Palm Bay Office
2123 Franklin Dr NE
Palm Bay, FL 32905

Suntree Office
1351 Bedford Dr
Melbourne, FL 32940

Rockledge Office
4185 US Highway 1
Rockledge, FL 32955

Phone: 321-724-1614

Fax: 321-256-5200

Patient Consent for Use and Disclosure of Protected Health Information

I, the undersigned, hereby authorize Atlantic Psychiatric Centers ("the Practice") to use and disclose my protected health information (PHI) for the purposes of treatment, payment, and healthcare operations (TPO).

Communication Consent: I permit the Practice to contact me via phone, email, or mail at my home or another specified location. This may include messages regarding appointment reminders, insurance inquiries, and other aspects of my clinical care such as lab results, labeled as "Personal and Confidential."

Financial Agreement: I agree to the Practice's financial terms. My health insurance will be billed for services rendered, and my provider will receive direct payment from my insurance company. I acknowledge my responsibility for any deductibles and copayments. If my insurance coverage is not valid at the time of service, I understand that I am responsible for the full payment.

Cancellation and Missed Appointments: I acknowledge that cancellations or missed appointments without at least one business day's notice may incur a fee of up to $75 or as per my insurance carrier's policies.

Consent for Treatment: I authorize Atlantic Psychiatric Centers to provide necessary mental health care services, examinations, treatments, and/or diagnostic procedures that are deemed advisable now or during my care. I understand that the purpose of these procedures will be explained to me upon request and will proceed only with my consent. I recognize that while therapy aims to be beneficial, it may at times provoke difficult and uncomfortable feelings.

Consent for Use of Artificial Intelligence in Clinical Documentation: Some providers at Atlantic Psychiatric Centers may use HIPAA-compliant Artificial Intelligence (AI) tools to assist in generating clinical documentation from patient sessions. These tools support—not replace—my provider’s clinical judgment and are used under direct supervision. The process may involve secure transcription or summarization of my session; resulting notes are reviewed, edited, and finalized by my provider before entry into my medical record. All data remains confidential and protected under HIPAA. By signing, I authorize this use as part of my care, and I may decline by informing my provider.

Consent for Telehealth/Telemedicine Services: Atlantic Psychiatric Centers offers care via telehealth (live video and/or audio) through HIPAA-compliant platforms. Telehealth is voluntary, and I may request an in-person visit at any time. My provider has explained, or will explain upon request, how telehealth works, including its benefits and limitations (such as technology disruptions or situations requiring in-person evaluation). The same confidentiality, documentation, and HIPAA protections apply as to in-person visits, and my election to use telehealth will be documented in my record. By signing, I authorize the use of telehealth as part of my care.

Revocation of Consent: I understand that I may revoke this consent in writing at any time, except where actions have already been taken based on this consent. Should I not sign this consent, or if I later revoke it, I understand that the Practice may refuse to provide treatment.

By signing below, I acknowledge that I have read and understood this consent form and agree to its terms.

Signature of Patient or Legal Representative: _____

Patient Name: _____

Date: _____

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, Atlantic Psychiatric Centers originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis to my bill;
- a means by which a third-party payer can verify that services billed were provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I may request a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Atlantic Psychiatric Centers' notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review Atlantic Psychiatric Centers' notice prior to signing this consent;
- Atlantic Psychiatric Centers reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that Atlantic Psychiatric Centers are not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that Atlantic Psychiatric Centers has already acted in reliance thereon.

Signature of Patient or Legal Representative: _____

Patient Name: _____

Date: _____

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature of Patient or Legal Representative: _____

Patient Name: _____

Date: _____

By signing this consent form, you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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Card on File Authorization for Patient Balances & Fees

Please complete and sign. This form authorizes APC to keep a payment method on file and to charge it for amounts for which you are financially responsible.

PAYMENT METHOD ON FILE

I authorize Atlantic Psychiatric Centers ("APC") to securely store my payment method and to charge it for any amounts I owe after insurance has processed my claims (including copays, coinsurance, deductibles, non-covered services, and other patient-responsibility balances), as well as fees under APC's published Late Cancellation/No-Show policy. **Timing of charges:** I agree APC may charge the card on file either (i) immediately upon determination of patient responsibility or (ii) within 24 hours after claim adjudication and posting of the Explanation of Benefits (EOB). I understand I will receive a receipt by email upon each charge.

