Behavioral Health Centers of Sarasota
6075 Rand Blvd., Suite 1, Sarasota, FL 34238
Phone (941) 921-2792 | Fax (941) 925-2438

CHILD/ADOLESCENT REGISTRATION

PATIENT INFORMATION					
Date					
Child's Full Name					
Birth Date (MM/DD/YYYY)			Age		Sex
Address					
City	State	Zip	Referred By		
Parent Name/Legal Guardian			Parent Social Security #		
Billing Address (if different)					
City	State	Zip	Email		
Home Phone	Work Phone		Cell Phone		
Primary Physician					
Adopted Child? ___ Yes ____ No	At what age?		Height (in)		Weight (lbs)
Mother's Name			Father's Name		
☐ Natural ☐ Adoptive ☐ Step ☐ Foster	Age Education		☐ Natural ☐ Adoptive ☐ Step ☐ Foster	Age Education	
Occupation			Occupation		
Place of Employment			Place of Employment		

Marital status of natural parents of child (check all appropriate spaces)

☐ Married	☐ Living together	☐ Mother remarried
☐ Not married	☐ Separated	☐ Father remarried
☐ One parent deceased	☐ Divorced	☐ Other

PRESENTING PROBLEMS

What is your child's difficulty and for how long?

What do you hope to gain from this referral?

FAMILY HISTORY

Biologic Family History (please specify who has been affected on lines below)

☐ Hyperactivity _____	☐ Drug Abuse _____	☐ Anxiety _____
☐ Learning Problems _____	☐ Alcoholism _____	☐ Suicide _____
☐ Intellectual Disability _____	☐ Criminal Behavior _____	☐ Psychosis _____
☐ Autism _____	☐ Depression _____	☐ Other Psychiatric Illness _____

LIVING SITUATION

Please list people in the home.

NAME	AGE	BIRTH DATE	SEX	PRESENT GRADE
1				
2				
3				
4				
5				
6				
7				
8				

DEVELOPMENTAL HISTORY

Mother's health during pregnancy: ____ Good ____ Problematic (describe below)
Describe:

Delivery: ____ Full Term ____ Early ____ Late

Birth Weight _____

Any problems or complications during or after delivery? ____ Yes ____ No (describe below)
Describe:

Was there any delay in achievement of developmental milestones? ____ Yes ____ No (describe below)
Describe:

Please check any of the following problems which have ever pertained to your child.

☐ Colic	☐ Sexual Behavior	☐ Eating Problems
☐ Speech Problems	☐ Runaway Behavior	☐ Weight Loss/Gain
☐ Head Injuries	☐ Aggressive Behavior	☐ Sleep Problems
☐ Seizures	☐ Self-harming Behavior	☐ Fatigue
☐ High Temperatures	☐ Temper Tantrums	☐ Hyperactivity
☐ Stomach Aches	☐ Fire Setting	☐ Depression
☐ Headaches	☐ Cruelty to Animals	☐ Anxiety
☐ Hospitalizations	☐ Coordination Problems	☐ Suicide Attempts
☐ Other Serious Injuries	☐ Concentration Problems	☐ Drug/Alcohol Abuse

Describe: _____

MEDICAL AND PSYCHIATRIC HISTORY

Does your child have any special medical problems? ____ Yes ____ No (describe below)
Describe:

Is your child receiving any medications? ____ Yes (list below) ____ No

Medication	Dose	Prescribing Physician	Results/Side Effects
1			
2			
3			
4			

Previous Medications (list below)

Medication	Dose	Prescribing Physician	Results/Side Effects
1			
2			
3			
4			

Any allergies to medications or foods? ____ Yes (describe below) ____ No
Describe:

EDUCATION

What school does your child attend?	Present Grade
Has your child ever been held back a grade? ____ Yes ____ No	If so, which grade?

