Heather Neeley MD, PA

905 E. Martin Luther King Jr. Dr.
Suite 430
Tarpon Springs, FL,34689
Phone: 727-446-8866
Fax: 727-446-2277
HeatherNeeleyMD.com

Consent for treatment

I, the undersigned, a patient of Heather Neeley MD, PA and/or I the undersigned (a parent of minor), or (guardian of), or (guardian advocate of),

_____, hereby authorize the professional staff of Heather Neeley MD, PA to evaluate and/or administer treatment, including the use of medication(s) if necessary. A minor will require the additional consent of a parent or guardian.

I agree to provide Heather Neeley MD, PA with urine and/or saliva specimens upon request to test for substance abuse. I agree to pay for these tests. I agree to provide a breathalyzer sample upon request. I understand that the results of these screenings may be used to help determine my treatment needs. I also understand that if I refuse to provide these samples or to perform a breathalyzer, I may be terminated from the practice.

I have read and fully understand and agree to the office policies/procedures including fees that may be charged for additional services. A copy of these fees is attached to the back of this paperwork please read **FULLY** before signing.

I have read and fully understand the above authorization for treatment. No guarantee or assurance has been made to me as to the results that may be obtained.

_____ _____
Client signature Date

_____ _____
Provider/Designee Signature Date

I have read and understand the Privacy Policy of Heather Neeley MD, PA.

_____ _____
Client Signature Date

I authorize the use of this form on all of my insurance submissions.
I authorize release of information to my insurance company, including mental health/substance abuse diagnosis and mental health /substance abuse treatment information requested by the insurance company for payment and/or authorization.
I understand that I am responsible for my bill, even if the insurance company does not pay.
I authorize my doctor (or her staff) to act as my agent in helping me obtain payment from my insurance companies.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.
I permit this document to act as ñSignature on Fileò for submission of claims to my insurance companies.

_____ _____ _____
Client Signature Client Printed Name Date

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name _____ Date _____
Print Patientôs Name

The undersigned does hereby acknowledge that he/she has received a copy of this officeôs Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this officeôs HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Dated this _____ day of _____, 20_____

By _____
Patientôs Signature

If patient is a minor or under guardianship order as defined by State Law:

By _____
Signature of Parent / Guardian (circle one)

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REVIEW OF SYSTEMS

Please answer all questions below.
This will become a part of your medical record.

Patient Name:_____

General:

Recent weight change	___NO	___YES
Fever	___NO	___YES
Fatigue	___NO	___YES

Eyes:

Blurry vision	___NO	___YES
Glaucoma	___NO	___YES

ENT:

Hearing loss	___NO	___YES
Ringing in ears	___NO	___YES
Mouth sores	___NO	___YES

Cardiovascular:

Chest pains	___NO	___YES
Palpitations	___NO	___YES
Fainting	___NO	___YES
Short of breath with activity	___NO	___YES
H/O fainting	___NO	___YES
Foot/ankle swelling	___NO	___YES

Respiratory:

Cough	___NO	___YES
Short of breath	___NO	___YES
Wheezing	___NO	___YES

Gastrointestinal:

Nausea	___NO	___YES
Vomiting	___NO	___YES
Diarrhea	___NO	___YES
Constipation	___NO	___YES
Abdominal pain	___NO	___YES

Genitourinary:

Urinary symptoms	___NO	___YES
Menstrual irregularity	___NO	___YES

Musculoskeletal:

Back pain	___NO	___YES
Joint pain	___NO	___YES
Muscle pain	___NO	___YES
Muscle weakness	___NO	___YES

Skin:

Rash	___NO	___YES
Itching	___NO	___YES
Easy bruising	___NO	___YES
H/O Stevens Johnson Syndrome	___NO	___YES

Neurological:

Headaches	___NO	___YES
Seizures	___NO	___YES
Numbness	___NO	___YES
Tremors	___NO	___YES
Tingling/burning	___NO	___YES

