Weight: ________________

If reporting for a child, has height changed in the past year?

[ ] Yes By how much?: _______________

[ ] No

Has there been significant weight change?

[ ] Yes By how much? (+/-): _______________

[ ] No

Personal Care:

Psychotherapy: Permission to Contact: ________________

Clinician	Type of Therapy	Started	Stopped	Outcome

Primary Care Provider:

Permission to Contact: _________________

Clinician	Last Visit	Phone Number

Specialist:

Permission to Contact: __________________

Clinician	Specialty	Last Visit	Phone Number

Specialist:

Permission to Contact: __________________

Clinician	Specialty	Last Visit	Phone Number

Dentist:

Permission to Contact: ___________________

Clinician	Last Visit	Phone Number

Do you use . . .?

Tobacco No Yes Last use: __________ Amount: _________ Frequency: __________

Type: [ ] None [ ] Cigarettes [ ] Cigars [ ] Chewing (spit) tobacco

[ ] Pipe Tobacco [ ] Dry Snuff [ ] Moist Snuff [ ] Plug Tobacco

[ ] Redman [ ] Smokeless Tobacco [ ] Snus [ ] Twist

Caffeine No Yes Last use: __________ Amount: _________ Frequency: __________

Alcohol No Yes Last use:__________ Amount: _________ Frequency: __________

Marijuana No Yes Last use: __________ Amount: _________ Frequency: __________

Heroine No Yes Last use: __________ Amount: _________ Frequency: __________

Cocaine No Yes Last use: __________ Amount: _________ Frequency: __________

Hallucinogens No Yes Last use: __________ Amount: _________ Frequency: __________

Vape/E-Cigarette No Yes Last use: __________ Amount: _________ Frequency: __________

Prescription Medications Abused No Yes Started ________ Stopped ________

List:

____

____

Other:

____

____

Traumatic Events in Life (to include abuse, neglect, exploitation):

Event Date Degree of Impact

____

____

____

____

Current Sources of Stress:

____

____

____

____

____

____

Nutritional Screening (check all that apply):

☐ No Problem
☐ Trouble Chewing or Swallowing
☐ Nausea
☐ Special Diet
☐ Vomiting
☐ Other

Comments:
____

Change in Eating Habits:
- ☐ No Change
- ☐ More
- ☐ Less
- ☐ Not Eating

Change in Appetite:
- ☐ No Change
- ☐ Increased
- ☐ Decreased

Comments regarding Changes in Eating Habits and Appetite:
____

Advanced Directive: Yes (*check all that are applicable*):

Designation of Health Care Surrogate: ___ Durable Power of Attorney: ___ Living Will: ___ Mental Health: ___

Name and Contact Number of Health Care Surrogate/Durable Power of Attorney:
____
____
____

No, but I would like additional information: ____

No, and I do not wish for additional information: ____

Would you like to be referred to a health care provider today?

Yes: ____

Primary Care Provider: _____ Dentist: _______ Specialty Care: _____ Smoking Cessation: _______

Other: ____

No: ____

Explain why would like referral:
____
____
____

Past Suicide Attempts: Number ______

Date	Method	Hospitalized (Y / N)	Follow Up Treatment

Current Psychiatric Diagnosis (month/year diagnosed):

____

____

____

____

Past Psychiatric Diagnosis (month/year diagnosed):

____

____

____

____

Brain Stimulation (ECT, TMS, VNS, DBS, Cranial Electrotherapy Device, tDCS, EpCS):

Treatment	Facility	Dates	No. of Treatments	Outcome (improvement/side effects)

Comments:

____

____

____

____

Psychiatric Medications	Reason for Taking	Dose	Duration

Clinical Information

Current Medications & Herbal Treatments:

Name	Dose	Date Started	Reason Taking

Over the counter (non-prescription medications), Vitamins, or Supplements:

Personal Safety Plan:

This is your personal safety plan, your answers on this form will be reviewed with your provider to ensure your care is tailored to your specific treatment needs. Please answer all questions as honestly and accurately as possible.