Frequency and amount limits: Recurring charges will occur only when a new balance becomes due. I may request a payment plan; if approved, APC will run scheduled installments as agreed and are separate from any new charges on the account. **Other payment options:** I understand I can pay with other methods (e.g., cash, check, HSA/FSA, portal) before the scheduled charge time. If I pay by another method, no card charge will be made to the card on file.

Disputes/Refunds: If a charge is made in error, APC will promptly refund the amount once verified. I will contact APC first to resolve any concerns. **Consent:** This authorization applies to this care episode and future services at Atlantic Psychiatric Centers. I certify I am an authorized user of the payment method.

Credit Card Information	
Card Type: ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover ☐ Other: _____	
Cardholder Name (as shown on card): _____	
Card Number: _____	CVV: _____
Expiration Date (mm/yy): _____	Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Atlantic Psychiatric Centers to charge my credit/debit card above for agreed upon purchases. I understand that my information will be saved for future transactions on my account.

_____ Responsible Party Signature

_____ Date

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Late Cancellation Fee

At Atlantic Psychiatric Centers, we are committed to providing timely mental health services. To ensure availability for all patients, we have implemented a late cancellation policy.

Policy on Late Cancellations:

Cancellation Notification: Please notify our office at least one business day in advance if you need to cancel or reschedule your appointment. This allows us to offer the slot to another patient in need of care.

Late Cancellation Fee: If you cancel less than one business day before your scheduled appointment, you may be assessed a fee of up to $75. This fee helps us manage resources and maintain service availability.

Waiver of Fees: The fee may be waived under certain circumstances, which will be evaluated on a case-by-case basis.

Acknowledgment and Consent:

By signing below, I acknowledge that I have read and understood the Late Cancellation Policy of Atlantic Psychiatric Centers. I agree to the potential assessment of a late cancellation fee up to **$75** if I fail to cancel my appointment more than **one business day** in advance.

Signature of Patient or Legal Representative: _____

Patient Name: _____

Date: _____

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Personal Information:

Legal Name:	Last	First	Middle Initial	Preferred Name:
Legal Sex (please check one): ☐ Female ☐ Male *While APC recognizes a spectrum of genders, many insurance companies and legal entities require legal sex for billing and official documents. Your preferred name and pronouns are respected.*				**Pronouns:**
Date of Birth:	month/day/year		**Social Security #:**	

Your answers below help us reach you quickly and discreetly with important information

Cell Phone: OK to leave voicemail? ☐ Yes ☐ No **( ) -**		**Work Phone: OK to leave Voicemail?** ☐ Yes ☐ No **( ) -**	
Address:	City	State	Zip
Email Address:			
Emergency Contact Name:	Phone Number	Relationship to you	
Primary Care Physician / Pediatrician Name:		Phone Number	

This information is for demographic purposes

Racial Group(s) (check all that apply)
- ☐ Black / African American
- ☐ Asian
- ☐ Caucasian / White
- ☐ American Indian / Alaska Native
- ☐ Native Hawaiian / Pacific Islander
- ☐ Another: _____

Ethnicity ☐ Prefer not to answer
- ☐ Hispanic/Latino/Latina
- ☐ Not Hispanic/Latino/Latina
- ☐ Don't know

Preferred Language (choose one)
- ☐ English ☐ Português
- ☐ Español ☐ Русский
- ☐ Other: _____

Marital Status
- ☐ Married ☐ Partnered
- ☐ Single ☐ Divorced
- ☐ Widowed ☐ Separated
- ☐ Other: _____

You think of yourself as (sexual orientation) ☐ Prefer not to answer
- ☐ Heterosexual ☐ Bisexual
- ☐ Gay or Lesbian ☐ Something else
- ☐ Don't know

Do you identify as transgender?
- ☐ Prefer not to answer
- ☐ Yes ☐ No ☐ Don't know

If yes, what is your gender?
- ☐ Female ☐ Male
- ☐ Genderqueer/Non-binary

Check all that apply, I…
- ☐ Am pregnant
- ☐ Exercise regularly
- ☐ Have pending legal affairs
- ☐ Have been arrested
- ☐ Have served in the military
- ☐ Belong to a religious group
- ☐ Am a victim of abuse

Highest Education Level?