Have report cards or school conferences indicated any special difficulty? _____ Classwork _____ Behavior _____ Attitude
Describe:

Any Special Education evaluations or services? ____ Yes ____ No	Date of Assessment
Learning Disability	Services

Other Professional Agency Contacts

☐ Regional Diagnostic Clinic
☐ Family and Children's Services
☐ Juvenile Court
☐ Other
Describe:

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PROVIDERS

Stephen G. Huk, MD
Gleydys Salgado Cardoso, MD
Erin Canuteson-Morales, LCSW
Daniel Huk, LMHC

Dear Patients and Families,

We thank you for choosing BHCS and look forward to working with you. We strive to provide the very best care and, in order to do so, we would like to take this opportunity to acquaint you with our office policies. Please take a few minutes to read over the following information. **In addition, we suggest that you review your health insurance policy and familiarize yourself with the coverage it provides.**

APPOINTMENTS

We ask that you try to schedule your appointments as soon as possible, hopefully after each visit, as routine follow-up time slots are typically booked for several weeks into the future at any given point.

If you are unable to keep your appointment, please notify our office at least one working day (24 hours) in advance to avoid being billed for the time. **A missed appointment will be billed as a rate determined by your physician and also charged to your account.** We will make an attempt to contact you to confirm each appointment one or two days ahead of time. This call is a courtesy, and our failure to reach you will not relieve you of your responsibility for any missed appointment charges.

PRESCRIPTIONS

If you are on medication, please request any needed renewal prescriptions at the time of your appointment. In general, you will be provided with enough refills to last until your next expected appointment. If you do require refills between appointments, **please notify your pharmacy and have them call our office during regular office hours.**
9 am to 12 pm & 1 pm to 4:30 pm, Monday through Thursday - 9 am to 12 pm & 1 pm to 4 pm, Friday.

Prescriptions for controlled substances cannot be called in and will require a electronic prescription. Please notify our office of a need for a prescription THREE BUSINESS DAYS in advance.

LETTERS AND FORM COMPLETION

We require a minimum of 48 hours for all letters and form completion. Any information that you would like forwarded to another provider, school, attorney, employer, etc., requires a signed release of information. In some cases, we may require you to schedule an appointment for the completion of these forms. Please contact our office to inquire whether a scheduled appointment will be necessary.

FINANCIAL POLICY

IF YOU DO NOT HAVE INSURANCE: If you do not have insurance, there will be a one-time, up-front payment of **$100.00** when scheduling your initial appointment. This payment will go towards your first appointment fee. If you cancel your appointment with 48 hours or more notice, your payment will be reimbursed in full. If you cancel with less than 48 hours notice or do not show up for your appointment, then payment is forfeited.

We ask that all self-pay patients pay in full at the time of service. If you cannot pay in full, we must receive payment before scheduling your next appointment.

IF YOU HAVE INSURANCE: In order to better serve your needs, our office accepts several insurance plans. Every plan is different. **It is up to the insured to know the exact requirements of their own insurance plan**. In order for us to f insurance claims on your behalf, you must present proper proof of insurance at the time of your appointment at our office. However, when appropriate, if your insurance company has not responded within 60 days, full and prompt payment will be expected from you. **NO INSURANCE WILL BE FILED WITHOUT A COPY OF THE INSURANCE CARD.**

Fees due at the time of service include: Co-pays, deductibles, non-covered services, or patients that are not covered by insurance.

For your convenience, we accept cash, check, MasterCard, Visa, American Express, and Discover.

FINANCIAL RESPONSIBILITY

The person who brings a child for care is ultimately responsible for the child's bill. The physicians will not get involved in a court decision or child support disputes.

In general, insurance companies should pay within 30 to 60 days after receipt of a claim. If your insurance company has not paid by 60 days after your visit, please check with your company as to the status of your claim.

Your insurance benefits are a contract between you and your insurance company. We cannot accept responsibility for collecting your insurance or for negotiating a settlement on a disputed claim, but we will assist you whenever possible.