The one thing that is most important to me and is worth living for is:

____

____

____

Warning Signs (thoughts, images, mood, situation, behavior, events that indicate a crisis may be developing.):

[ ] Angry outbursts
[ ] Being bullied
[ ] Being reminded of trauma
[ ] Excessive crying
[ ] Extreme mood swings
[ ] Feeling anxious or overwhelmed
[ ] Feeling irritable or angry
[ ] Feeling like a burden
[ ] Feeling like I do not belong
[ ] Feeling like I want revenge
[ ] Feeling overly tired
[ ] Feeling restless or agitated
[ ] Feeling Sad
[ ] Giving away belongings
[ ] Health problems worsening
[ ] Hearing voices
[ ] Hurting others
[ ] Impulsive behavior
[ ] Injuring self
[ ] Not eating
[ ] Not taking care of self
[ ] Planning to hurt self
[ ] Recent trauma or life crisis
[ ] Sleeping too little or too much
[ ] Substance use/abuse
[ ] Thinking I would be better off dead or gone.
[ ] Thoughts of killing myself
[ ] Withdrawing from activities
[ ] Withdrawing from people
[ ] Other

Specify: ____

____

____

____

Coping/Calming Strategies (tasks, practices, and distractions that help you feel better or take your mind off problems):

[ ] Clean room/house
[ ] Deep breathing
[ ] Do a puzzle
[ ] Do artwork
[ ] Download a crisis/safety app
[ ] Drink a beverage/eat favorite food
[ ] Encourage myself
[ ] Exercise
[ ] Write in a journal
[ ] Other
[ ] Go outside
[ ] Help others/volunteer
[ ] Hold an ice cube
[ ] Hug a stuffed animal
[ ] Listen to Music
[ ] Play a smartphone/video game
[ ] Play an instrument
[ ] Pray or meditate
[ ] Wrap yourself in a blanket
[ ] Push away thoughts
[ ] Read religious/spiritual material
[ ] Social Media
[ ] Surf the internet
[ ] Take a bath/shower
[ ] Talk to peers
[ ] Time with pets
[ ] Watch TV/movies
[ ] Yoga

Specify:

____

____

____

____

Distractions (people and social settings that can help provide distraction):

Name: ____________________________ Phone Number: ________________

Name: ____________________________ Phone Number: ________________

People who help/People whom I can ask for help:

Name: ____________________________ Phone Number: ________________

Name: ____________________________ Phone Number: ________________

Professionals or Agencies I can contact during a crisis:

Name: ____________________________ Phone Number: ________________

Name: ____________________________ Phone Number: ________________

- 24/7 Crisis Hotline: 1-800-342-0774
- Apalachee Center – Central Receiving Facility: 850-523-3303
- Mobile Response Team: 800-226-2931
- 211 Big Bend: 850-617-6333
- Suicide Prevention Hotline: 1-800-273-8255
- Emergency: 911
- Crisis Text Line: Text “Home” to 741-741

Safe Environment

Explain ways in which your environment at home can be made safe:

____

____

____

____

____

APALACHEE CENTER, INC.

Acknowledgment of Orientation / Treatment Authorization

Client Name: ____ Client #: ____________________
Last *First* *M.I.*

Introduction:
This form is used to outline and document your orientation to Apalachee Center, and provides the Center with an authorization for treatment. Please review carefully. Please contact a staff member with any questions. Thank you.

Orientation Items:

Copy Given/ Discussed	*N/A*	*(check all that apply)*
☐		**Client Rights & Responsibilities Listing** (CF 37)
☐		**Apalachee Privacy Notice** (CF 38)
☐		**Program Rules and Procedures** (including scheduling and canceling appointments, office hours, costs of services, limitations on services [if applicable], rules of conduct, orientation to facility/premises/safety, Important Message from Medicare [if applicable], grievance form [if applicable])
☐		**Services & Treatment Planning** (including services available, proposed treatment, alternatives for care, staff involved in care, participation and involvement in planning for services, and after-hours emergencies. Provide copy of "Speak Up-Help Prevent Errors in Care" [CF 308], HIV/AIDS Information Fact Sheet [CF 6], and Treatment Planning Survey [ACHS 121 - OP only]).
☐	☐	**Chemical Dependency (CD) Program Orientation** (Admission and Discharge Criteria, HIV/HBV Self-Assessment Form)

Authorizations/Consents:

Treatment Authorization: I hereby authorize Apalachee Center, Inc. to provide care and services as deemed necessary. I understand that I shall be financially responsible for service charges, if any, not covered by insurance.

Lifetime Medicare/Medicaid Certification and Authorization: Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVII or XIX or the Social Security Act is correct, and request that said payment of authorized benefits be made on my behalf to Apalachee Center, Inc.

Authorization to Pay Insurance Benefits/Release of Information: I hereby assign and authorize payment directly to Apalachee Center, Inc. for all treatment or insurance benefits applicable. I hereby authorize the release of any health information necessary, to support benefits payable for services by my insurance or third party payor / health plan. I hereby authorize Apalachee Center, Inc. to submit an appeal for payment of services on my behalf.

