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

Dr. Mark Ashby, MD
Wendi Conklin, APRN
John McNeal, LCSW
Jana Grooms, LMHC

New Patient Information

Last Name: _____ First Name: _____ Middle: _____

Social Security No: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Email: _____

Marital Status (circle): S M D W

Employment(circle): Employed Retired Legally Disabled Student

Employer: _____ Occupation: _____
Work Phone: _____ Work E-Mail Address: _____

REQUIRED

Emergency Contact: _____ Contact No: _____

Relationship to Patient:

Referred By:

_____

Insurance Assignment

I hereby authorize my insurance benefits to be paid directly to Mark Ashby, M.D P.A. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of any services rendered.

Patient Signature: _____ Date: _____

Release of Medical Records to Insurance Company

I hereby authorize the release of all medical, psychiatric, alcohol testing, and any drug abuse information to my insurance company if requested to verify dates of service and continuity of care.

Patient Signature: _____ Date: _____

Consent for Evaluation and Treatment

In signing my name below, I acknowledge that I am giving my informed consent to receive psychiatric treatment at Florida Psychiatric Associates. Psychiatric treatment consists of diagnostic services and medication management. I understand that I may decline further participation or recommended treatment at any time. I have read this description of services and understand and consent to the stated policies.

Patient Signature: _____ Date: _____

What issue(s) brings you to our office?

_____

_____

_____

If any, what has been the source of your stress as of late? (family, work, recent loss of a loved one, financial difficulties, etc.)

_____

_____

_____

Are you currently experiencing any of the following? (Please circle all that apply):

Loss of interest in activities	Feeling hopeless /worthless
Seeing things	Worrying excessively
Phobias and/or fears	Having tense muscles/headaches
Concerns about alcohol/drug use	Memory problems
Repetitive or compulsive behavior	Thoughts of not being alive
Grunts, tics, or jerking movements	Problems finding words
Problems caring for yourself	Racing thoughts
Hearing voices	

Change in appetite:	Increased	Decreased
Change in energy:	Increased	Decreased
Change in sleep:	Increased	Decreased

Psychiatric History

Have you ever been diagnosed with a mental health condition by a medical provider? (depression, bipolar disorder, schizophrenia, ADHD, anxiety, etc.) If so, please list all diagnoses.

_____

_____

Have you ever been treated by a psychiatrist (medical professional who prescribes medication) or a therapist/counselor (professional who provides talk therapy/coping skills)? If so, please list and describe.

_____

_____

Date last seen: _____ Reason: _____

Have you ever been to the emergency room, hospitalized, or admitted into a facility for treatment of your mental health? If so, please list dates and reasons.

_____

_____

Medical and Surgical History

Primary Care Doctor/Clinic: _____

Height: _____ft. Weight: _____ lbs.

Do you have any of the following medical conditions? (Please circle all that apply):

Anemia Brain Injury (TBI) Autoimmune Disease Stroke/TIA

Asthma/COPD Cancer Thyroid Disease Liver Disease Diabetes

Chronic Pain Fibromyalgia GERD/Reflux /GI Conditions

Kidney Disease Heart Disease Headaches/Migraines Seizure Disorder

Please list any surgeries, including the approximate date of surgery:

_____

_____

Do you have any medication allergies? If so, what reaction do you have to the medication(s)?

_____

_____

_____

_____

Current Medication List

Please list all medications you are currently taking, including any over-the-counter medications.

Medication Name	Dosage/Strength	How Often	Diagnosis

Substance Use History

Have you used any of the following substances? Please report only NON-PRESCRIBED use. If you have a written prescription from a doctor, do not list that below.

Substance	Last Time Used	Approximately How Often	How much in one sitting?
Tobacco/Nicotine			
Alcohol			
Marijuana/THC			
Heroin			
Methamphetamines			
Opiates			
Tranquilizers (Xanax, Ativan, Valium)			
PCP/LSD			
Mushrooms/ Psychedelics			
Other:			

Family History

Please list **blood relatives** who have been diagnosed with any of the following conditions:

ADD/ADHD:

_____

Anxiety Disorder/Panic Disorder:

_____

Bipolar Disorder:

_____

Dementia/Alzheimer's:

_____

Depression:

_____

Diabetes:

_____

Heart Disease/Arrhythmias:

_____

Parkinson's Disease:

_____

Thyroid Disease:

_____

Schizophrenia:

_____

Suicidal Death:

_____

Social History

Do you live alone? Yes No

If not, who lives with you? _____

Are you married? Yes No

If so, for how long? _____

What was your highest level of education? _____

Do you have children? Yes No

If so, how many and what are their ages? _____

Do you have any religious beliefs? Yes No

If yes, how important are these beliefs in your life? _____

Have you had any legal issues? (arrests, charges, incarceration) Yes No

If yes, please describe _____

Have you ever been a victim of a violent crime? Yes No

Have you ever been the victim of physical, emotional, mental, sexual abuse, or rape?

