Department of Clinical and Health Psychology
P. O. Box 100165
Gainesville, FL 32610-0165
352-265-0294

University of Florida Psychology Clinic

INSURANCE INFORMATION REQUEST

****PLEASE COMPLETE THIS FORM CORRECTLY OR YOUR INSURANCE COMPANY WILL NOT BE BILLED APPROPRIATELY AND THE BALANCE WILL BECOME YOUR RESPONSIBILITY****

Date__________

Patient Name______________________________

Date of Birth ___________

Primary Insurance	**Secondary Insurance**
1. Name of Insurance Company________________	1. Name of Insurance Company________________
Address ______________________________	Address ______________________________
Insurance Phone Number________________ (see back of card)	Insurance Phone Number________________ (see back of card)
2. Subscriber/Policy/Member/Contract ID # ____________________	2. Subscriber/Policy/Member/Contract ID # ____________________
3. Name of Policy Holder ________________	3. Name of Policy Holder ________________
4. Policy Holder's Date of Birth ______________	4. Policy Holder's Date of Birth ______________
5. Relationship of Policy Holder to Patient ________	5. Relationship of Policy Holder to Patient ________
6. Is this group or individual insurance? Group____ Individual___	6. Is this group or individual insurance? Group____ Individual___
IF GROUP, PLEASE COMPLETE:	**IF GROUP, PLEASE COMPLETE:**
Group Number ____________________	Group Number ____________________
Employer Name ____________________	Employer Name ____________________
Address ________________________	Address ________________________
Phone______________________	Phone______________________

7. AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND PAY INSURANCE BENEFITS:
I hereby authorize Clinical and Health Psychology to release information related to all psychological care, attention and treatment to the above listed carrier. I also hereby authorize and request payment directly to Florida Health Professions Association, Inc. for bills covering this period of treatment, by all Insurance carriers with whom I have coverage. I further agree to pay all charges connected with this treatment not covered by any insurance I may have, and understand insurance coverage does not release me of obligation to begin payment upon initial visit. (Copies of this agreement shall be valid as the original)

____ ____________________
Signature - Patient or Guardian Date

____ ____________________
Signature - Policy Holder or Guarantor (if other than patient/guardian) Date

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Patient Information Form

Thank you for choosing the University of Florida Psychology Clinic for your healthcare needs. Please complete this form to ensure we have the most accurate and current information. We may ask you to review this information from time to time to make sure it stays up-to-date.

Patient **First** Name: ______________________
Patient **Last** Name: ______________________

Address: ______________________________
____
City: ______________________________
State: __________ Zip Code: __________

Home Phone: (____) ________________
Work Phone: (____) ________________
Cell Phone: (_____) ________________
Parent/ Guardian's Name: (if applicable)
____

May we contact you at home? Yes/ No
May we contact you at work? Yes/ No
If yes, what time(s) would be good for contacting you? ________________
Can a message be left at home? Yes/ No

Social Security #: ________________

Date of Birth: ____________________
Age: _______

Marital Status: **(circle one)** Single Married Divorced Widow(er) Other

Religion: ____________________

Ethnic/Racial Background: **(circle one)**
African-American Asian
Caucasian Hispanic/Latino
Native American Multiracial
Other: (explain)

Employer: ____________________

Emergency contact person: ____________________ Relationship: ________________
Emergency Contact Phone #: (_____) ________________
Who referred you to us? ______________________________

************DO NOT WRITE BELOW THIS LINE************

OFFICE USE ONLY

Primary Insurance: ______________________ Phone: ____________ Other Notes:
Address ______________________ Fax: ____________
____
Policy Holder: ______________________ Policy #: ______________
Group #: ______________________

Secondary Insurance: ______________________ Phone: ____________
Address: ______________________ Fax: ____________
Policy Holder: ______________________ Policy #: ______________
Group #: ______________________
Provisions: Authorization Needed? Yes/ No Date Obtained: __________
Authorization #: ________________
Deductible Amount: ________________ Amount Satisfied: ________
Co-pay Amount: ________________
Co-Insurance Amount: ________________ Self-pay Amount: ________
\# Visits Authorized: ________________ Terms: ________
Testing Authorization: ________________ ________________

College of Public Health and Health Professions
Department of Clinical and Health Psychology
Psychology Clinic

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Phone: (352) 265-0294
Fax: (352) 265-0096

