James B. Bartlett, LMHC

NEW PATIENT INFORMATION

Patient: ____________________ Date of Birth (DOB): ____________ Today's Date: ____________

Address: ____

City: ____________________ State: ____________ Zip: ____________

Home Phone: ____________ Work Phone: ____________ Cell: ____________

Sex: ___ Male ___ Female Age: ____________ Marital Status: ____________

Emergency Contact: ____________________ Relationship: ____________

Address: ____

City: ____________________ State: ____________ Zip: ____________

Home Phone: ____________ Work Phone: ____________ Cell: ____________

Referred By: ____________________

PRIMARY INSURANCE INFORMATION (Please complete information for policy holder)

Insured: ____________________ DOB: ____________ Relationship: ____________

Insurance Company: ____

Group Cumber: ____________ Insured ID: ____________ Phone: ____________

Address: ____

City: ____________________ State: ____________ Zip: ____________

Employer Name: ____

Phone: ____________

SECONDARY INSURANCE INFORMATION (Please complete information for policy holder)

Insured: ____________________ DOB: ____________ Relationship: ____________

Insurance Company: ____

Group Cumber: ____________ Insured ID: ____________ Phone: ____________

Address: ____

City: ____________________ State: ____________ Zip: ____________

Employer Name: ____

Phone: ____________

COORDINATION OF CARE

It is important for your health care providers to speak to each other so we may work together to help you. Please complete the information below and indicate your approval for us to coordinate care.

Primary care physician: ______________________________ **Phone:** ______________

Address: ____

City: ______________________________ **State:** __________ **Zip:** ______________

May we contact your physician: ___ **YES** ___ **NO** ___ **I DO NOT HAVE A PHYSICIAN**

Psychiatrist/Therapist: ______________________________ **Phone:** ______________

Address: ____

City: ______________________________ **State:** __________ **Zip:** ______________

May we contact your Psychiatrist/Therapist: ___ **YES** ___ **NO**
___ **I DO NOT HAVE A PSYCHIATRIST/THERAPIST**

Name: ______________________________

CURRENT INFORMATION

Reason for appointment:

Appetite problems or changes:

Concentration problems or changes:

Sleep problems or changes:

Losses in the past few years: (Deaths, relationships, job, etc.)

MEDICAL HISTORY

Allergies: ___ None ___ Allergic to:

Date of last physical exam:

Surgeries:

Medical conditions:

CURRNET MEDICATIONS (Dosage, frequency – include supplements and over-the-counter medications)

PSYCHIATRIC HISTORY (Include treatment dates, name of provider[s])

Psychiatric admissions: ___ No ___ Yes - If so, where and dates?

This form is provided as a sample. It is not being provided to fit a particular set of circumstances nor is it to be used as a clinical assessment tool. You have the sole responsibility for ensuring that the release of information that follows all state and Federal requirements and in accordance with applicable standards of practice for your license/specialty.

Coordination of Care between Health Care Providers and Release of Information

J. Bryan Bartlett, M.S., LMHC
727-422-6564

Communication Between behavioral health care providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patients Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in six (6) months from the date of my signature below unless otherwise stated herein.**

________________________ is authorized to release protected health information related to the
(Current Provider Name-Please Print)

evaluation and treatment of ______________________________ ____________________________
(Member Name) (Member ID#)

_______/_______/__________
(Date of Birth – MM/DD/YYYY)

PCP Name: ________________________________ PCP Phone: ______________________________

PCP Address: ____ ______________
(Street) (City) (State) (Zip Code)

Other BH Provider Name: ___________________________ BH Provider Phone: ____________________

BH Provider Address: ____ ______________
(Street) (City) (State) (Zip Code)

Other Name: ______________________________________ Other Phone: ______________________

Other Address: ____ ______________
(Street) (City) (State) (Zip Code)

Disclosure may include the following verbal or written information: (Check all that apply)

___ Face Sheet
___ Discharge summary
___ ER record report
___ Substance abuse treatment record
___ History & physical
___ Medical records
___ Psychiatric evaluation
___ Laboratory/diagnostic testing results
___ Behavioral health/psychological consult
___ Psychological assessment
___ Summary of treatment records & contact dates
___ School information
___ Psychological eval/testing results
___ Other

___ I hereby refuse to give authorization for any release of information

____ ____________________
(Signature of Patient, Parent, Guardian or Authorized Representative) (Date)

James Bryan Bartlett, LMHC

Procedure for Telephone Contact

Please note that it is sometimes necessary to notify you of a change in appointment time. Please be assured that your confidentiality is very important at these times and if you cannot be reached a message will be left with only a first and last name and phone number. Please initial here as to the procedure you wish to be followed:

_______ Do not contact me under any circumstances

_______ Yes, you may contact me as described above

_______ Yes, you may contact me, but only under these conditions:

Notice of Therapist Availability

Please be advised that I am not available at all times. I will attempt to return phone calls in a timely manner for brief conversations between sessions when needed.

In the event that you cannot reach me at any given time (day, evening, weekend, holiday) and you feel it is an emergency, go to any emergency room for psychological consultation, or call 911. Keeping yourself safe is your responsibility and if you are unable to do this you must contact me, your Primary Care Physician, or 911.

I would like your permission to send appointment reminders by text. Please initial one of the options below:

________ Yes

________ No

In order to protect your confidentiality, please limit the use of communicating by text. If communication by text is your preference, please limit content to generic content. By signing below you are agreeing to the above terms.

Signature: ____ Date: ________________

Financial Responsibility

I, ____________________________, understand that I am responsible for any service rendered, regardless of whether this service is covered by insurance. I further understand that it is my responsibility to give James Bryan Bartlett 24 hours notice if I am going to cancel my appointment. Failure to notify may result in a charge commensurate with the total session fee, up to $50.00.