Yes No

Do you currently have thoughts of hurting yourself? Yes No

Have you tried to hurt yourself in the past? Yes No

Do you currently have thoughts of hurting anyone else? Yes No

Have you tried hurting anyone in the past? Yes No

Patient Financial Responsibilities

All professional services are billed to the patient or their legal guardian, unless an agreement has been made with a third-party payer (e.g., health insurance, medical group, workers' compensation, etc.). It is the patient's responsibility to know and understand the contract with their insurance company. If the patient does not understand their benefits, member services can be reached via the contact number specified for behavioral/mental health on the back of the insurance card. Some insurance companies' mental health benefits are managed by a third party and, at times, may not reflect the medical benefits. Pre-authorization may also be required before seeing the physician, and/or a limited number of visits may be allowed per month or year. Always verify if a referral from your primary care physician is required. Initial here _____

Patients are personally responsible for any co-payments, co-insurance, and deductibles stated by your insurance company before seeing the physician. It is solely the patient's responsibility to keep our office informed of any changes regarding their insurance. Failure to do so will result in any charges accrued during this time being the patient's responsibility. As a courtesy, our insurance department will verify your insurance benefits. However, please understand insurance companies do make errors when explaining benefits; we do our best to record the information given and verify it against the Explanation of Benefits (EOB) that is mailed to us. The insurance company will also send a copy of the EOB to the patient, allowing them to verify the accuracy. Should the insurance company deny payment of a claim, it will become the patient's responsibility.

Initial here _____

In the event a patient does not have insurance coverage or our practice is not in network with their insurance company, and their plan does not offer out-of-network benefits, we do offer a self-pay rate. The charge for a new patient appointment at the self-pay rate is ***$250.00.*** *The charge for a follow-up appointment after the patient's initial visit is* ***$125.00.*** *Therapy sessions are* ***$85****.* **This payment is due at the time of service (i.e, payment must be collected before the patient is seen by the physician).** Initial here _____

Returned checks by the bank will result in a $30.00 fee in addition to the co-pay, co-insurance, or deductible. Initial here _____

Medical records requests: Charges depend on the number of pages and whether the request is made by the patient, a government entity, or someone other than the patient (as per Florida State Statute §395.3025 and Florida Administrative Code Rule 64B8-10.003). Any reports and/or letters that require completion by the physician and/or staff are subject to additional fees. Dictated letters or reports may take up to three days to complete and may require a dedicated appointment; therefore, we require at least one week's notice to be given to our office.

Initial here _____

The patient's appointment is reserved exclusively for the patient. If an appointment is missed or canceled without providing at least 24 hours' notice, a fee of $50.00 will be charged for established patients and $100.00 for new patients. This fee must be paid in cash prior to rescheduling the appointment. Medications cannot be called in at this time until the date of the new appointment.

Initial here _____

I have read, understand, and agree to my financial responsibilities as a patient of Florida Psychiatric Associates. I understand that failure to comply may result in a discharge from the practice.

Patient Signature: _____ Date: _____

Notice of HIPAA Privacy Law

Health Insurance Portability and Accountability Act (HIPAA) standards address the use and disclosure of a patient's health information to entities subject to the privacy rule. These individuals or organizations are referred to as covered entities. HIPAA also contains standards for a patient's right to understand and control how their health information is used. The primary goal of HIPAA is to ensure that a patient's health information is properly protected while still allowing the movement of important health information necessary to provide and promote high-quality healthcare and protect the public's health and well-being.

The following types of individuals and organizations are subject to the HIPAA law and are considered covered entities:

Healthcare Providers: This applies to every healthcare provider who electronically transmits health information in connection with certain transactions. These transactions include claims, benefit eligibility inquiries, referral authorization requests, and other transactions for which the Department of Health and Human Services has established standards under the HIPAA Transactions Rule.

Health Plans: This applies to all entities that provide and/or pay the cost of Medicare. Health plans include health, dental, vision, and prescription drug insurers, health maintenance organizations (HMOs), Medicare, Medicaid, Medicare supplement insurers, employer/multi-employer sponsored group health plans, government and church sponsored health plans, and long-term care insurers, excluding nursing home fixed indemnity policies.

