GUSTAVO J. CUADRA, M.D.

Board-Certified Psychiatric Care

Office: 727) 265-1781
Fax: (727) 330-7578

3023 Eastland Boulevard, Suite 106
Clearwater, Florida 33761

JUST A FRIENDLY REMINDER

New Patient Paperwork must be completed and returned to our office at least **three business days** prior to your scheduled appointment.

This allows the doctor to read background history prior to seeing a new patient.

Failure to receive the completed paperwork three business days prior to the appointment time will result in the appointment being cancelled.

Returning the completed paperwork t our office as soon as possible could potentially allow us to move up our appointment, should a cancellation allow earlier availability

Gustavo J. Cuadra, M.D.

Board-Certified Psychiatric Care

3023 Eastland Blvd. Suite 106
Clearwater, FL 33761

Phone: 727-265-1781
Fax: 727-330-7578

PATIENT INFORMATION

Last Name_____ First Name_____ MI____

Address_____ City_____ State___ Zip_____

Home Phone_____ Social Security No._____ DOB_____

Work Phone_____ Age_____ Sex_____ Marital Status_____

Cell Phone_____ Prefered Confirmation Phone_____

RESPONSIBLE PARTY NAME

Insured's Employment Information

Employer_____

Address_____

Business Phone_____ May we contact you at work? Yes_____ No_____

INSURANCE INFORMATION

Company_____ Policy No._____

Address_____

Phone Number_____ Social Security Number of Policy Holder_____

Policy Holder's Name_____ DOB_____

EMERGENCY INFORMATION

Person to contact in case of emergency_____

Address_____ Phone No._____

Relationship_____ Who referred you to this practice?_____

AGREEMENT FOR SERVICES

1. Consent is hereby given to Dr. Gustavo J. Cuadra to render mental health services/treatment to my child or myself.
2. Confidentiality is assumed unless client expresses harm to self and/or others or in case of judicial mandates (i.e. court subpoenas/orders).
3. I authorize the release of any medical information necessary to process this or a related claim to my insurance company or the billing service.
4. I authorize payment of insurance benefits to Gustavo J. Cuadra or other treating professionals.
5. I, the Undersigned, understand that I am responsible for payment of services and understand that any co-payment or deductible is due when services are rendered..
6. I understand that I am responsible for any charges not covered by my insurance or if payment has not been received from my insurance company within 60 days from the date of service.
7. I agree to pay all incurred costs and authorize release of all personal demographics should bill be forwarded to collections.
8. If you are unable to keep an appointment, please call the office at least 24 hours before the appointment. I understand that a charge will apply if I fail to provide the 24-hour notice of cancellation.
9. I understand that there will be a charge for completion of forms for medical records, disability, employment, prescription pre-authorization, etc., and also for any requested typewritten letters and/or reports.

Please sign this document in the presence of a member of Dr. Cuadra's staff

Signature _____ Date:_____

Print Name _____

ParentGuardian _____ Date: _____

Witness _____ Date: _____

EMAIL ADDRESS_____

CURRENT PHARMACY_____ PHONE_____

Concord Treatment Center Financial Policy

In order to promote an atmosphere of understanding and trust, we have detailed our financial policy below. We ask that you carefully read and sign this financial agreement. If you have any questions, please discuss them during your first visit.

- **Payment**-Full payment is due at the time of service. We accept cash, checks and major credit cards. Any other financial arrangement must be made with the office prior to your visit and specified in writing.

Cancellation policy-Continuity of treatment is essential in order to benefit from your sessions. Therefore, we encourage you to plan ahead to avoid any last minute problems in coming to your appointment. Since the treatment requires that doctor reserve a significant amount of time exclusively for your benefit, cancellations and missed appointments necessitate a policy that is fair to both you and the doctor. In the event that your health, family, work responsibilities or other reasons require to cancel your appointment, there will be no charge for cancellation made at least 24 hours prior to the appointment. Such notification will allow your doctor to schedule other commitments. If insufficient notice provided, a fee will be charged. "NO SHOW" fee is $50.00. Those charges cannot be submitted to your insurance company. This policy applies to all clients.

- **Late Appointment policy**-Patients who arrive late for an appointment will be asked to wait to see the doctor until there is a sufficient time to complete the visit/appointment or the patient will be asked to reschedule the appointment.

- **Insurance**-Once we have a proof of your insurance coverage we will verify your benefits. However, we cannot guarantee the amount of reimbursement you will receive from your insurance company. We will file insurance claims weekly and we will be happy to file claim for you, however, you are ultimately responsible for all charges in our office. Please remember that insurance is primarily a contract between you and your insurance. We can't become involved in disputes about coverage, deductibles and secondary insurance or other matters.

- **Prescription refills**- Obtaining prescription refills on a timely basis is the patients responsibility. If you don't have refills available, you will need to call our office at least (5) business days prior to the last dose. This office is not open on weekends or during holidays and refills are not available during that time. If patient allows the prescription to expire, doctor will not issue medication "to see me through" until patient is scheduled for appointment.