Privacy Notice Acknowledgement: As a behavioral health care provider, Apalachee must collect confidential information from persons served for treatment, payment, and health care operations. In addition to a client's name, address, phone number, social security number, date of birth, and other identifying or general profile information, medical information must be obtained which may include present complaints, past illnesses, prior treatment and hospitalization, medications, and other matters relating to a person's individual and family health. While Apalachee obtains most of this information from the person served, with a client's specific written authorization we will request relevant medical information from previous health care providers or other sources identified by the client that may be needed for treatment and health care operations. The confidentiality of protected health information is safeguarded and secured in accordance with all applicable State and/or Federal regulations. I acknowledge that I have received a copy of Apalachee Center, Inc.'s Privacy Notice.

Acknowledgment:

____/____/____ ______________________________ ______________________________
Client / Guardian Signature Responsible Staff Signature

Rights & Responsibilities of Persons Served

At Apalachee Center, Inc. we are concerned that each person entrusted to our care is treated with dignity, courtesy and respect. We recognize that all persons served have basic rights and we are committed to honoring these rights. Likewise Apalachee has a right to expect reasonable and responsible behavior from persons served, their relatives and friends.

Following is a summary of rights and responsibilities that we believe serve as the foundation for a good relationship between persons served and staff.

Rights

Access to Care: Individuals shall be given impartial access to treatment or services that are available and / or medically indicated without regard to race, color, sex, religion, national origin, age, disability, cultural or spiritual values.

Providers of Care: You have the right to know the identity and professional status of individuals providing treatment and the right to be informed of any changes in the professional staff responsible for your care.

Consent: You have the right to reasonable, informed participation in decisions involving your care. You have the right to know the risks and side effects of any medications we prescribe and to be informed of the outcomes of care including unanticipated outcomes. You have the right to refuse medications and treatment unless you have been committed by a court order.

Respect and Dignity: You have the right to receive considerate, respectful care at all times and under all circumstances, with recognition of personal dignity and diversity. You also have the right to be free from mental, physical, sexual and verbal abuse, neglect, exploitation. **You have the right to report abuse neglect, or exploitation by calling toll free 800-96-ABUSE (DCF Abuse Registry).** You have the right to a safe environment of care.

Participation in Treatment: You have the right to be involved in decisions about your care, treatment and services. We invite you and your family to join us as active members of your treatment team.

Information / Education: You have the right to current information about your diagnosis, treatment, alternatives and risks.

Privacy and Confidentiality: You have the right to expect all communication and records pertaining to your care to be treated as confidential.

Safety: Patient safety is a priority at Apalachee. Please inform staff if you are aware of any risks to safety and/ or have suggestions for improving safety. Your concerns and suggestions will be heard and handled appropriately.

Communication: You have the right to effective communication. Reasonable accommodations, including interpreter services can be arranged at no cost for persons with hearing, speech, visual and cognitive impairments. Please inform staff of any needed services.

Medical Records: You have the right to know how your medical records will be used and the right to request restrictions to its use however, Apalachee may decline to honor a request that creates an undue administrative hardship or interferes with your treatment team's ability to provide essential care and services. You have the right to see and receive copies of your medical record (unless determined harmful by your doctor) and may request an addendum be made to information

contained in the record that you believe is incorrect through a statement of disagreement / clarification. You have the right to know upon request to whom protected health information has been released.

Charges: You have the right to know the cost of services rendered.

Research: You have the right to refuse to participate in any research project.

Writ of Habeas Corpus: If you are being involuntarily retained, you have the right to petition the Circuit Court for a Writ of Habeas Corpus to question the cause and legality of your detention or a redress of grievances if you feel you are being unjustly denied a right or privilege or that an authorized procedure is being abused. Staff will provide you with a copy of the Writ.

Concerns: If you have a complaint or grievance about any aspect of your care, please let staff know so we can resolve it promptly. A grievance / complaint form (available from any staff) may be used. If staff is unable to address your concern they will inform their supervisor who will arrange to meet with you. We consider your comments opportunities to improve your care and service. To report concerns about your care you may also contact the Agency for Healthcare Administration Hotline 1-888-419-3456, Big Bend Community Based Care (Managing Entity) 850-410-1020, or the Substance Abuse and Mental Health Program office 850-488-2419 (Circuit 2 & 14), 352-955-5053 (Circuit 3). You may also contact Disability Rights Florida 800-342-0823 if you feel your rights have been violated. If you feel your civil rights have been violated you may contact Apalachee's ADA Coordinator at 850-523-3245 or the DCF Office of Civil Rights at 850-487-1901, TDD 850-922-9220 or the US Dept of Health & Human Services Office of Civil Rights 404-562-7886; TDD 404-331-2867.

