GUSTAVO J CUADRA, M.D.

Board-Certified Psychiatric Care

3023 Eastland Blvd, Suite 108

Clearwater, FL 33761

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

JUST A FRIENDLY REMAINDER-IMPORTANT!!!!!

New patient paperwork needs to be filled out before your upcoming appointment with Dr. Cuadra. Entering information on the clinic website is helpful to the doctor, however we must have the paperwork that is attached here completed and returned to the office no later than 3 business days prior to your scheduled appointment. This allows the doctor to read background history prior to seeing new patient. Completed paperwork may be emailed, faxed, or dropped off to our office.

If you would like to be added to our cancellation list to see the doctor sooner, please indicate that on the paperwork when you return the forms to us.

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PATIENT INFORMATION

Last Name_____First Name_____MI_____
Address_____City_____State_____Zip_____
Home Phone_____Social SecurityNo._____DOB_____
Cell Phone_____Age_____Sex_____Martial Status_____

INSURANCE INFORMATION

Company_____Policy No._____
Address_____Phone No_____
Secondary Ins._____

EMERGENCY INFORMATION

Person to contact in case of emergency_____
Address_____Phone No_____
Relationship_____Who referred you to this Doctor_____

AGREEMENT FOR SERVICES

*Consent is hereby given to Dr Gustavo J Cuadra to render mental health services/treatment to myself or my child.
*Confidentiality is assumed unless patient expresses harm to self or others or in case of judicial mandates (i.e. Court subpoenas/orders).
*I authorize to release any medical information necessary to process this or relates claim to my insurance company or the billing service.
*I authorize payment of insurance benefits to Dr Gustavo J Cuadra.
*I, the undersigned, understand that I am responsible for payment of service and understand that any co-payment or deductible is due when the service is rendered.
*I understand that I am responsible for any charges not covered by insurance or if the payment has not been received form my insurance comp within 60 days from the day of service.
*I agree to pay all incurred costs and authorize release of all personal demographics should bill be forwarded top collections.
*If you are unable to keep an appointment, please call the office at least 24 hrs. before the appointment. I understand that a charge will apply if I fail to provide 24 hrs. notice of cancelation.
*I understand that there will be a charge for completion of forms for medical records, disability, employment, prescription pre-authorization, etc. and for any requested typewritten letters and/or reports.

PLEASE SIGN THIS DOCUMENT:

Signature_____Date_____
Print Name_____
Parent/Guardian_____
Witness_____Date_____

EMAIL:

PHARMACY:

Dr Gustavo J Cuadra 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.

1. **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.
2. **Cancellation policy**-Continuity if 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 $75.00. Those charges cannot be submitted to your insurance company. This policy applies to all clients.
3. **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.
4. **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 untimely responsible for all charges in our office.
   Please remember that insurance is primarily contract between you and your insurance company.
   We cannot become involved in disputes about coverage, deductibles, secondary insurance or other matters beyond supplying factual information as required.
5. **Prescription refills**- Obtaining prescriptions refills on timely basis is patients responsibility. If you have refills available, you will have the pharmacy fax the request to 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 trough" until patient is scheduled for appointment.
6. **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.
7. **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 extend of the paperwork
8. **Endorsement**-I have carefully read and fully understand this financial agreement.

Please sign this document:

Client_____Date_____

Print Name_____

Parent/Guardian_____Date_____

Witness_____Date_____

Notice of Privacy Practices

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

Your Rights

- Obtain a copy of your medical and mental health record.
- Request corrections to your record if you believe it is inaccurate or incomplete.
- Request confidential communication (e.g., only contact you at work or by mail).
- Ask us to limit what we use or share regarding your treatment.
- Request an accounting of disclosures—who we have shared your information with and why.
- Receive a paper or electronic copy of this privacy notice.
- Appoint someone to act on your behalf.
- File a complaint if you believe your privacy rights have been violated.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you – Coordinate your psychiatric care with other professionals involved in your treatment.
- Run our practice – Improve our services, perform quality reviews, and manage operations.
- Bill for services – Submit claims to insurance for reimbursement.

We may also disclose your information in the following cases, when required or permitted by law:

- For public health and safety issues.
- To comply with legal or regulatory obligations.
- To respond to court orders or legal proceedings.
- To assist with law enforcement or government investigations.
- To avert a serious threat to health or safety.

Please note: In the field of psychiatry, certain types of mental health records—such as psychotherapy notes—receive special protection and are not shared without your specific, written permission except in very limited circumstances (e.g., threat of harm, court order).

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will notify you promptly if a breach occurs that may compromise your information.
- We will follow the practices described in this notice and provide you with a copy upon request.
- We will not share your information other than as described here unless you give written authorization. You may revoke this authorization at any time.

LAW ENFORCEMENT.

WE MAY RELEASE HEALTH INFORMATION IF ASKED TO DO SO BY LAW ENFORCEMENT OFFICIAL IN RESPONSE TO COURT ORDER, SUBPOENA, WARRANT, SUMMONS OR SIMILAR PROCESS, SUBJECT TO ALL APPLICABLE LEGAL REQUIREMENTS. ANY INDICATORS WITH CRIMINAL ACTIVITIES SUCH AS DOCTOR SHOPPING, TRADING OR SELLING MEDICATIONS OR FRAUDULENT PRESCRIPTIONS WILL BE SHARED WITH LAW ENFORCEMENT LOCAL, STATE OR FEDERAL.

If you have any questions about this notice or your privacy rights, or if you wish to file a complaint, please contact:

Contact information

Dr. Gustavo J. Cuadra, M.D.
3023 Eastland Blvd, Suite 108
Clearwater, FL 33761 Phone # 727-265-1781

You may also file a complaint with the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Please sign this documentation:

Signature_____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 than my old self:

Do Not Agree Slightly Agree Moderately Agree Strongly Agree

9)Lacking 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	Tegretol	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		Poloxin			Vyvanse
Nortriptyline		Latuda			Focalin
Viibryd		Vraylar			Aptensio
Trazodone		Saphris			
Luvox		Fanapt			
Pamelor		Rexulti			
Palmate					
Cymbalta					
Trintellix					
Pristiq					
Aplenzin					
Anafranil					

TARDIVE DYSKINESIA	*MEMORY MEDICATION*
INGREZZA	DONEPAZIL
AUSTEDO	MEMANTINE

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Directions from the North:

Take US 19 South

Turn left onto S.R. 580

Turn right onto Landmark

Turn left onto Eastland

Directions from South:

Take US 19 North

Turn right onto Enterprise

Turn left onto Landmark

Turn right onto Eastland