- **Billing**-Any unpaid balances will be billed to you monthly. Full payment is expected by the fifteenth of the month. The Concord Treatment Center reserves the right to report seriously delinquent accounts to the Credit Bureau and you will be responsible for any costs incurred for collections to include any legal fees.

- **Office fees for medical records, copies/forms/reports:** $1.00 per page for copies up to 25 pages, $0.25 per page per copy for 25 pages and more. Request for medical records, FMLA, legal forms, Physical forms, disability forms, require a minimum of 5 days. There is a charge of $50-$75 for completing forms depending on extent of the paperwork.

- **Endorsement**-I have carefully read and fully understand this financial agreement.

Please sign this document in the presence of a member of Dr. Cuadra's staff.

Client_____Date_____

Print Name_____

Parent/Guardian_____Date_____

Witness_____Date_____

NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this notice, please contact Gustavo J. Cuadra, M.D. His office is located at 3023 Eastland Blvd, Suite 106, Clearwater, Florida 33761. Tel: 727-265-1781.

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our employees, staff, and other office personnel. The practice described in this notice will also be followed by healthcare providers you consult with by telephone (when your regular healthcare provider from our office is not available) who provide "call coverage" for your healthcare provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed consent to use and disclose health information for the following purposes:

For Treatment. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that the doctor can help determine the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

For Payment. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a service you received here so that your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Healthcare Operations. We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services. We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes. You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time. If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment, or healthcare operations, and we may therefore choose to discontinue providing you with healthcare treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law. We will disclose health information about you when required to do so by federal, state, or local law.
Research. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care at the office.
Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantations, or to an organ donation bank, as necessary to facilitate such donation and transplantation.
Military, Veteran, National Security, and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence administrations, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
Worker's Compensation. We may release health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Public Health Risks. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order, subject to all applicable legal requirements.
Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
Coroners, Medical Examiners, and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make a reasonable inference that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may evoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or healthcare operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:
Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to Gustavo J. Cuadra, M.D. in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed

healthcare professional to review your request and denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to Gustavo J. Cuadra, M.D. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

Right to an Accounting of Disclosure. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and healthcare operations. To obtain this list, you must submit your request, in writing to Gustavo J. Cuadra, M.D. It must state a time period, which may not be longer than six years, and it should indicate in what form you want the list (for example, on paper or electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to Gustavo J. Cuadra, M.D.

The Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communication, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to Gustavo J. Cuadra, M.D. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Gustavo J. Cuadra, M.D.

CHANGES TO THIS NOTICE We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Gustavo J. Cuadra, M.D. at (727) 265-1781. You will not be penalized for filing a complaint.

Please sign this document in the presence of a member of Dr. Cuadra's staff.

Signature _____ Date: _____

Print Name _____

Parent/Guardian _____ Date: _____

Witness _____ Date: _____

Concord Treatment Center Financial Policy

In order to promote an atmosphere of understanding and trust, we have detailed our financial policy below. We ask that you carefully read and sign this financial agreement. If you have any questions, please discuss them during your first visit.

- Payment-Full payment is due at the time of service. We accept cash, checks and major credit cards. Any other financial arrangement must be made with the office prior to your visit and specified in writing.

Cancellation policy-Continuity of treatment is essential in order to benefit from your sessions. Therefore, we encourage you to plan ahead to avoid any last minute problems in coming to your appointment. Since the treatment requires that doctor reserve a significant amount of time exclusively for your benefit, cancellations and missed appointments necessitate a policy that is fair to both you and the doctor. In the event that your health, family, work responsibilities or other reasons require to cancel your appointment, there will be no charge for cancellation made at least 24 hours prior to the appointment. Such notification will allow your doctor to schedule other commitments. If insufficient notice provided, a fee will be charged. "NO SHOW" fee is $50.00. Those charges cannot be submitted to your insurance company. This policy applies to all clients.

- Late Appointment policy-Patients who arrive late for an appointment will be asked to wait to see the doctor until there is a sufficient time to complete the visit/appointment or the patient will be asked to reschedule the appointment.

- Insurance-Once we have a proof of your insurance coverage we will verify your benefits. However, we cannot guarantee the amount of reimbursement you will receive from your insurance company. We will file insurance claims weekly and we will be happy to file claim for you, however, you are ultimately responsible for all charges in our office. Please remember that insurance is primarily a contract between you and your insurance. We can't become involved in disputes about coverage, deductibles and secondary insurance or other matters.

- Prescription refills- Obtaining prescription refills on a timely basis is the patients responsibility. If you don't have refills available, you will need to call our office at least (5) business days prior to the last dose. This office is not open on weekends or during holidays and refills are not available during that time. If patient allows the prescription to expire, doctor will not issue medication "to see me through" until patient is scheduled for appointment.

- Billing-Any unpaid balances will be billed to you monthly. Full payment is expected by the fifteenth of the month. The Concord Treatment Center reserves the right to report seriously delinquent accounts to the Credit Bureau and you will be responsible for any costs incurred for collections to include any legal fees.

