RIVERVIEW
Community Mental Health Center

## ***General Information***

**Child's Name**_____ **Today's Date** _____

**Child's Address**_____ **City, State, Zip** _____

**Child's Gender:** ❒Male ❒Female ❒Other_____ **Child's DOB:** _____|_____|_____ **Age:**_____

**Is your child adopted?** ❒Yes ❒No If yes, at what age? _____

**Who is filling out this form:**

❒Mother
❒Father
❒Guardian (please explain relationship to child)_____

**The child's parents are:**

❒Single ❒Married ❒Divorced ❒Separated ❒Widowed ❒Living together, but not married

❒Other (please explain)_____

| ***Main Adult Contact for child*** | ***Other Adult contact for child*** |
|---|---|
| Name: | Name: |
| Relationship to Child:<br>❒Mother ❒ Father ❒Guardian<br>❒Other _____ | Relationship to Child:<br>❒Mother ❒Father ❒Guardian<br>❒Other _____ |
| Address: ❒Same as Child<br>_____<br>_____<br>_____<br>_____ | Address: ❒Same as Child<br>_____<br>_____<br>_____<br>_____ |
| Home Phone: | Home Phone: |
| Cell Phone: | Cell Phone: |
| Work Phone: | Work Phone: |
| Email: | Email: |
| SSN: | SSN: |

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## ***Family***

Check all the people that the child lives with:

☐ Mother ☐ Father ☐ Brothers (how many?) _____ ☐ Sisters (how many?) _____
☐ Other family members (list) _____
☐ Friends or other people (list) _____

***What medical problems do people in the child's family have?***

| ***Family Member*** | ***Medical Problems*** |
|---|---|
| **Mother** | ☐ Depression ☐ Anxiety ☐ Learning Disability ☐ Overweight ☐ Cancer<br>☐ Hypertension ☐ Diabetes ☐ Heart Problems<br>Other:_____ |
| **Father** | ☐ Depression ☐ Anxiety ☐ Learning Disability ☐ Overweight ☐ Cancer<br>☐ Hypertension ☐ Diabetes ☐ Heart Problems<br>Other:_____ |
| **Sister** | ☐ Depression ☐ Anxiety ☐ Learning Disability ☐ Overweight ☐ Cancer<br>☐ Hypertension ☐ Diabetes ☐ Heart Problems<br>Other:_____ |
| **Brother** | ☐ Depression ☐ Anxiety ☐ Learning Disability ☐ Overweight ☐ Cancer<br>☐ Hypertension ☐ Diabetes ☐ Heart Problems<br>Other:_____ |

***Names of other children at this practice:***

_____

_____

_____

## ***Consent for Treatment***

- I, _____ (parent/ guardian) give permission for Riverview Community Mental Health Center to give me psychiatric treatment.
- I allow Riverview Community Mental Health Center to file for insurance benefits to pay for the care I receive. I understand that:
    - Riverview Community Mental Health Center will have to send medical record information to my insurance company.
    - I will be responsible for paying for any services or balances incurred.
    - I have the right to refuse any treatment.
    - I have the right to discuss all treatment plans with my provider.

**Parent/ Guardian Name _____ Date _____**
**Parent/ Guardian Signature _____ Date _____**

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## ***Health Insurance Portability and Accountability Act***

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). One component of HIPAA was to streamline the process to exchange information and to make health information more readily accessible to patients. The HIPAA Privacy Rule went into effect it April 2003 and created a federal standard for protecting the privacy of health information. The Privacy Rule also requires DOH to comply with Florida laws that provide greater protection to patients.

The Privacy Rule generally prohibits the use and disclosure of health information without written permission from the patient. The Privacy Rule also gives patients' rights to access their medical and billing records, request amendments to those records, and obtain an accounting of disclosure of protected health information. The Department's Notice of Privacy Practices further describes the use and disclosure of patient medical information and how patients may obtain access to their information. If you believe your privacy rights have been violated by a DOH employee, you may file a complaint with the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 or with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The session content and all relevant materials to the client's treatment will be confidential unless the client requests in writing (release of Information form) to have all or portions of such content released to specifically names person(s). Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts their self in a manner which there is substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has reasonable suspicion that a client or other name victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. If the provider has reasonable suspicions as stated above in the case of an elderly person who may be subject to abuse.
5. If records are court ordered.