_____

Employment (check all that apply)
- ☐ Full Time ☐ Part Time
- ☐ Retired ☐ Work from Home
- ☐ Unemployed

FMLA and/or Disability: Do you intend to apply for either FMLA or Disability? ☐ Yes ☐ No

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Insurance Information:

☐ I am Self Pay (Skip Insurance Information)

Insurance Provider:	**Provider Phone Number:**
Policy No:	**Group No:**
Insurance Policy Is: ☐ Primary ☐ Secondary ☐ Tertiary ☐ Workers' Comp	**Responsible party:** (if other than patient) **Subscriber Name:** _____ **Subscriber Date of birth:** _____ **Subscriber relationship to patient:** _____
Workers' comp: use this space to provide contact details for your case manager.	

Insurance Provider:	**Provider Phone Number:**
Policy No:	**Group No:**
Insurance Policy Is: ☐ Primary ☐ Secondary ☐ Tertiary ☐ Workers' Comp	**Responsible party:** (if other than patient) **Subscriber Name:** _____ **Subscriber Date of birth:** _____ **Subscriber relationship to patient:** _____
Workers' comp: use this space to provide contact details for your case manager.	

Insurance Provider:	**Provider Phone Number:**
Policy No:	**Group No:**
Insurance Policy Is: ☐ Primary ☐ Secondary ☐ Tertiary ☐ Workers' Comp	**Responsible party:** (if other than patient) **Subscriber Name:** _____ **Subscriber Date of birth:** _____ **Subscriber relationship to patient:** _____
Workers' comp: use this space to provide contact details for your case manager.	

Employee Assistance Program: Do you intend to use EAP for services rendered here? ☐ Yes ☐ No

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History and Presenting Problem

Name the problem for which you/your child are seeking help:

☐ Anger Management	☐ Relationships	☐ Obsessive Compulsive Disorder
☐ Grief	☐ Substance Abuse	☐ Panic Disorder
☐ Mood Disorder (Bipolar)	☐ Body Image/Self-esteem	☐ Stress Management
☐ Psychosis (Hallucinations)	☐ Pain Management Evaluation	☐ Personality Disorder
☐ Eating Disorder	☐ PTSD/Trauma	☐ Other: _____
☐ Depression	☐ Anxiety	

How long have these problems existed in your life? ☐ Past month ☐ Past six months ☐ All my life

What would you like to see different about yourself or your child?

Current Symptom Checklist: Check ONCE for any symptoms present, TWICE for major symptoms

☐☐ Depressed mood	☐☐ Racing thoughts	☐☐ Anxiety attacks
☐☐ Unable to enjoy activities	☐☐ Impulsivity	☐☐ Avoidance
☐☐ Sleep pattern disturbance	☐☐ Increased risky behavior	☐☐ Hallucinations
☐☐ Loss of interest	☐☐ Increased libido	☐☐ Suspiciousness/Paranoia
☐☐ Concentration/Forgetfulness	☐☐ Decreased need for sleep	☐☐ Flashbacks
☐☐ Change in appetite	☐☐ Excessive energy	☐☐ Angry outbursts
☐☐ Excessive guilt	☐☐ Increased irritability	☐☐ Poor social interactions
☐☐ Thoughts of self-harm	☐☐ Panic attacks	☐☐ Feelings of hopelessness
☐☐ Fatigue	☐☐ Crying spells	☐☐ Feelings of abandonment
☐☐ Decreased libido	☐☐ Excessive worry	☐☐ Other: _____

List any allergies you may have here:

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Medication History

Immunizations	**Childhood Immunizations are up to date?** ☐ Yes ☐ No	
Chicken Pox? ☐ Yes ☐ No	**Flu?** ☐ Yes ☐ No	**Covid?** ☐ Yes ☐ No

If you are currently taking or have ever taken any of the medications listed below, please document the dosage, indicate whether the medication was effective and if you experienced any side effects.