Healthcare Clearinghouses: This applies to entities that process non-standard information received from another entity into a standard format (e.g., data content) or vice versa. In most instances, healthcare clearinghouses receive individually identifiable health information only when they provide these processing services to a health plan and/or healthcare provider as a business associate.

Business Associates: This applies to any person or organization (other than a member of a covered entity's workforce) using or disclosing individually identifiable health information to perform or provide functions and services for a covered entity. These functions or services include claims billing and processing, data analysis, and utilization review.

I have received, read, and understand Florida Psychiatric Associates' office policies and HIPAA privacy rules.

Patient Signature: _____ Date: _____

Persons we may discuss your treatment/care with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Controlled Substance Agreement

The Controlled Substance Agreements' purpose is to prevent misunderstanding regarding medications a patient may be prescribed as a part of their treatment plan with Florida Psychiatric Associates. Controlled substance medications (e.g., benzodiazepines, amphetamines, and anti-anxiety medications), while helpful, also have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments.

Initial here _____

I am solely responsible for any controlled substance medications prescribed to me. If my prescription is misplaced, stolen, or finished before the next refill date, I understand that this medication may not be replaced. In the event of a theft, explicit proof must be provided, including direct evidence from authorities (e.g., a police report). I understand and agree not to share, sell, or permit others, including my spouse or family members, to have access to any controlled medications that have been prescribed to me. I understand that such mishandling of my medication is a serious violation of this agreement and may result in the termination of my treatment without any recourse for appeal.

Initial here _____

Refills of controlled substance medications will be sent only during regular office hours, Monday through Friday, or during a scheduled appointment. Refills will not be sent on nights, weekends, or holidays. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining amount.

Initial here _____

I also agree and understand the importance of keeping all scheduled appointments. If I miss an appointment, I understand that a follow-up appointment must be made and kept before any prescriptions will be refilled or changed, as all prescriptions are issued only during a scheduled appointment with my physician.

Initial here _____

I further understand that if I violate this controlled substance agreement, including but not limited to failure to take medications as prescribed, utilizing other illicit drugs, or the abuse of controlled medications, I may be subject to dismissal from Florida Psychiatric Associates.

Initial here _____

I agree and understand that I will make my physician aware of all medications I am currently taking, including over-the-counter medications and controlled substances prescribed by other physicians. I understand it is unlawful to attempt to obtain prescriptions for controlled substances from multiple physicians and will not seek duplicate prescriptions from any other physician, healthcare provider, or dentist.

Initial here _____

I agree and understand that altering any prescription is a **felony** offense, and any suspicion of this behavior will be reported to the proper authorities. I agree to take my medication as my physician has instructed and not alter the dosage without consulting my physician.

Initial here _____

I also agree not to alter the medication form in any way. (e.g., chew, crush, inject, or snort).

Initial here _____

I agree to abstain from abuse of non-prescribed controlled substances.

Initial here _____

I agree to take full responsibility for the consequences of driving a motor vehicle, operating machinery, or any other activity in which alertness, reflexes, coordination, and/or judgment are necessary.

Initial here _____

I agree and understand that the controlled substance I have been prescribed has addictive qualities. I am aware I may also develop a tolerance to this medication. These controlled substance medications should not be stopped abruptly, as withdrawal symptoms may occur. I understand I am at risk for psychological dependence or addiction if I abuse my medication and use it to achieve feelings of well-being and/or mood changes apart from its prescribed medicinal purposes.

Initial here _____

I agree and understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such persons for their own safety.

Initial here _____

I agree and understand it is Florida law that any patient prescribed a controlled substance medication must have a follow-up appointment with the physician at the very least, **every three months**. I understand my controlled substance medications will be discontinued if I do not keep my appointments for this three-month period.

Initial here _____

I agree and understand that recent updates to Federal law may require patients prescribed certain classes of controlled substance medications to have a follow-up appointment with their physician at least **once a month**. I understand my controlled substance medications will be discontinued if I do not keep my appointments for this one-month period.

Initial here _____

I give my consent for my physician or his designee to contact all of my physicians and pharmacies to ensure I follow this agreement. Florida Psychiatric Associates will check the State of Florida Monitoring Database to monitor prescriptions that have been filled. If I violate this agreement by obtaining these medications from another individual or by the concomitant use of non-prescription illicit drugs, I may also be reported to other physicians, pharmacies, medical facilities, and appropriate authorities.