Psychiatric:

Memory loss	___NO	___YES
Suicidal ideation	___NO	___YES
Hallucinations	___NO	___YES
Paranoia	___NO	___YES

Endocrine:

Excessive thirst	___NO	___YES
Frequent urination	___NO	___YES
Increased appetite	___NO	___YES

HemeLymphatic:

Abnormal bruising	___NO	___YES
Bleeding	___NO	___YES

Allergic/immunologic:

Excessive skin itching	___NO	___YES
Hay fever	___NO	___YES
Ongoing infection	___NO	___YES

Health screening:

Labwork in last 12 months	___NO	___YES

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Medication List

Please list all *current* medications in the space provided below.

Patient Name: _____

	Medication	Dosage	Frequency
	EX: Alprazolam	0.5 mg	1x daily
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Preferred Pharmacy

Pharmacy Name: _____

Pharmacy Location: _____

Phone: _____ Fax: _____

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PRIMARY CARE PHYSICIAN

Authorization for Release of Medical Records

I,_____ (DOB_____) authorize Heather Neeley, MD PA and employees of Heather Neeley, MD PA __**X**__Release to __**X**__Secure from __**X**__PCP_____THERAPIST_____PSYCHIATRIST
Name:_____
Location:_____

Fax_____ Contact number_____
The following information:
___ Psychiatric evaluation
_**X**_ Alcohol and Drug History
___ Psychiatric Hospitalization records With Psychiatric evaluation, Discharge Summary And Copy of Discharge instructions with Discharge medications list
___ Psychological Evaluation Report
___ Therapy ï Initial evaluation, most recent encounter and Treatment Plan
_**X**_ FIRST REQUEST ï Primary Care Record of Most Recent Physical exam, most recent encounter and Lab results
_**X**_ Other REQUEST/SHARE PSYCHIATRIC TREATMENT INFORMATION AND REQUEST OTHER MEDICAL RECORDS FOR COORDINATION OF CARE ï VERBAL, ELECTRONIC, PAPER INFORMATION

For the Purpose of: TREATMENT WITH COORDINATION OF CARE

*I understand that if I consent to the release of any of my medical records, the results of any Psychiatric/psychological, Alcohol and/or Drug Dependency information will be released. I agree to hold Heather Neeley MD, PA harmless and release them from any liability for any claims or actions, which may occur as a result of the release of the information to the person(s) named herein.

*I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F. R. pts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

1 YEAR
(Specification of the date, event or condition upon which this consent expires)

I understand this consent is revocable upon written notice to the Heather Neeley MD PA to the extent that the action by Heather Neeley MD PA has been taken in reliance on this authorization and that this authorization shall remain in force for a period of ninety (90) days in order to affect the purpose for which it was given.

Clientôs Signature Date

Staff Signature Date

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PREVIOUS THERAPIST

Authorization for Release of Medical Records

I,_____ (DOB_____) authorize Heather Neeley, MD PA and employees of Heather Neeley, MD PA __**X**__Release to __**X**__Secure from _____PCP__**X**__THERAPIST_____PSYCHIATRIST
Name:_____
Location:_____

Fax_____ Contact number_____
The following information:
___ Psychiatric evaluation
_**X**_ Alcohol and Drug History
___ Psychiatric Hospitalization records With Psychiatric evaluation, Discharge Summary And Copy of Discharge instructions with Discharge medications list
___ Psychological Evaluation Report
_**X**_ FIRST REQUEST ï Therapy ï Initial evaluation, most recent encounter and Treatment Plan
_**X**_ Other ALLOW SHARING OF PSYCHIATRIC/THERAPY TREATMENT RECORDS BOTH VERBALLY AND ELECTRONICALLY ï SHARE PAPER RECORDS IF NEEDED TO ALLOW FOR COORDINATION OF CARE

For the Purpose of: TREATMENT WITH COORDINATION OF CARE

*I understand that if I consent to the release of any of my medical records, the results of any Psychiatric/psychological, Alcohol and/or Drug Dependency information will be released. I agree to hold Heather Neeley MD, PA harmless and release them from any liability for any claims or actions, which may occur as a result of the release of the information to the person(s) named herein.