Current	Medication	Dosage	Effective?	Side Effects	Current	Medication	Dosage	Effective?	Side Effects
	Anafranil *(Clomipramine)*					Depakote *(Valproate)*			
	Celexa *(Citalopram)*					Lamictal *(Lamotrigine)*			
	Cymbalta *(Duloxetine)*					Lithium *(Lithium)*			
	Effexor *(Venlafaxine)*					Tegretol *(Carbamazepine)*			
	Elavil *(Amitriptyline)*					Topamax *(Topiramate)*			
	Lexapro *(Escitalopram)*					Clozaril *(Clozapine)*			
	Luvox *(Fluvoxamine)*					Haldol *(Haloperidol)*			
	Pamelor *(Nortriptyline)*					Prolixin *(Fluphenazine)*			
	Paxil *(Paroxetine)*					Risperdal *(Risperidone)*			
	Prozac *(Fluoxetine)*					Seroquel *(Quetiapine)*			
	Remeron *(Mirtazapine)*					Zyprexa *(Olanzapine)*			
	Serzone *(Nefazodone)*					Ambien *(Zolpidem)*			
	Tofranil *(Imipramine)*					Desyrel *(Trazodone)*			
	Wellbutrin *(Bupropion)*					Restoril *(Temazepam)*			
	Ativan *(Lorazepam)*					Rozerem *(Ramelteon)*			
	Buspar *(Buspirone)*					Sonata *(Zaleplon)*			
	Klonopin *(Clonazepam)*					Adderall *(Amphetamine)*			
	Tranxene *(Clorazepate)*					Concerta *(Methylphenidate)*			
	Valium *(Diazepam)*					Ritalin *(Methylphenidate)*			
	Xanax *(Alprazolam)*					Strattera *(Atomoxetine)*			

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Please list any over-the-counter supplements you take:

Personal and Family History

☐ Arthritis	☐ Asthma/Respiratory Problems	☐ High Cholesterol
☐ Anemia	☐ Stomach/Intestinal Problems	☐ High Blood Pressure
☐ Liver Disease	☐ Obesity	☐ Head Trauma
☐ Chronic Fatigue	☐ Heart Disease	☐ Chronic Pain
☐ Kidney Disease	☐ Epilepsy or Seizures	☐ Other (specify)_____
☐ Diabetes	☐ Cancer (type)_____	

Any relevant family history?

History of Outpatient Psychiatric treatment? ☐ Yes

History of Inpatient Psychiatric treatment? ☐ Yes

If *Yes to either* please detail dates and brief treatment details

Personal and Family Psychiatric History		**Which family member?**
Alcohol abuse	☐ Patient ☐ Family	
Anger	☐ Patient ☐ Family	
Anxiety	☐ Patient ☐ Family	
Attention Deficit Disorder	☐ Patient ☐ Family	
Bipolar Disorder	☐ Patient ☐ Family	
Depression	☐ Patient ☐ Family	
Post-traumatic stress	☐ Patient ☐ Family	
Schizophrenia	☐ Patient ☐ Family	
Other substance abuse	☐ Patient ☐ Family	
Self-Harm	☐ Patient ☐ Family	
Suicide (attempts or ideation)	☐ Patient ☐ Family	

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Substance Use		
Check if you (patient) have ever tried the following:		**How long and when did you last use it?**
Tobacco	☐ Yes	
Methamphetamine	☐ Yes	
Cocaine	☐ Yes	
Stimulants (pills)	☐ Yes	
Heroin	☐ Yes	
Inhalants	☐ Yes	
LSD or Hallucinogens	☐ Yes	
Painkillers (Not as prescribed)	☐ Yes	
Methadone	☐ Yes	
Marijuana	☐ Yes	
Opioids	☐ Yes	
Tranquilizer/sleeping pills	☐ Yes	
Alcohol	☐ Yes	
Ecstasy	☐ Yes	
Other: _____	☐ Yes	
How many caffeinated beverages do you drink in a day? Coffee _____ Sodas _____ Tea _____		