Responsibilities

To assist us in your care and improve the outcome of services and treatment we ask that you:

Share all relevant information with staff about your current health concerns or conditions, and past illnesses, hospitalizations, medications and other physical and mental health matters.

Actively participate in your service plan development and in decisions affecting your care.

Inform staff or ask questions when you do not understand something about your care or what you have been told by staff.

Inform staff of concerns you have related to your care, treatment, services or safety issues.

Report any changes in your health or condition or living circumstances that can affect your care.

Respect the confidentiality and privacy of other persons receiving services at Apalachee.

Treat other persons and the Center=s property with respect and consideration.

Keep all appointments or notify the Center at least 24 hours in advance of necessary cancellation (if applicable to your services).

Follow program rules and regulations. No weapons, illegal drugs, or alcohol are to be brought to the Center.

Contact your personal physician or pharmacist or local emergency room as appropriate to the situation in the event of a mental health emergency / crisis or if you are unable to reach Apalachee staff during severe weather or a disaster.

APALACHEE CENTER, INC.
Notice of Privacy Practices

This notice describes how clinical information about individuals served may be used and disclosed, and how clients can get access to this information. Please read it carefully.

Your privacy is important to us. We want you to understand:

- Who will follow this NOTICE.
- The common ways in which we may use and share your medical information.
- How you can enable better care from other providers that you see.
- The ways in which we may use and share your medical information without your permission.
- Your rights concerning your medical information.
- How to file a complaint about your privacy.

Who will follow this NOTICE?

- This NOTICE applies to Apalachee Center, Inc. (Apalachee) and all of its employees.
- The law requires us to maintain the privacy of your medical information and to tell you our duties and practices regarding your medical information. These duties and practices include notifying you of a breach (improper sharing of your data).
- The law requires us to follow the terms of our current NOTICE. We reserve the right to make changes to this NOTICE, which may include new privacy provisions about the medical information that we keep. IF we make any changes, we will give you a copy of the new NOTICE the next time you visit us. The latest version of the NOTICE can always be found on our website at apalacheecenter.org. You have the right to a paper copy even if you have received an electronic version from our website.

What are the common ways in which we may use and share your medical information (including psychotherapy notes)?

- **Treatment Purpose:** We will share your information with those who are caring for you. As such, we may disclose your health information from time-to-time to a specialist, pharmacist, and laboratory or to other providers who are assisting Apalachee in your care and treatment.
- **Payment Purposes:** We may share your medical information with the insurance company paying for your care.
- **Health Care Operations:** We may use your medical information to improve the way we provide care to you and others. For example, a team of experts from our staff may review your medical information to ensure quality of care.
- **Appointment Reminders:** We may call you or send you a letter to remind you about your appointment. Please tell us if you do not want your information used in this way.
- **Sign-In Sheets**: We may use sign-in sheets in our offices and call your name when the doctor is ready to see you.
- **Research:** We may share your information for research. If we do this, the law requires us to take extra steps to protect your privacy and tell why we will be using your information.
- **Family and Others in Your Personal Life**: If you ask us to share specific information with a specific person, then we may do so. Otherwise, we will not share any information with these persons unless we are required to do so by law.
- **Satisfaction Surveys**: We may send a survey to you in the mail. Your answers will help us provide better care.
- **Specific Releases Authorized By You:** This is a release requested, signed, and dated by you that identifies what is to be released, to whom the information is to be released, and the reason for the release.

How can you enable better care from other providers that you see?

- In the future, we will be part of a Health Information Exchange (HIE). This HIE receives medical information in an electronic (not Paper) Form, and makes it available to other health care providers to enable improved treatment. With your authorization (by opting in), we can share a limited part of your medical information, including mental health and substance abuse information, with the HIE so your other care providers can better serve you. You have the right to participate (opt in) or not participate (opt out) at any time.

In what other ways may we use and share your medical information without your permission (including psychotherapy notes)?

- **As Required By Law**: We must contact the police if we suspect you are involved in child abuse or neglect.
- To stop a serious threat to the health or safety of someone or the public: We have a duty to warn others if we feel you could cause them harm.
- **Law Enforcement:** We may contact the police if we believe you are a victim of abuse. We may also contact the police if you commit a crime at our facility.
- **Public Health:** We may share your medical information with a public agency, such as the Centers for Disease Control and/or the Local County Health Department.
- **Reviews by Outside Agencies:** We may share your medical information when being reviewed by outside agencies that have authority over us. This includes state, federal and other licensing agencies. Certain identifying, demographic, and clinical

information pertaining to persons receiving Federal, State and/or Leon County supported services will be reported to the Big Bend CoC HMIS System, Department of Children & Families and Leon County HSCP Management System.