If you are a member of a health plan for which we are participating providers, we will honor any restrictions on charges or fees, and these will be adjusted accordingly.

WE RESERVE THE RIGHT TO SEND AN ACCOUNT TO COLLECTION IF NOT PAID IN FULL. IF BHCS REFERS YOUR ACCOUNT OVER TO A COLLECTON AGENCY, YOU WILL BE RESPONSIBLE FOR YOUR BALANCE PLUS COLLECTION AGENCY FEES.

FEES FOR THE DOCTORS

Initial Evaluation	$375
Extended Medicine Check	$225
Medicine Check	$175
Missed Appointment	TBD by doctor

FEES FOR THE THERAPIST

Initial Evaluation	$150
Therapy Follow Up	$135

Our office will do whatever we can to assist you. If you have any questions or problems, please do not hesitate to contact our office.

All patients must complete the patient information form and sign this policy agreement in order to be seen in this office.

I have read and agreed to the above office policies.

Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF MEDICAL INFORMATION

I authorize Behavioral Health Centers of Sarasota to release any medical information which may be requested to process claims for payment of medical services through an insurance carrier, prepaid medical plan, or government agency.

I request that payment be made to Behavioral Health Centers of Sarasota for any bills for service rendered to me by my doctor.

I understand that I am financially responsible to my doctor for any balance not covered by this authorization. I understand that insurance filing is done as a courtesy for the patient and my doctor takes no responsibility for denial or delay of payment.

Responsible Party's Signature _____ Printed Name of Signee _____

Patient Name _____ Date _____

Behavioral Health Centers of Sarasota has adopted a policy, in order to comply with HIPAA Privacy Regulations, requiring physicians and staff to obtain authorization from the patient in order to leave detailed messages for that patient. This policy is meant to protect the patient's privacy. If there is not a signed consent on file, physicians and staff will leave only a name and telephone number on an answering machine, voicemail, or with a live person answering the phone.

With my consent, Behavioral Health Centers of Sarasota may use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). Please refer to Behavioral Health Centers of Sarasota Notice of Privacy Practices for a more complete description of uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Behavioral Health Centers of Sarasota reserves the right to revise its Notice of Privacy Practices at any time.

INFORMED CONSENT FOR TREATMENT

I give my consent for services for myself or my child/legal dependent with Behavioral Health Centers of Sarasota and associated members of the professional staff to include evaluation, psychotherapy, medication management, testing (if indicated), and involvement in the treatment planning process. I may at any time decline specific recommendations.

We reserve the right to discharge any patient from this practice at any time for failure to comply with treatment recommendations or office policy responsibilities.

Responsible Party's Signature _____ Printed Name of Signee _____

Patient Name _____ Date _____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.

I, ___DO/___DO NOT, authorize Behavioral Health Centers of Sarasota to release information related to my evaluation and treatment to:

Primary Care Physician			Phone	
Street	City		State	Zip

Responsible Party's Signature _____ Printed Name of Signee _____

Patient Name _____ Date _____

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HIPAA ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document updated November 14, 2014.

Signature of Patient/ Patient's Representative _____ Printed Name of Signee _____

Relationship to Patient _____ Date _____

AUTHORIZATION TO VERBALLY OBTAIN/RELEASE/EXCHANGE PHI

I hereby authorize Behavioral Health Centers of Sarasota to verbally release, receive from, or exchange with the names below. Please list only family members – NOT TREATING PROVIDERS. Please **circle** any or all that apply.

Name	**Type of Information**		
	Scheduling	Billing	Treatment
	Scheduling	Billing	Treatment
	Scheduling	Billing	Treatment

This authorization has no expiration date, but I understand that I may revoke this authorization at any time by providing a written statement to our office.

Signature of Patient/ Patient's Representative _____ Printed Name of Signee _____

Relationship to Patient _____ Date _____