Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Use of your medical information within Osprey Behavioral Health:
1. To provide, coordinate or manage your health care and related services with other health care professionals for the purpose of providing health care to you.
2. To file insurance claims for health care services or collect from other sources that may be paying for your health care.
3. To support the operation of the behavioral health practice and any other use required by law.

Use of your medical information outside Osprey Behavioral Health:
1. When requested for Public Health reporting, oversight agencies, state coroners and medical examiners, specialized government agencies and funeral directors as required by law.
2. To support Law enforcement when needed for audits, inspections, investigations and to comply with mandates.
3. As it relates under Florida law to protect at risk individuals or potential victims from abuse, neglect, or domestic violence.
4. To facilitate continuation of your care in the event you are incarcerated.
5. When requested by you or legal court mandate for administrative and judicial proceedings.

We may use or disclose, as needed your protected health information in order to support the business activities of Osprey Behavioral Health. These activities include but are not limited to, quality assessment activities, employee review activities, training medical and nursing students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk. We may also call you by name in the waiting room when your physician is ready to see you.

Your Individual Rights

Under the Federal Privacy Standards:
1. Confidential communications about your treatment with your provider.
2. To Inspect, amend, submit corrections to and copy your protected health information. Filling out a form available at our office can do this.
3. Tracking of disclosure of your protected health records.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your physician or physician's other practice has taken action in reliance on the use or disclosure indicated in the authorization.

OSPREY
Behavioral Health
PROUDLY SERVING BOTH MILITARY AND CIVILIAN PATIENTS
Since 1993

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Registration

105 S. Riverside Drive,
Suite #151
Indialantic, FL 32903

Name: _____ Date of Birth: _____ Today's Date: _____
(First) (MI) (Last)

Social Security Number: _____ Gender: ◯Male ◯Female

Residence: _____
(Street) (City) (State) (Zip)

Employer: _____ Occupation: _____

Check appropriate circle: Ethnicity: (Optional) ◯White ◯Hispanic ◯Other/Refuse

◯Minor ◯Single ◯Married ◯Divorced ◯Widowed ◯Separated ◯Non-White ◯Non-Hispanic

How did you learn about our office? _____

Previous Mental Health Professional: _____

Primary Phone: _____ Secondary Phone: _____ Email: _____

Responsible Party Telephone Numbers (if different): Home Phone: _____ Cell: _____

Where do you prefer to receive phone calls? ◯Home ◯Work ◯Cell Phone ◯Please do not call at Work

In the event of an Emergency, whom should we contact?

Name: _____ Home Phone: _____ Cell: _____

Responsible Party for Payment of this Account: ◯Same as Patient

Name: _____ Relationship to Patient: _____

Birthdate: _____ Residence: _____
(Street) (City) (FL) (Zip)

Do you have medical insurance? ◯Yes ◯No If Yes, Name of Insured (Policy Holder): _____

Relationship to Patient: _____ Insured's Birthday: _____ Insured's Social Security #: _____

Employer: _____ Employer's Address: _____

Insurance Company: _____ Group #: _____ ID #: _____

Insurance Co. Phone #: _____ Do you have additional Insurance? ◯Yes ◯No ◯Accident/Injury

2nd Policy Holder Name: _____ Birthdate: _____ Employer: _____

Company Name: _____ Group #: _____ ID #: _____

Informed Consent: I, the undersigned or parent/guardian, voluntarily give consent to Osprey Behavioral Health, medical professional to provide and perform diagnostic procedures and treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination the office.

Assignment of Benefits: I hereby authorize Osprey Behavioral Health, to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Osprey Behavioral Health (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a copy of this agreement shall be considered as effective and valid as the original.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

_____

Signature of Patient or Legal Representative Date

Primary Care Physician_____ What is his/her contact information?_____

How would you rate your overall health? Excellent Good Fair Poor

Have you ever suffered from the following conditions?