Informational Handout

The Psychology Clinic in Shands Hospital at the University of Florida provides assessment and treatment services for children, adolescents, adults, older adults, couples, and families. Our clinic provides services for emotional problems and those with a range of medical illnesses. Licensed and board certified faculty psychologists are responsible for all services in our clinic. Like Shands Hospital and the University of Florida Clinics, the psychology clinic is a training site. Therefore, trainees are likely to be involved in your care. In all cases, these trainees work under the direction of a faculty member. This may involve the faculty member watching the trainee through a one-way mirror or taped recording. Our trainees are bound by the same ethical and legal standards as our licensed psychologists. Please discuss with your provider any questions or concerns you might have about this or any issue related to our clinic.

Hours of Operation

The Psychology Clinic schedules patient appointments between 8AM-5PM Monday, Wednesday, Thursday, and Friday. Appointments are scheduled between the hours of 8AM -7PM on Tuesday's.

What to Expect

The Licensed Psychologist and trainee assigned to you work as a team. Your team will likely start with an assessment. This assessment gathers information to answer questions about your particular case. This information is also helpful in planning effective treatment if needed. Your team conducts this assessment through an interview with you and/or family and friends. In addition, testing may be appropriate. This may include paper and pencil testing of your thinking and learning abilities, memory, emotions and/or behaviors.
You should be sure and understand the purpose {purposes} of this testing by talking with either the licensed psychologist or trainee. In all cases, all procedures will be explained to you. This evaluation may take from 2-8 hours.

Following your assessment, it may be suggested to you that you begin treatment in our clinic. We attempt to provide the most helpful treatment possible for your situation based on our own research and the research of others. Previous research studies indicate that many patients are helped by therapy. However, treatment benefits cannot be guaranteed. Your therapist will be happy to discuss any questions you may have. These therapy sessions can last as little as 30 minutes or as long 80 minutes. Your therapist will discuss the length of your sessions before you begin treatment.

If you have any concerns about your assessment or treatment, you should discuss them with the supervising licensed psychologist or trainee. As we mentioned earlier, this is a training clinic and you may be observed during your assessment or treatment. If your psychologist or trainee wishes to tape record your assessment or treatment for use in supervision of your care, they will ask you to sign a separate form. This form grants them permission for taping <u>before</u> it occurs. You also <u>may</u> be offered the opportunity to participate in a research study. Participation in our research is voluntary. If you agree to participate, you will be informed about the particular study and will be asked to sign a separate permission form.

About Privacy

The information you provide at these sessions will be treated with great care and kept private according to state law and the rule of our profession. In a few rare circumstances, your privacy cannot be protected. Here are the most common examples:

1} if a court has ordered you to seek evaluation and treatment here, then the court has a right to this information
2} if a court orders release of your records for a legal proceeding
3} if you make a serious threat to harm yourself or another person
4} if your provider believes that either a child or an elderly person is being abused or neglected

There are other times when your information may be released. If you have concerns, please discuss these concerns with your provider.

My signature below indicates that I have read the above statements.

Please read, sign, and bring with you to your visit.

______________________________ _______________

Signature of patient, parent or guardian Date

Consent and Authorization

Section A: Notice of Limited Liability

I, on behalf of myself, my child, and/or my ward, hereby acknowledge I have been informed that: Care and treatment that I/we receive at this and other Florida Health Professional Association clinics/facilities, associated with the Department of Clinical and Health Psychology, will be provided by University of Florida employees and/or agents. I understand that these health-care providers are under the exclusive supervision and control of the University of Florida Board of Trustees and liability for their acts or omissions is limited to $100,000 per claim or judgment by any one person and to $200,000 for all claims or judgments arising out of the same incident or occurrence (see Florida statutes 726.28). Effective October 1, 2011 the amounts will be adjusted to $200,000 per claim or judgment by any one person and to $300,000 for all claims or judgments arising out of the same incident or occurrence.

Section B: Treatment Authorization, Assignments of Proceeds, Authorization to Release Information and Guarantor Agreement

1. Authorization for Routine Diagnostic Procedure and Psychological Treatment-I hereby consent to such diagnostic procedures which in the judgment of my healthcare provider may be considered necessary or advisable while a client at a Florida Health Professionals Association (FHPA) clinics/facility. I recognize that the FHPA providers are employees of a healthcare teaching and research institution and that my treatment and care will be observed and in some instances aided by students under appropriate supervision.