- **Court Order:** We may share your medical information when responding to an appropriate legal process such as a court order or when initiating involuntary court proceedings (Baker Act / Marchman Act).
- **Children:** In some cases we may not share your child's medical information with you. For example, there are times when your child can seek care without your permission.
- **In Case of Death:** We may share limited medical information with the medical examiner.
- **Inmates:** If you are a prisoner, we may share your information as appropriate.
- **National Security:** We may share your medical information as required by law for national security purposes.
- **For Protection of President and Other Important Leaders:** We may share your medical information as required by law for protection of the President and other important leaders.

We will not share your medical information for reasons other than noted above without your written authorization. This includes not sharing information for marketing and fund raising.

What are your rights concerning your medical information?

- **Right To Request Restrictions:** You can ask us not to share your medical information for treatment, payment, and health care operations. IF you do not want us to share information with or bill your insurance you will be expected to pay in full for your services. Please note, if you need emergency medical treatment we may share your medical information even if you have asked us not to.

- **Right to Revoke Authorizations:** You have the right to revoke your authorization at any time. Your revocation must be in writing.

- **Right to See and Get a Copy:** You have the right to see and get a copy of your medical information for as long as we have it. We may charge a fee for giving you a copy. If requested by you, this can be provided in an electronic format, paper, or fax. Sometimes the law does not allow us to let you see all or parts of your medical information. If this happens, you can appeal our decision. Your appeal must be in writing.

- **Right to Request Confidential Communications:** You can ask us to contact you in certain ways. For example, you can ask that we not send your bills or appointment reminders to your home address or call you at your work number. This request must be made in writing and tell us how you would like to be contacted. We will agree to reasonable requests.

- **Right to Change Information:** You can ask us to change your medical information. For example, you can ask us to correct errors such as your date of birth. This request must be made in writing. The law does not require us to agree to your request. If we deny your request to change your medical information, you can appeal our decisions. Your appeal must be made in writing.

- **Right To An Accounting:** You can ask us to give you a list of people we have shared your medical information with. This does not include information shared for treatment, payment, and healthcare operations. This also does not include information shared at your request. This request must be made in writing. We are required to keep track of your shared information for six years. This right starts on April 14, 2003 and we will not have any information prior to that date. If you request more than one accounting in a twelve- month period, we may charge you a fee.

Right to a Paper Copy of This NOTICE: If asked, we will give you a paper copy of this NOTICE.

How can you complain about our handling of your privacy?

- You have the right to complain if you feel your privacy rights have been violated by anyone who works for Apalachee Center, Inc. There will be no retaliation against you for filing a complaint. The quality of health care or services we provide will not be affected in any way because a complaint was filed.

- We ask that you please give us the opportunity to resolve any issues you have concerning your privacy. If you have any concerns about your privacy or feel any of your privacy rights have been violated, please file a written complaint with the Apalachee Privacy Officer at the address below. If you prefer, we will be happy to assist you in completing a written complaint. You can call us at (850) 523-3204 for assistance.

  Privacy Officer, Apalachee Center, Inc., 2634 J Capital Circle N.E., Tallahassee, FL 32308, (850) 523-3204

- You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services, but we ask that you first allow us the opportunity to correct any issues you may have concerning your privacy.

U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW, Atlanta GA Phone: (404) 562-7886 Fax: (404) 562-7881 ORRCComplaint@hhs.gov

FSU Behavioral Health Center @ Apalachee

Phone: (850) 644-6543
Fax: (850) 848-4400
Clinic Hours: 8 a.m. – 4 p.m., Mon-Fri

Patient Name: ______________________

Patient Date of Birth: ______________________

Program Rules and Procedures

I. Psychiatry Clinic Services

a. I understand that the Behavioral Health Center @ Apalachee is a provider of psychiatric services in coordination with Florida State University, and Apalachee Center, Inc.

b. Services may include, but are not limited to, psychiatry and psychotropic medication management, short-term psychotherapy and crisis intervention.

