FLORIDA PSYCHIATRIC ASSOCIATES
Mark A. Ashby M.D. P.A.
2821 Alternate, US-27 S
Sebring, FL 33870, USA
Phone: 863-382-3914
Fax: 863-451-5569

Dr. Mark Ashby, MD
Wendi Conklin, APRN
John McNeal, LCSW
Kathryn Webb, PMHNP

New Patient Information & Consent Forms

Patient Information

First Name:_____Last Name:_____Date of Birth:_____

Sex (circle one): M / F Address:_____

Phone:_____Email:_____

SSN: _____

Emergency Contact

Name:_____Phone:_____Relationship to Patient: _____

Insurance & Billing Information

Primary Insurance:_____Subscriber Name: _____

Subscriber DOB:_____Member ID: _____

Secondary Insurance: _____Member ID: _____

Signature: _____

Financial Policy & Attendance

Financial Responsibility (Initial)

_____Payment is due at the time of service unless prior arrangements have been made.

____If you are using insurance, you are responsible for all applicable copayments, deductibles, coinsurance, and any services not covered by your insurance plan. Insurance verification is not a guarantee of payment. Any balance not paid by your insurance company is the patient's responsibility.

____If your insurance denies or delays payment, you agree to be responsible for the balance.

Self-Pay Services (Initial)

____Patients paying out of pocket are responsible for payment in full at the time of the appointment unless otherwise arranged in advance.

Missed Appointments & Late Cancellations (Initial)

____Because appointment times are reserved specifically for you, we require advance notice for cancellations or rescheduling.

____Cancellations made with less than 24-hour notice may be subject to a no-show fee of **$50.** These fees are not billable to insurance and are the patient's responsibility.

Outstanding Balances (Initial)

____Patients with outstanding balances may be required to resolve the balance before scheduling future appointments.

Telehealth Consent (If Applicable)

- I understand that my provider may offer **telehealth sessions** (video or phone).
- I understand that telehealth has **risks and limitations** compared to in-person visits.
- I understand that **privacy is maintained** as required by law, but there are limits if there is a threat of harm to myself or others.
- I understand that I can **refuse or stop telehealth** at any time.

Patient Initials: _____

Patient / Legal Guardian Signature: _____

Consent for Treatment (Initial)

____I voluntarily consent to receive psychiatric and/or mental health services from this practice. I understand that treatment may include, but is not limited to, psychiatric evaluation, psychotherapy, medication management, and referrals as clinically indicated.

____I understand that the purpose of treatment is to address mental health concerns and that outcomes cannot be guaranteed. I acknowledge that I may ask questions about my treatment at any time and that I have the right to participate in treatment decisions.

____I understand that I may withdraw my consent for treatment at any time by notifying my provider in writing, except in situations where treatment is required by law or necessary to prevent serious harm to myself or others.

____If I am the parent or legal guardian of a minor patient, I certify that I have the legal authority to consent to treatment on the patient's behalf.

Confidentiality & Limits

Information shared during psychiatric or therapy services is confidential and protected by federal and Florida law. This means that, in most situations, information about your treatment will not be released without your written permission.

Limits of Confidentiality

Confidentiality does not apply in certain circumstances, including but not limited to:

- If there is a serious risk of harm to you or to another person
- If there is suspected abuse or neglect of a child, elderly person, or vulnerable adult
- If required by court order, subpoena, or other legal process for purposes of billing, payment, and healthcare operations
- When disclosure is otherwise required or permitted by law

Florida law requires mental health professionals to take reasonable action when there is a credible threat of harm.

Communication & Coordination of Care

Information may be shared with other healthcare providers, insurance companies, or billing services as necessary for treatment, payment, and healthcare operations. Additional disclosures to family members, schools, employers, or others require your written authorization unless otherwise permitted by law.

Signature: _____

HIPAA Notice of Privacy Practices

This practice is required by law to protect the privacy of your Protected Health Information (PHI). Your mental health and medical information will be kept confidential and used only as permitted by federal and Florida law.