2. Assignment of Benefits-I hereby assign to the FHPA payment from all third-party payers* and with whom I have coverage or from whom benefits are or may become payable to me, for the charges of health care services I receive for, related to, my treatment (past, present, or future). I agree to be personally responsible for payment of any healthcare services that are not covered by my third-party payers*, including, but not limited to, not covered or out-of-network services, deductibles, co-insurance, and/or co-payments.

3. Release of Medical Information by the Florida Health Professionals Association-By signing in the space below as Patient/Guardian, I hereby authorize the FHPA providing services during my outpatient clinical care, to release information from and/or copies of my psychological records and other information as may be required for my psychological care and to secure payment for charges incurred by me or on my behalf, to any other FHPA clinic/facility, my physician, to my referring physician, the guarantor on my accounts, insurance companies for which I have assigned benefits for my treatment and care, or to any sponsors that the

FHPA may later obtain to contribute payments for my treatment and care. I also authorize release of any information to any and all regulatory and/or accrediting organizations as necessary to the outpatient clinics to maintain its licensure and accredited status.

4. Guarantor Agreement- By signing in the space below as Patient/Guardian or guarantor, or as patient's/guardian's spouse or guarantor's spouse, I hereby agree that all charges connected with the treatment, not covered by any insurance, program, sponsorship or other third-party coverage I may have are due and payable by me at the time of the visit or discontinuation of treatment or in a pre-arranged payment plan agreeable to FHPA. If the insurance information I have provided is not active at the time of service or if the services provided are not covered by my insurance company, I will be responsible for any balance due. The charges I agree to pay are those listed in the master billing charge manual, which are available for inspection upon request and incorporated herein by reference. I hereby acknowledge that, unless the FHPA and my insurance company or third-party carrier have agreed that I will not be billed, if the FHPA has agreed to bill my insurance or other third-party carrier it has agreed to do so as a courtesy and that the FHPA has the right to demand payment in full from me at any time prior to full payment from any insurance carrier. If an overdue account is referred by collections, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the outpatient clinic charges I have agreed to pay.

*Third-party payers include, but are not limited to, coverage available from: Medicare, Tri-care, or governmental programs; health, accident, automobile, or other insurance; workers compensation; HMO (commercial, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

Patient/ Guardian Signature: ______________________________

Patient's/ Guardian's Spouse Signature: ______________________________

Guarantor Signature (if other than patient/ guardian): ______________________

Guarantor's Spouse Signature: ______________________________

Name of Insured (if other than patient): ______________________________

Witness (Adult 18yrs and over): ______________________ Date: __________

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AUTHORIZATION to Use or Disclose Protected Health Information (PHI)

Patient's Name	Date of Birth	Verification of Identity Driver's License
Patient's Address	Medical Record Number	Other:

** Complete the following only if the **person authorizing** the use or disclosure is **not the patient:**

Representative's Name	Relationship to Patient Parent	Legal Authority Parent and Legal Repr.
Representative's Address	Verification of Identity Driver's License	Verification of Authority Person known to facility

By signing this form, I authorize the following:

Disclosure of the patient's PHI **from**:		Disclosure of the patient's PHI **to**: Patient/Parent Name & Address	
Person, class of persons, or organization Shands Teaching Hospital		*Person, class of persons, or organization*	
Address P.O. Box 100165, University of Florida		*Address*	
Gainesville, FL 32610-0165			
Attn:	*Phone* 352-265-0294	Attn:	*Phone*

The following protected health information may be disclosed *(describe in detail)*:

I further authorize the disclosure of the following information which may be included in the protected health information listed above. (*Check all that approved.*)

☐ Mental Health	☐ Substance Abuse	☐ HIV/AIDS	☐ Records created by non-UF/Shands providers

The purpose of the disclosure is:

I understand that, by federal law, the University of Florida may not use or disclose protected health information without authorization except as provided in the University's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

This authorization expires automatically one (1) year from the date signed, if no other date or event is specified:	*Expiration Date or Event*
This authorization may be used to disclose protected health information of the same type described above, which may be created in the future, until the expiration date.	☐ YES ☐ NO
I have read and understand the information in this authorization form.	
Signature of Patient or Legal Representative:	*Date*

Complete all parts of the form, print out and sign and date. Patient or representative should keep a copy. Give, fax, or mail the original form to the person or organization releasing the information.

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