***HIPPA Acknowledgement***

My signature confirms that I have been offered the opportunity to view the Notice of Privacy Practices of Riverview Community Mental Health Center. A copy of this document is available for my viewing, as well as available on our website.

_____ _____

***Patient/ Legal Guardian Signature*** ***Date***

***Scan this QR Code to visit our Patient Resources Page for more information on our policies and your rights as a patient.***

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## ***Permission to Bring/ HIPPA***

I, _____ the parent/ legal guardian of _____, give the following person(s) permission to seek medical care for the above-mentioned child in my absence. This is to be effective on date signed and to remain in effect until further notice is given.

The listed person(s) should also consider as "emergency contacts" if you (the parent/ guardian) are unable to be reached.

**If we are allowed to discuss your child's condition and treatment plan with any person listed on the "permission to bring" you must indicate below.**

| ***Name*** | ***Relationship to Patient*** | ***Phone Number*** | ***Allowed to discuss HIPPA information? Yes/ No*** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***Signature of Parent _____***

***Date _____***

*FOR OFFICE USE ONLY*

*WITNESS:_____*

*IDENTIFICATION VERIFIED: Y_____ N _____*

*EMPLOYEE INITIALS: _____*

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## ***Responsibility for Patient's Payment***

**Responsible party: ❑Self ❑Guarantor/ Legal Guardian ❑Other_____**

**Relationship to patient: _____**

**Responsible party name: _____ DOB: _____/_____/_____**

**Phone #_____-_____-_____**

**Address:_____**

**City, State, ZIP:_____**

## ***Insurance Information*** *(please provide us with copies of all insurance cards)*

- The insurance policy and/or plan was chosen by you and/or your family member**. It is your responsibility to understand the frequencies, clauses, and coverages in your insurance policy/plan**. If we are providers, our office will request a basic breakdown of benefits to determine an "**approximate"** out-of-pocket co-payment/ co-insurance for your mental health visit. Please be advised, coverages vary by plan types. It is not a guarantee of payment by your insurance carrier, and **you are responsible for all charges, whether paid by your insurance or not.** ***Initial_____***
- We are more than happy to work with your insurance company to maximize your mental health benefits. We will gladly file your mental health claims as a courtesy to you. Dr. Olivera has elected to participate with certain insurance companies and accept their contracted fees**.**
  ***Payment is due at the time of the session unless other arrangements have been made. We will file your insurance claim, but you are responsible for deductibles, co-insurances, and co-payments. It is your responsibility to familiarize yourself with your insurance benefits and to call your insurance company to have the authorization for your session sent to this office. Initial_____***
- **As of January 1, 2024**, **there will be a card processing charge of 3% added to all card transactions.** Amounts not paid within 30 days will encourage a monthly financial charge of 1.5%, calculated from the date of service. If collection measures become necessary, all related expenses, including agent and/or attorney's fees, will be the responsibility of the patient, parent, or legal guardian. ***Initial_____***
- **Self-Pay**: *Payment is due at the time of the appointment unless other arrangements have been made**. Initial_____***

**Primary Insurance Carrier:_____ Member ID:_____**

**Group #:_____**

**Policy Subscriber Name:_____Policy Subscriber DOB_____/_____/_____**

**Secondary Insurance Carrier: _____ Member ID: _____**

**Prescription Coverage Carrier:_____ Member ID:_____**

**RxBIN:_____**

**PCN: _____ Rx Group #: _____**

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## ***Patient Health Questionnaire (PHQ-9)***

Name_____ Date_____

| *Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle one)* | **Not at all** | **Several days** | **More than half the day** | **Nearly every day** |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself, that you are a failure, have let yourself/ your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have bene moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you woold be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

add columns _____+_____+_____+_____

**TOTAL**_____

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10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

**NOT DIFFICULT AT ALL** _____
**SOMEWHAT DIFFICULT** _____
**VERY DIFFICULT** _____
**EXTREMELY DIFFICULT** _____

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