Initial here _____

I have been fully informed of the above controlled substance medication agreement and have a full understanding of my duties as a patient of Florida Psychiatric Associates. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, medications, instructions for use, risks and hazards, and all other provisions in this agreement.

Patient Signature: _____ Date: _____

For Female Patients Only

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

Initial here _____

I acknowledge that the controlled substance I am prescribed may cause birth defects in the first trimester of a pregnancy. Therefore, I agree to a method of contraception to prevent pregnancy during the time my physician is prescribing my controlled substance medication.

Initial here _____

I agree to inform my physician immediately should I become pregnant, so that my controlled substance medication can be tapered and discontinued.

Initial here _____

I understand that controlled substance medications may be passed to my infant through breast milk; therefore, I agree not to breastfeed while taking my medication.

Initial here _____

I acknowledge that my controlled substance medication may cause drowsiness, sedation, and slowed reaction time. I agree to have a family member or friend present to assist me in the care of my child when I am taking my medication.

Initial here _____

Patient 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.

List two or three people as emergency contacts for your pet(s). Include the contact's name and telephone number. 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.

Pet's Name: _____ Sex/Neutered: _____ Age: _____

Pet's Name: _____ Sex/Neutered: _____ Age: _____

Pet's Name: _____ Sex/Neutered: _____ Age: _____

Veterinarian (established or preferred): _____

Up to date on vaccines? Date? _____

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

Name: _____ Contact Info: _____

Name: _____ Contact Info: _____

Name: _____ Contact Info: _____

We can keep your pet's picture on file, too! Email us at psychmd.jj@gmail.com

Client Rights

As a client of **Florida Psychiatric Associates**, you are entitled to certain rights under the **Florida Mental Health Act (Chapter 394, Florida Statutes)**, the **Florida Patient's Bill of Rights and Responsibilities (Chapter 381.026, Florida Statutes)**, and the **Health Insurance Portability and Accountability Act (HIPAA) of 1996**. These rights include, but are not limited to, the following:

1. You have the right to receive services in a safe, respectful, and humane environment, free from abuse, neglect, or exploitation.
2. You have the right to receive treatment in the least restrictive environment appropriate to your clinical needs.
3. You have the right to participate in the development and periodic review of your individualized treatment plan.
4. You have the right to be informed of the nature of your treatment, including possible risks, benefits, and alternatives.
5. You have the right to accept or refuse services, including medications, and to be informed of any potential consequences of refusal.
6. You have the right to be informed of the potential side effects of prescribed medications.
7. You have the right to be free from restraint or seclusion, except when used as an emergency measure to prevent immediate risk of harm to yourself or others, and only in compliance with Florida law.
8. You have the right to confidentiality of your medical record, in accordance with HIPAA and Florida law, except in cases where disclosure is required by law (e.g., risk of harm to self or others, suspected abuse or neglect).
9. You have the right to file a grievance or complaint regarding your services. You will not be penalized for filing a grievance, and your services will not be reduced or terminated as a result of exercising this right.
10. You have the right to have your grievance reviewed and to receive a written response in a timely manner. If you are not satisfied, you have the right to contact the **Florida Agency for Health Care Administration (AHCA)** or the **Florida Department of Children and Families (DCF)** for further review.
11. You have the right not to be discriminated against in the provision of services on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, age, marital status, disability, or source of payment.
12. You have the right to reasonable accommodations under the **Americans with Disabilities Act (ADA)**.

Patient Signature: _____ Date: _____

Client Responsibilities

As a client of **Florida Psychiatric Associates**, you share responsibility for your care. To help ensure safe and effective treatment, clients are expected to:

1. **Provide Accurate Information**
    - Share complete and honest information about your health, symptoms, medications, and personal history.
    - Update your provider about any changes in health status or medications.
2. **Participate in Treatment**
    - Work with your provider to develop and follow your treatment plan.
    - Discuss any difficulties with treatment so adjustments can be made.
3. **Medication Use**
    - Take medications as prescribed.
    - Report any side effects or concerns promptly.
4. **Appointments**
    - Attend all scheduled appointments.
    - Provide at least **24 hours' notice** if you need to cancel or reschedule.
5. **Respect**
    - Treat staff, providers, and other clients with courtesy and respect.
    - Help maintain a safe and professional environment.
6. **Financial Responsibility**
    - Pay for services and fees as agreed.
    - Provide accurate insurance information and notify the office of changes.
7. **Confidentiality**
    - Respect the confidentiality and privacy of others you may encounter in the practice setting.