II. Appointments

a. Patients seen in the Behavioral Health Center may be referred from the community, self-referred, and community mental health facilities post hospitalization.

b. Patients are expected to arrive on time for scheduled appointments.

c. If a patient arrives more than 10 minutes late for an appointment, or initial paperwork is not completed, the patient may be asked to reschedule.

d. Treatment by a psychiatrist involves open and uninterrupted communication. Therefore, we request that arrangements are made for childcare (if applicable) prior to the scheduled appointment time. Also, cell phones should be turned off or placed on vibrate.

III. Cancelling Appointments and No Shows

a. *No Show Fees* may be incurred if the patient does not give proper notification of the inability to attend an appointment before the scheduled appointment time.

Phone: (850) 644-6543
Fax: (850) 848-4400
Clinic Hours: 8 a.m. – 4 p.m., Mon-Fri

i. Proper notification is by 4 p.m. on the business day prior to the scheduled appointment date.

b. **If the patient does not call and cancel their appointment by 4 p.m. on the business day prior to the scheduled appointment, a cancellation/no show fee may be charged. Insurance does not cover these costs.**

IV. Messages and Medication Refills

a. Questions regarding care or medication refills will be documented by the staff member taking the message.

b. Clinicians check their messages throughout the day. A clinician or staff member from the Behavioral Health Center will return patient calls within 24 hours or the next business day, if it is a weekend or holiday.

c. Please ensure the most current address, telephone number, and e-mail address is on file.

d. Messages for medication refill requests are generally honored if the patient has been compliant in attending their appointments and following their treatment regimen.

e. The patient may be asked to schedule an appointment for medication refills or concerns about treatment at the clinician's request.

f. **Please do not send messages via electronic mail. We are unable to respond due to HIPAA regulations.**

V. Transfer of Care and Dismissal from Psychiatry Clinic

a. Patients may be dismissed from the Behavioral Health Center at the discretion of the Psychiatry clinician due to non-eligibility, non-compliance to medication management, non-compliance to prescribed treatments and habitual appointment *No Shows* (x3).

FSU Behavioral Health Center @ Apalachee

Phone: (850) 644-6543
Fax: (850) 848-4400
Clinic Hours: 8 a.m. – 4 p.m., Mon-Fri

VI. After Hour Emergencies and Important Phone Numbers

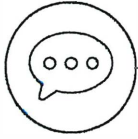
a. **Behavioral Health Center staff are not available for urgent/emergent calls when the clinic is not open during evenings, weekends, and holiday times. Patients will need to use other resources during these times. Below is a list of contact numbers for use during these times.**

Life threatening emergency	Dial 911
Mobile Response Team (MRT)	1-800-342-0774
Central Receiving Facility (CRF)	850-523-3483 **or** 1-800-342-0774
Big Bend 24-Hour Crisis Hotline	211 **or** 1-877-211-7005
Tallahassee Memorial Hospital Emergency Room	850-431-5411
Capital Regional Medical Center Emergency Room	850-325-5093
National Suicide Prevention Lifeline (suicidepreventionlifeline.org)	800-273-TALK (8255)

The Joint Commission

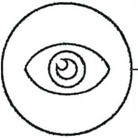
SpeakUp™

Speak Up™ About Your Care



Speak up...

- If you don't understand something or if something doesn't seem right.
- If you speak or read another language and would like an interpreter or translated materials.
- If you need medical forms explained.
- If you think you're being confused with another patient.
- If you don't recognize a medicine or think you're about to get the wrong medicine.
- If you are not getting your medicine or treatment when you should.
- About your allergies and reactions you've had to medicines.

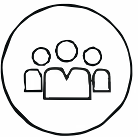


Pay attention...

- Check identification (ID) badges worn by doctors, nurses and other staff.
- Check the ID badge of anyone who asks to take your newborn baby.
- Don't be afraid to remind doctors and nurses to wash their hands.

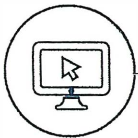
Educate yourself...

- So you can make well-informed decisions about your care.
- Ask doctors and nurses about their training and experience treating your condition.
- Ask for written information about your condition.
- Find out how long treatment should last, and how you should feel during treatment.
- Ask for instruction on how to use your medical equipment.



Advocates (family members and friends) can help...

- Give advice and support — but they should respect your decisions about the care you want.
- Ask questions, and write down important information and instructions for you.
- Make sure you get the correct medicines and treatments.
- Go over the consent form, so you all understand it.
- Get instructions for follow-up care, and find out who to call if your condition gets worse.



Know about your new medicine...

- Find out how it will help.
- Ask for information about it, including brand and generic names.
- Ask about side effects.
- Find out if it is safe to take with your other medicines and vitamins.
- Ask for a printed prescription if you can't read the handwriting.
- Read the label on the bag of intravenous (IV) fluid so you know what's in it and that it is for you.
- Ask how long it will take the IV to run out.