Your health information may be used or shared for:

- Treatment (including coordination of care with other healthcare providers)
- Payment (billing and insurance-related activities)
- Healthcare Operations (administrative, quality, and compliance activities)
- Your information may also be disclosed when required by law.

You have the right to:

- Access or request a copy of your medical records
- Request corrections to your health information
- Request restrictions on certain uses or disclosures
- Request confidential communications
- Receive a copy of the full Notice of Privacy Practices at any time

We are required to:

- Maintain the privacy and security of your health information
- Provide notice of our privacy practices
- Notify you in the event of a breach of unsecured protected health information

Persons Involved in My Care or Communications (Optional)

I authorize this practice to communicate limited information (such as appointment scheduling, billing questions, or general treatment status) with the person(s) listed below. This authorization does not allow release of full medical records unless a separate written authorization is completed.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____

Patient History

Prior Mental Health Treatment (check all that apply)

☐ None ☐ Therapy / Counseling only

☐ Psychiatric evaluation / treatment ☐ Hospitalization for mental health

☐ Medication management by a psychiatrist

Past or Current Mental Health Diagnoses (if known)

☐ Depression ☐ Anxiety / Panic

☐ Bipolar disorder ☐ PTSD / Trauma

☐ ADHD / Attention concerns ☐ Other: _____

Current Medications

_____

_____

_____

_____

_____

_____

More details may be discussed with the provider during appointment session.

Controlled Substance Acknowledgment of Risks (Initial)

___I understand that controlled substance medications **may cause drowsiness, sedation, or slowed reaction time**, and I agree to take precautions when performing activities that require alertness (e.g., driving).

___I understand that **these medications can be habit-forming** and must be taken only as prescribed.

___I agree to **notify my provider immediately** if I experience side effects, concerns, or questions about my medication.

___I understand that **sharing, selling, or misusing these medications is illegal** and may result in termination of treatment.

For Female Patients Only (Initial)

___To the best of my knowledge, I am **not pregnant** at this time.

__I understand that **controlled substances prescribed to me may cause birth defects** if taken during the first trimester of pregnancy. I agree to **notify my physician immediately** if I become pregnant so my medication can be safely tapered or discontinued.

___I understand that **controlled substances may pass into breast milk**, and I agree **not to breastfeed** while taking this medication.

____I understand that **controlled substances may cause drowsiness, sedation, or slowed reaction time**. I agree to **have a family member or friend assist me in the care of my child** while I am taking this medication.

Authorization to Release Information (ROI) – (Optional)

Patient Name: _____
Date of Birth: ____ / ____ / _____

I authorize **Florida Psychiatric Associates** to release my medical and mental health information to the person(s) or organization(s) listed below. I understand that signing this authorization is **voluntary** and **not required for my treatment**.

Recipient / Organization Name: _____
Relationship / Purpose: _____
Phone / Email (optional): _____

Information to Release (check one):
☐ Limited information only (appointments, billing, general treatment status)
☐ Full medical records (specify below):

I understand that:

- I may **revoke this authorization at any time in writing**, except to the extent action has already been taken.
- Once my information is released, the recipient **may re-disclose it**, and it may no longer be protected by HIPAA.

Patient Initials: _____
Patient / Legal Guardian Signature: _____
Date: ____ / ____ / _____

In Case of Emergency: Pet Information (Optional)

Who would take care of your pet if you are unable to do so? To ensure that vital information regarding your pet is readily available to our office in the event of an unforeseen need, please take a moment to complete this emergency information sheet. **Make sure at least one of the contacts has a set of your house keys.** You may also want to keep similar information in your wallet. If you are unable to care for your pet due to an accident or emergency, someone will be able to follow the instructions on the sheet to provide necessary care.

Veterinarian (established or preferred): _____

People who should be contacted to care for my pets in case of emergency:

Name: _____

Phone: _____

Name: _____

Phone: _____

We can keep your pet's picture on file, too! Email us at psychmd.jj@gmail.com and we will add your pet to our Pets of Honor board in the lobby!