*I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F. R. pts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

1 YEAR
(Specification of the date, event or condition upon which this consent expires)

I understand this consent is revocable upon written notice to the Heather Neeley MD PA to the extent that the action by Heather Neeley MD PA has been taken in reliance on this authorization and that this authorization shall remain in force for a period of ninety (90) days in order to affect the purpose for which it was given.

Clientôs Signature Date

Staff Signature Date

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PREVIOUS PSYCHIATRIST

Authorization for Release of Medical Records

I,_____ (DOB_____) authorize Heather Neeley, MD PA and employees of Heather Neeley, MD PA __**X**__Release to __**X**__Secure from _____PCP_____THERAPIST__**X**__PSYCHIATRIST
Name:_____
Location:_____

Fax_____ Contact number_____
The following information:
_**X**_ Psychiatric evaluation
_**X**_ Alcohol and Drug History
_**X**_ Psychiatric Hospitalization records With Psychiatric evaluation, Discharge Summary And Copy of Discharge instructions with Discharge medications list
_**X**_ Psychological Evaluation Report
_**X**_ Therapy ï Initial evaluation, most recent encounter and Treatment Plan
___ Primary Care Record of Most Recent Physical exam, most recent encounter and Lab results
_**X**_ Other COORDINATION OF CARE SUMMARY, LIST OF MEDICATIONS PRESCRIBED
_____

For the Purpose of:
TREATMENT WITH COORDINATION OF CARE
_____

*I understand that if I consent to the release of any of my medical records, the results of any Psychiatric/psychological, Alcohol and/or Drug Dependency information will be released. I agree to hold Heather Neeley MD, PA harmless and release them from any liability for any claims or actions, which may occur as a result of the release of the information to the person(s) named herein.

*I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F. R. pts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

90 DAYS
(Specification of the date, event or condition upon which this consent expires)

I understand this consent is revocable upon written notice to the Heather Neeley MD PA to the extent that the action by Heather Neeley MD PA has been taken in reliance on this authorization and that this authorization shall remain in force for a period of ninety (90) days in order to affect the purpose for which it was given.

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Staff Signature Date

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CANCELLATION / MISSED APPOINTMENT POLICY AGREEMENT

Please read carefully.

At least 24 hour notice is *REQUIRED* to cancel or reschedule appointments. Follow up appointments cancelled or rescheduled less than 24 hours prior to the scheduled appointment will result in the assessment of a $25 same day cancellation fee to the patients account which must be paid prior to the next appointment. Therapy appointments cancelled or rescheduled less than 24 hours prior to the scheduled appointment will result in the assessment of a $50 same day cancellation fee to the patients account which must be paid prior to the next appointment.

Missed or "no show" follow up appointments will result in the assessment of a $25 missed appointment/no notice fee to the patients account which must be paid prior to the next appointment. **Missed or "no show"** therapy appointments will result in the assessment of a $50 missed appointment/no notice fee to the patients account which must be paid prior to the next appointment. **Missed or "no show"** new patient appointments will result in the assessment of a $100 missed appointment/no notice fee to the patients account which must be paid prior to the next appointment.

I, _____, do hereby acknowledge that I have read and reviewed
Print Patientôs Name
thisofficeôs Notice of Practice Cancellation / Missed Appointment policy and do hereby agree to the terms and conditions stated in the Notice of Practice Cancellation / Missed Appointment Policy implemented by the office of Dr. Heather Neeley, MD PA.

_____ _____
Patientôs Signature Date

If patient is a minor or under a guardianship order as defined by State Law:

By _____ _____
Signature of Patent/Guardian (circle one) Date