Use a quality health care organization that...

- Has experience taking care of people with your condition.
- Your doctor believes has the best care for your condition.
- Is accredited, meaning it meets certain quality standards.
- Has a culture that values safety and quality, and works every day to improve care.

Participate in all decisions about your care...

- Discuss each step of your care with your doctor.
- Don't be afraid to get a second or third opinion.
- Share your up-to-date list of medicines and vitamins with doctors and nurses.
- Share copies of your medical records with your health care team.

The goal of Speak Up™ is to help patients and their advocates become active in their care.

Speak Up™ materials are intended for the public and have been put into a simplified (i.e., easy-to-read) format to reach a wider audience. They are not meant to be comprehensive statements of standards interpretation or other accreditation requirements, nor are they intended to represent evidence-based clinical practices or clinical practice guidelines. Thus, care should be exercised in using the content of Speak Up™ materials. Speak Up™ materials are available to all health care organizations; their use does not indicate that an organization is accredited by The Joint Commission.

AIDS AND HIV FACT SHEET APALACHEE CENTER, INC.

AIDS is caused by a virus called HIV (Human Immunodeficiency Virus).When a person is infected with HIV, the virus infects and can kill certain cells in the immune system called T-helper cells. This weakens the immune system so that other opportunistic infections can occur. The HIV infected person is said to have AIDS (Acquired Immunodeficiency Syndrome) when they become sick with other specific infections or when the number of T-helper cells has dropped below 200.

PEOPLE AT HIGHEST RISK OF AIDS AND HIV INFECTION ARE:

- Those who share needles
- Babies born to mothers who have HIV infection
- Those who have received blood transfusions or blood products before 1985
- Those who engage in unprotected sex
- Anyone who has sex with anyone who has or is at risk for AIDS or HIV infection

ANYONE who has engaged in any of the above noted behaviors is encouraged to get tested for HIV. Speak with your primary Doctor about this, or contact your county health department.

*Don't be afraid to get tested. It can even be done anonymously.

HIV virus is found in blood, vaginal and seminal secretions, breast milk of HIV infected mothers, and amniotic and cerebrospinal fluids.

The HIV virus is not spread through casual contact such as working with a person who is HIV positive, holding hands, or hugging.

** HIV and AIDS are preventable **

*Abstaining from sex, monogamy with an uninfected partner, and using condoms are the most protective prevention strategies.

*Practice Universal and Standard Precautions, such as handwashing, gloves, goggles, etc..

*Women who are pregnant or planning a pregnancy are encouraged to speak with their doctor about getting tested for HIV. Early treatment may protect the baby.

==

No safe and effective cure currently exists, but scientists are working hard to find one, and remain hopeful. Meanwhile, with proper medical care, HIV can be controlled. Treatment for HIV is often called antiretroviral therapy or ART. It can dramatically prolong the lives of many people infected with HIV and lower their chances of infecting others.

AGREEMENT TO MEDIATE

In accepting care at this FSU facility and/or at any of the following facilities where FSU employees and/or agents provide medical care and treatment, i.e. NAME OF FACILITY, I agree that before I file any lawsuit against the FSU Board of Trustee for medical care and treatment rendered by its health care providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party who has been certified to be a mediator tries to help settle claims. FSU will pay the cost of the mediator. I further agree that any mediation must take place in the state and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

______________________________ ____________

Signature of Patient/Authorized Representative/Guardian Date

____

Printed Name of Patient/Authorized Representative/Guardian

Relationship to patient: □ Self □ Authorized Representative □ Guardian

______________________________ ____________

Printed Name of Witness Date

COPIES OF THIS STATEMENT SHALL BE VALID AS THE ORIGINAL/ORIGINAL SIGNATURES ON FILE WITH FSU.

Attachment B

NOTICE OF LIMITED LIABILITY PURSUANT TO SECTION 1012.965, FLORIDA STATUTES

I, on behalf of myself, my child, and/or my ward, acknowledge that I have been notified that:

I, my child, and/or my ward, will receive medical care and treatment provided by employees and/or agents of the Florida State University Board of Trustees (hereafter referred to as "FSU") at this FSU facility and one or more of the following non-FSU health care facilities where FSU employees provide medical care and treatment, including:

NAME OF FACILITY

The FSU employees and/or agents providing this medical care and treatment may include, but are not limited to physicians, residents, fellows, medical students, pharmacy students, other healthcare students, physician assistants, advanced registered nurse practitioners, perfusionists, nurses, pharmacists, and technicians who will at all times be under the exclusive supervision and control of FSU.