Patient Signature: _____ Date: _____

Client Grievance Procedure

Florida Psychiatric Associates is dedicated to delivering high-quality psychiatric and mental health services in a respectful and professional environment. If you have concerns about your care, you have the right to file a grievance without fear of retaliation or loss of services.

Step 1: Informal Resolution
Clients are encouraged to discuss their concerns directly with their provider or a staff member. Many issues can be resolved quickly through open communication.

Step 2: Written Grievance
If the concern cannot be resolved informally, clients may submit a written grievance. The grievance should include:

- Your name and contact information
- The date of the grievance
- A description of the concern, including dates and staff involved
- The outcome you are seeking

Grievances may be submitted to:

Florida Psychiatric Associates
2821 Alternate US Hwy 27 S
Sebring, FL 33870

Step 3: Review and Response

- The Practice Director (or designee) will review the grievance.
- You will receive a written response within **15 business days** of receipt.
- The response will include findings, any actions taken, and options for further review.

Step 4: External Review
If you are not satisfied with the resolution, you may contact the following agencies for additional review:

- **Florida Agency for Health Care Administration (AHCA)**
  Phone: 1-888-419-3456
  Website: ahca.myflorida.com
- **Florida Department of Children and Families (DCF)**
  Abuse Hotline: 1-800-962-2873
  Website: myflfamilies.com

Important Notes

- You will not be denied, suspended, terminated, or otherwise penalized for filing a grievance.
- All grievances and resolutions will be documented and maintained in accordance with HIPAA and Florida law.

Acknowledgment of Receipt
I acknowledge that I have received a copy of Florida Psychiatric Associates' Client Rights and Responsibilities and the Grievance Procedure and that it has been explained to me.

Patient Signature: _____ Date: _____

Informed Consent for Evaluation and Treatment

This document provides important information about your treatment at Florida Psychiatric Associates. Please read it carefully and ask any questions you may have before signing.

Nature and Purpose of Treatment

- Psychiatric and mental health treatment may include diagnostic evaluation, psychotherapy, medication management, and other appropriate interventions.
- The purpose of treatment is to assist you in addressing mental health concerns and improving your overall well-being.

Potential Risks and Benefits

- **Benefits** may include relief from symptoms, improved functioning, and enhanced quality of life.
- **Risks** may include temporary discomfort, increased emotional distress when discussing difficult topics, possible side effects of medication, or lack of improvement.
- No specific outcome can be guaranteed.

Rights of the Client

You have the right to:

1. Be treated with dignity, respect, and without discrimination.
2. Participate in the development and review of your treatment plan.
3. Be informed about the risks, benefits, and alternatives to recommended treatment.
4. Accept or refuse treatment or medication, and to be informed of possible consequences of refusal.
5. Request a second opinion or referral to another provider.
6. Confidentiality of your medical record is protected under HIPAA and Florida law, with certain legal exceptions.

Limits of Confidentiality

Your information is confidential except in the following circumstances:

- If you present a danger to yourself or others.
- If there is suspected abuse or neglect of a child, elder, or vulnerable adult.
- If records are required by court order.
- To comply with insurance or payer requirements, as authorized by you.

Medication Management

- If medication is prescribed, the risks, benefits, and alternatives will be explained.
- You may refuse medication, but this could affect your treatment plan.
- You are responsible for taking medication as prescribed and reporting side effects promptly.

Emergencies and After-Hours Care

- Florida Psychiatric Associates is not an emergency service.
- If you are experiencing a psychiatric emergency, call **911** or go to the nearest emergency department.
- You may also call the **Suicide and Crisis Lifeline at 988**.

Telehealth Services

- Services may be provided via telehealth in compliance with Florida law.
- You have the right to withdraw consent for telehealth at any time.
- Telehealth may involve limitations such as reduced privacy or technical issues.

Financial Responsibility

- You are responsible for payment of all services not covered by insurance, including deductibles, co-pays, and non-covered services.
- Fees, cancellation policies, and payment requirements are described in the Financial Responsibility Agreement provided separately.

Consent to Treatment

By signing below, I acknowledge that:

- I have read and understood the information in this document.
- I have had the opportunity to ask questions about my treatment.
- I voluntarily consent to psychiatric evaluation and treatment, including therapy and/or medication management, as recommended by my provider.
- I understand I may withdraw consent at any time, except as required by law or contract.

Patient Signature: _____ Date: _____