- Office fees for medical records, copies/forms/reports: $1.00 per page for copies up to 25 pages, $0.25 per page per copy for 25 pages and more. Request for medical records, FMLA, legal forms, Physical forms, disability forms, require a minimum of 5 days. There is a charge of $50-$75 for completing forms depending on extent of the paperwork.

- Endorsement-I have carefully read and fully understand this financial agreement.

Please sign this document in the presence of a member of Dr. Cuadra's staff.

Client_____Date_____

Print Name_____

Parent/Guardian_____Date_____

Witness_____Date_____

GUSTAVO J. CUADRA,M.D.
HEALTH SURVEY
PAST PSYCHIATRIC HISTORY

Previous Psychiatrist or Nurse Practitioner:_____

Previous Psychologist,Therapist,Counselor:_____

Previous Inpatient Hospitalizations and Baker Acts:_____

PAST MEDICAL HISTORY

Hospitalizations and Surgeries

YEAR WHERE NAME OF ILLNESS

Please list any head injuries: Was unconsciousness present? Yes No

Is there a history of the following in:

YOURSELF	A BLOOD RELATIVE	YOURSELF	A BLOOD RELATIVE
[] High Blood Pressure	[] High Blood Pressure	[]Stomach ulcer	[]Stomach ulcer
[] Diabetes	[] Diabetes	[]Kidney stones	[]Kidney stones
[] Alzheimer's	[]Alzheimer's	[]Arthritis	[]Arthritis
[]Stroke	[]Stroke	[]Chronic Headaches	[]Chronic Headache
[]Heart Attacks	[]Heart Attacks	[]Thyroid problems	[]Thyroid problems
[]Cancer	[]Cancer	[]Asthma	[]Asthma
		[]Other	[]Other

CURRENT MEDICATION INFORMATION

Medication **Dosage** **Reason on this medication** **How long on it?**

ALLERGIES:_____

Personal And Family Psychiatric History

Is there a history of any of the following in:

Yourself :			**A Blood Relative:**		
*Depression	Yes	No	*Depression	Yes	No
*Anxiety Disorder	Yes	No	*Anxiety Disorder	Yes	No
*Substance Abuse	Yes	No	*Substance abuse	Yes	No
*Psychiatric Hospitalization	Yes	No	*Psychiatric Hospitalization	Yes	No
*Legal Problems	Yes	No	*Legal Problems	Yes	No
*Suicide Attempts	Yes	No	*Suicide Attempts	Yes	No
*Other self harm	Yes	No	*Other self harm	Yes	No

DEPRESSION ASSESMENT SCALE

Please circle the answer to each question below which best applies to you:

For the past two weeks I have been:

1)Feeling unhappy or sad:

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

2)Angry or irritable more often my old self:

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

3)Having little interest in fun activities:

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

4)Not sleeping like I normally do (whether sleeping too much or too little):

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

5)Not eating like I normally do(whether eating too much or too little):

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

6)Wishing I was dead or thinking of suicide:

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

7)Unable to concentrate or pay attention very well:

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

8)More forgetful then my old self:

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

9)Locking the motivation and energy that I normally have:

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

10)Feeling down on myself and/or my future:

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

Please Circle Previously Taken Medications

ANTIDEPRESSANT	MOOD STABLIZER	ANTYPSYCHIOTIC	ANTIPARKINSONIAN	ANTIANXIETY	PSYCHOSTIMULANT
Prozac	Lithium	Zyprexa	Benadryl	BusPar	Ritalin
Paxil	Depakote	Risperdal	Artane	Vistaril	Dexedrin
Zoloft	Tegretal	Seroquel	Cogentin	Xanax	Adderall
Effexor	Neurontin	Clozaril		Klonopin	Concerta
Celexa	Lamictal	Haldol		Ativan	Cotempla
Wellbutrin	Topiramate	Geodon		Valium	Mydayis
Remeron	Gabapentin	Abilify		Librium	Journay
Luvox		Prolixin			Vyvanse
Nortryptyline		Latuda			Focalin
Viibryd		Vraylar			Aptensio
Trazodone		Saphris			
Luvox		Fanapt			
Pamalor		Rexulti			
Pamate					
Cymbalta					
Trintellix					
Prisitiq					
Aplenzen					
Anafranil					

TARDIVE DYSKINESIA	MEMORY MEDICATION
INGREZZA	DONEPAZIL
AUSTEDO	MEMANTINE

Concord Treatment Center

Michelle Scargle, M.D.

Gustavo Cuadra, M.D.

3023 Eastland Boulevard
Suite 106
Clearwater, FL 33761
Phone: (727) 265-1781

FROM THE NORTH:
Take U.S. 19 South
Turn left onto S.R. 580
Turn right onto Landmark
Turn left onto Eastland

FROM THE SOUTH:
Take U.S. 19 North
Turn right onto Enterprise
Turn left onto Landmark
Turn right onto Eastland