I, on behalf of myself, my child, and/or my ward, understand that the employees of FSU are not employees or agents of any entity other than FSU.

Additionally, I, on behalf of myself, my child, and/or my ward, understand that liability, if any, that may arise from the care rendered by FSU health care providers is limited as provided by law. The law provides that "Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $200,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $300,000." (Section 768.28(5), Florida Statutes)

______________________________ ______________

Signature of Patient/Authorized Representative/Guardian Date

____

Printed Name of Patient/Authorized Representative/Guardian

______________________________ ______________

Printed Name of Witness Date

Confidentiality

Confidentiality Agreement & Consent for Taping and Observation

FSU BehavioralHealth Center at Apalachee Center provides services to the Tallahassee community and functions as a training facility for the graduate students in the Department of Psychology, College of Nursing and College of Medicine. Clinicians in training may conduct intake and ongoing diagnostic procedures, medication management, and psychological treatment as approved by their supervisor(s). Because clinicians in training need to receive thorough supervision, it is necessary for sessions to be recorded. These recordings are used only for approved clinic training activities. In addition, the clinicians in training may be observed by clinic staff (for example, the faculty supervisor or other members of the treatment team).

Consent to the above procedures is required of all clients who receive clinic services. Within the purview of the Florida Public Records Law (119 F.S.) the clinic staff with safeguard your confidentiality and your relationship with the clinic will not be revealed to anyone without your prior written consent. However, under certain conditions, the clinic is legally and ethically obligated to release information about a client whether or not the client approves. These conditions include:

1. Suspected abuse (physical, sexual, or neglect) of children, the elderly, and the disabled. As psychologists, we are required by law to report suspected abuse to the proper authorities.
2. Potential homicide or suicide. In instances where a client threatens homicide we may have to notify the intended victim and police. Likewise, if a client is thought to be at high risk for suicide, family and/or authorities may need to be notified for the client's protection.
3. Court Order. We must release a client's records if a judge issues a court order compelling us to do so.

This consent shall remain in effect as long as services are being provided. I understand I may revoke consent; however, services may be impacted in doing so.

If you have any problem or questions about any of these procedures and wish to discuss them with a staff member, please sign your initials here: __________. You should withhold your signature from the following page until any difficulties, problems, or questions have been satisfactorily answered.

Confidentiality Agreement & Consent for Taping and Observation (page two)

Your signature, giving consent to these procedures, is required in the appropriate section before we can provide services.

Adult Clients (18 years of age or older)

I, ________________________ have read and agree and understand the foregoing information concerning taping and observation, and by my signature do hereby give full and complete consent to allow audio/videotapes to be made of my sessions. I further understand and agree that these sessions may be observed by certified clinic staff members. I also understand the limits of confidentiality as specified above and that my consent may be revoked at any time, though it may impact my services.

______________________________ ______________________

Client's Signature Date

____

Witness

Child Clients (those under 18 years of age)

I, ______________________ have read and understand the foregoing information concerning taping and observation, and by signature do hereby give full and complete consent to allow audio/videotapes to be made of my sessions and that of my child, ___________________________. I further understand and agree that these sessions may be observed by certified clinic staff members. I also understand the limits of confidentiality as specified above and that my consent may be revoked at any given time, though it may impact my services or that of my child.

______________________________ ______________________________

Signature of Parent/Guardian Relation to Minor

______________________________ ______________________

Witness Date

FSU BehavioralHealth ™
at Apalachee Center
1126 Lee Avenue
Tallahassee, Florida 32303
(850) 644-6543

Date ________
Participant Initials________

Patient Health Questionnaire (PHQ-9)

Instructions: Please circle one number for each statement.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	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 over eating	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.	0	1	2	3

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
10. If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

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NNDC Common Baseline Assessment: Self-Rated (April 2, 2018)

For Internal Office Use Only

Site: ________
Visit Date: ________

Site Staff Data Entry Initials ____________
Provider Reviewed Initials:____________

Date ________
Participant Initials________

Generalized Anxiety Disorder Scale (GAD-7)

Instructions: Please circle one number for each statement.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

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
	☐	☐	☐	☐

Spitzer, R.L., Kroenke, K., Williams, J.B.W., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med, 166, 1092-97.
NNDC Common Baseline Assessment: Self-Rated (April 2, 2018)

For Internal Office Use Only

Site: ________
Visit Date: ________

Site Staff Data Entry Initials ________
Provider Reviewed Initials: ________