____ ____________________

(Client's Signature) **(Date)**

James Bryan Bartlett, LMHC

Agreement for Service/Informed Consent

1. I have chosen to receive psychotherapy services. My choice is voluntary and I understand that I may terminate at any time.

2. I understand that there are no assurances that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with the therapist in a cooperative manner to resolve my difficulties.

3. I understand that during psychotherapy, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

4. I have read and had explained to me the basic rights of an individual receiving mental health treatment. These rights include:

   A. The right to be informed of the various steps and activities involved in receiving services.
   B. The right to confidentiality under federal and state laws relating to the receipt of services.
   C. The right to make an informed decision whether to accept or refuse treatment.

5. I understand that each individual appointment is scheduled for approximately 45-50 minutes. If I am unable to keep the appointment, I will call Bryan Bartlett at (727) 422-6564 to cancel twenty – four hours before the appointment.

Client: ______________________________ Date: ______________
(Signature)

Witness: ______________________________ Date: ______________
(Signature)

Medical Records Release Informed Consent

James Bryan Bartlett, LMHC MH# 8008
111 2nd Ave. NE, Suite 918
Saint Petersburg, FL 33701
(727) 422-6564

Records created during our therapeutic work/talk therapy will not be released for the purpose of Disability Claims, Employment/Workers Compensation Claims, Divorce Dissolution or Child Custody Cases.

By signing below you acknowledge understanding and agreeing to the above limits to records release.

I have been provided an opportunity to ask questions and have had my questions answered to my satisfaction.

Client's Printed Name: ____

Client's Signature: ____

Date: ____________________

Therapist's Printed Name: ____

Therapist's Signature: ____

Date: ____________________

James Bryan Bartlett, LMHC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: CLIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ______________________ Date of Birth: ______________________

SECTION B: TO THE CLIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your healthcare information. A copy of our Notice accompanies this Consent. We encourage you to read carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

James Bryan Bartlett, LMHC
34421 Tranquiview Lane
Dade City, FL 33523
Phone: (727) 422-6564
Fax: (813) 866-1332

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to James Bryan Bartlett, LMHC at the address above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operation.

Signature: ______________________________ *Date:* ______________

If this consent is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: ______________________________

Relationship to Client: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in the client's file

James Bryan Bartlett, LMHC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health Information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provides such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us by using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operation. For example:

Treatment: We may use or disclose your health information to your Primary Care physician, psychiatrist, or other healthcare provider.

Payment: We may use and disclose your health information to your insurance company of Employee Assistance, in order to obtain payment for our services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. These activities are limited to billing, treatment planning, audits by insurance companies or state agencies, requests for authorizations from insurance companies or other payers and regulatory boards or agencies involved in audits for licensing and credentialing purposes.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason, with the following exceptions:

A. If I sign a waiver requesting release of information.
B. If a court orders the release of my records.
C. If I raise the matter of my mental status or competency in legal proceedings.
D. If there is reason to believe that there is a clear and immediate probability that I will harm myself or others.

To Your Family and Friends: We must disclose your health information to you, as described in the Client Rights section of this Notice. We may disclose your health information to a family member, friend, or other person only with a release signed by you authorizing release of confidential information specifically to that person.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to that person's involvement in your healthcare.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Harm to Self or Others/Abuse or Neglect: We may disclose your health information directly to the Florida Department of Children & Families in the case of abuse or neglect.

The Florida Legislature has enacted laws to protect a client's confidentiality while under the care of a Licensed mental Health Councilor. Confidentiality refers to the broad expectation that what is reveled by individuals in therapy will not be shared with third parties. The concept of confidentiality is designed to allow for the free and open discussion of material. As with most laws within our country and Florida, there are limitations. You will find below the limitations of this confidentiality as determined by the Florida Psychological Services Act (491.0) and Florida Statues 415.504 and 415.103.

Florida Statue 491
In essence this statue requires Licensed Mental health Councilors to breach confidentiality if it is determined that a client presents a danger of harm to him/herself or others. If a client presents an imminent danger to someone else, then that person must be notified according to Florida Statues "Duty to Warn". If a client presents a danger to himself or herself, then appropriate therapeutic intervention is mandated, which may include hospitalization.

Florida Statue 415.504
This Florida Statue requires the mandatory reporting of any knowledge of child abuse or neglect. This information must be reported to the Department of Children and Families both verbally and in writing. It is the policy of this office to notify the client prior to the reporting of such information. This prior notification is a courtesy provided to the client and will in no way inhibit or delay the reporting of suspected abuse or neglect.

Florida Statue 415.203
This Florida Statue requires the mandatory reporting of any knowledge of child abuse, neglect, or the exploitation of the aged or disabled adults. This information must be reported to the Department of Children and Families both verbally and in writing. Again, it is the policy of this office to notify the client prior to the reporting of such information. This prior notification is a courtesy provided to the client and will in no way inhibit or delay the reporting of suspected abuse or neglect.

CLIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We will prepare a summary or an explanation of your health information upon your written request.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information, other than treatment, payment, and healthcare operations and certain other activities for the last six years, but not before April 14, 2003.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure on your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or location.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, or to the U.S. Department of Health and Human Services. The addresses for the above entities are available upon request.

Contact Information: *James Bryan Bartlett, LMHC*
34421 Tranquiview Lane
Dade City, FL 33523
Phone: (727) 422-6564
Fax: (813) 886-1332

James Bryan Bartlett, LMHC

ACKNOWLEGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, ____ have received a copy of this office's Notice of Privacy Practices.

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please Specify)

____

____

____