Headaches/migraines ◯Yes ◯No	Stroke/TIA ◯Yes ◯No	CAD/ MI ◯Yes ◯No	Parkinsons Dz ◯Yes ◯No
High Blood Pressure ◯Yes ◯No	Head Injury ◯Yes ◯No	Thyroid Dz ◯Yes ◯No	Diabetes ◯Yes ◯No
GERD/PUD ◯Yes ◯No	Cancer ◯Yes ◯No	Liver Disease ◯Yes ◯No	Lung Disease ◯Yes ◯No
Kidney Disease ◯Yes ◯No	Sleep Apnea ◯Yes ◯No	Chronic Pain ◯Yes ◯No	Arthritis ◯Yes ◯No

Height _____ Weight _____ LMP _____ Hospitalizations/Surgeries: _____

What Medications and Over the Counter Vitamins and Supplements do you take? _____

Do you have any Allergies to medications? _____

Have you ever been involuntarily admitted to the hospital for a mental illness? _____

Do you have any family history of mental illness or substance abuse? _____

Current Stressors:

Do you have a place to live? ◯Yes ◯No Do you have access to Health Care? ◯Yes ◯No Do you have a source of income? ◯Yes ◯No

Do you have financial problems? ◯Yes ◯No Are you currently employed? ◯Yes ◯No When where you last employed? _____

Are you currently experiencing relationship problems? ◯Yes ◯No Legal Problems? ◯Yes ◯No

Are you a Care giver? ◯Yes ◯No Are you suffering from loss of a loved one? ◯Yes ◯No If so when?_____

Do you fear for your Safety? ◯Yes ◯No Have you been a victim of domestic violence? ◯Yes ◯No If so, when?_____

Tobacco Dependency - Do you smoke? How many cigarettes per day? _____

Have you smoked cigarettes in the past? If so, when did you quit?_____

Do you drink alcoholic beverages? Y/N If so, how many drinks daily?_____

Do you use recreational drugs? Y/N If so, what and how often?_____

Please identify agents used in the past?

Caffeine ◯Yes ◯No Cocaine ◯Yes ◯No Ecstasy ◯Yes ◯No Heroin ◯Yes ◯No

LSD/PCP ◯Yes ◯No Meth ◯Yes ◯No Marijuana ◯Yes ◯No

Consequences of Drug Use: DUI ◯Yes ◯No Incarceration ◯Yes ◯No Rehab ◯Yes ◯No

Safety Behaviors:

Do you wear a motorcycle helmet when you ride a motorcycle? _____

Do you wear a bicycle helmet when you ride a bicycle? _____

Do you talk or text on a cell phone while driving? _____

Do you drink alcoholic beverages and drive? _____

_____ _____

Initials Date

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Privacy Preferences - See Reverse for HIPPA Policy

Please list with whom we may discuss your private mental health records with (e.g., family members, primary care physician). Documentation describing diagnosis, treatment, and payment information may be included in personal information.

Name:_____ Relationship:_____

Address:_____ Phone #:_____

Name:_____ Relationship:_____

Address:_____ Phone #:_____

Advanced Directives:

Having an ADVANCED DIRECTIVE in place can give you peace of mind regarding your future health care needs making your wished known in advance of a life threatening event/illness.

If you have a living will and/or an assigned health care surrogate, we will gladly make a copy of your documents and place it in the medical record.

Declaration to decline Life-Prolonging Procedures

◯ I have made a living will

◯ I do NOT have a living will

Health Care Surrogate

◯ I have designated a health care surrogate

◯ I do NOT have a health care surrogate

Durable Power of Attorney (DPA) ◯ I have appointed a DPA for my health care ◯ I have NOT appointed a DPA for my health care

Please Read Carefully:

◯ I have received and read a copy of Osprey Behavioral Health Privacy Practices.

◯ I understand that correspondence will be sent from this office marked CONFIDENTIAL.

◯ CONFIDENTIAL messages may be left on my phone, voice mail, or answering machines.

◯ I am fully aware that a cell phone is not a secure and private line.

Osprey Behavioral Health Office Policy:

Our providers only see one patient at a time so that each patient has their complete attention. Cancellations or rescheduling of appointments made over 24 hours in advance will be appreciated, even if you do this through our messaging services.

Cancellations made less than 24 hours and No Shows are subject to the following fees:

1st Missed Appointment: $25.00

2nd Missed Appointment $50.00

3rd Missed Appointment Automatic Discharge

Documentation will be required for true emergency, in which case, the cancellation policy does not apply.

Signatures

By signing this document, I acknowledge that I or my Legal Representative have read and fully understand the policies and procedures indicated as above.

_____Signature of Patient or Legal Representative

_____Date