

### **INTAKE APPOINTMENT INFORMATION**

Appointment Date \_\_\_\_\_ Appointment Time \_\_\_\_\_

**Your child has been referred for an initial intake interview at Dr. Brenda Wiens' Child Psychology Clinic at the Shands Hospital Psychology Clinic.** Since Shands is a teaching hospital, Dr. Wiens typically has doctoral and/or intern trainees assisting her in the interviews.

1. If you are seeking a comprehensive evaluation/testing for your child and your child's insurance requires an interview prior to gaining approval for testing, this initial intake appointment will consist of gathering developmental history and other information needed to request testing approval from the insurance company.
2. If you are seeking therapy for your child, this initial intake appointment will gather information about the concerns you would like addressed in therapy, as well as developmental history information.

It is important to **have a parent/legal guardian present for the full intake appointment.** If you have any school records (recent report card & IEP), medical information (medications, etc), or reports from prior testing (OT, Speech/Language, psycho-educational, or neuropsychological evaluations), **please bring any such available records for us to review.**

**In most cases, this intake appointment takes 1 ½ - 2 hours, and will consist of an interview and completing some questionnaires.**

**Enclosed are forms for you to complete prior to your child's appointment. Please complete all of these forms and bring them with you to your child's appointment – they will be collected when you arrive.** The forms include: 1) clinic forms requiring parent signature and insurance information and 2) a questionnaire about your child's developmental history (BASC-3 Structured Developmental History). Included with your clinic forms is an Authorization to Use or Disclose Protected Health Information. Please put **your name and address in the "To" section.** This will allow us to provide you with a copy of the intake report if needed.

**Should you need to cancel/reschedule, please contact us no later than 3 business days prior to your appointment.** If you should have any questions, please contact the clinic at (352) 265-0294 or 1-800-749-7424 (extension 50294). The Psychology Clinic is located on the Ground Floor of Shands Hospital, Room G-901. Please see the enclosed map for directions. **If you are a new patient to Shands,** it will be necessary to register prior to your appointment. For further information, contact the Psychology Clinic at (352) 265-0294 or 1-800-749-7424 (extension 50294). Patients that have a Shands medical record number will need to update registration and insurance information when you arrive for the appointment.

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 \_\_\_\_\_

<b><u>Primary Insurance</u></b>	<b><u>Secondary Insurance</u></b>
1. Name of Insurance Company _____	1. Name of Insurance Company _____
Address _____	Address _____
Insurance Phone Number _____ <small>(see back of card)</small>	Insurance Phone Number _____ <small>(see back of card)</small>
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 _____
<b>IF GROUP, PLEASE COMPLETE:</b>	<b>IF GROUP, PLEASE COMPLETE:</b>
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

**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 **F**irst Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Patient **L**ast Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_

Age: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Home Phone: (\_\_\_\_) \_\_\_\_\_

Religion: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Parent/ Guardian's Name: (if applicable)  
\_\_\_\_\_

Ethnic/Racial Background: **(circle one)**

African-American Asian

Caucasian Hispanic/Latino

Native American Multiracial

Other: (explain) \_\_\_\_\_

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? \_\_\_\_\_

Employer: \_\_\_\_\_

Can a message be left at home? Yes/ No

Emergency contact person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone #: (\_\_\_\_) \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

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

**OFFICE USE ONLY**

**Primary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Address \_\_\_\_\_ Fax: \_\_\_\_\_

Other Notes:

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

1600 SW Archer Rd, Room G-901  
PO Box 100165  
Gainesville, FL 32610-0165  
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 before it occurs. You also may 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: \_\_\_\_\_

**Record Request: Authorization to Use and Disclose Protected Health Information ("PHI") Maintained by UF Health\***

\*For purposes of this agreement, UF Health describes a collaboration of the University of Florida Board of Trustees for the benefit of the University of Florida College of Medicine, Shands Jacksonville Medical Center, Inc., Shands Teaching Hospital and Clinics, Inc., and Shands Recovery, LLC. Collectively, these entities are referred to as UF Health in this form.

Patient's Name	Date of Birth	Medical Record #	Verification of Identity <input type="checkbox"/> Driver License/State ID <input type="checkbox"/> Personally known <input type="checkbox"/> Other:
Patient's Address	City	State	Zip
Phone #	Last 4 digits of SSN (Optional)		<input type="checkbox"/> Check if patient is an employee of UF Health Shands
<b>Complete the section below <u>only</u> if the person requesting records is not the patient:</b>			
Name of Representative	Relationship to Patient <i>Parent/Guardian</i>		Legal Authority
Representative's Address & Phone Number	Verification of Identity <i>Drivers License</i>		Verification of Authority

By signing this form, I authorize the release of PHI (i.e., medical records) as follows:

**From the doctor, office, facility of other health care provider checked or written below:**

<input checked="" type="checkbox"/> University of Florida person, class of persons, or organization: <i>UF Psychology Clinic</i> Clinic, person, class of persons, or organization <i>PO Box 100165, Gainesville, FL 32610</i> Address <i>352-265-0294</i> Phone	<input type="checkbox"/> UF Health Shands Hospital • PO Box 100345, Gainesville, FL 32610-0345 Phone: 352.265.0131 • Fax: 352.265.1098 <input type="checkbox"/> UF Health Shands Rehab Hospital • 4101 NW 89th Boulevard, Gainesville, FL 32606 Phone: 352.265.5491 • Fax: 352.627.4425 <input type="checkbox"/> UF Health Shands Psychiatric Hospital • 4101 NW 89th Boulevard, Gainesville, FL 32606 Phone: 352.265.5497 • Fax: 352.627.4425 <input type="checkbox"/> UF Health Florida Recovery Center • 4001 SW 13th Street, Gainesville, FL 32608 Phone: 352.265.5500 • Fax: 352.265.5504 <input type="checkbox"/> UF Health Shands HomeCare • 3515 NW 98th Street, Gainesville, FL 32606 Phone: 352.265.0789 • Fax: 352.265.9276
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**To the facility / person below:**

Clinic, person, class of persons, or organization <i>Parent/Guardian</i> <i>Name + Address</i>	Address and Fax Number	<input type="checkbox"/> Check here if same as patient <input type="checkbox"/> Check here for records pick-up only
Attn:		

<b>The following PHI may be released (describe in detail or use the check boxes below):</b>			<b>I further authorize the release of the following information which may be included in the PHI:</b>
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Operative Reports(s)	<input type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Mental Health/Psychiatric Treatment
<input type="checkbox"/> Problem List	<input type="checkbox"/> Medication List	<input type="checkbox"/> Treatment Notes	<input type="checkbox"/> Alcohol or Substance Abuse Treatment
<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Radiology Reports/Films	<input type="checkbox"/> Lab/Pathology Reports	<input type="checkbox"/> STD/HIV/AIDS Treatment(s) or Test(s)
<i>Intake/Assessment results and reports; letters</i>			<input type="checkbox"/> Genetic Testing
<b>Is this needed for a doctor's appointment?</b>	Write date below:	<b>Are there specific dates needed?</b>	Write dates below:

<b>Purpose of this request?</b>	<input type="checkbox"/> Treatment/Continued Care <input type="checkbox"/> Payment/Billing <input checked="" type="checkbox"/> Personal Use <input type="checkbox"/> Other:
<b>Format of Records?</b>	<input type="checkbox"/> Through a web portal, with notice provided to my e-mail account at: _____ To request records in electronic PDF form, please check the box above and provide a valid and clear e-mail address. You will receive an e-mail from HealthPort and that e-mail will tell you how to get the records. <input checked="" type="checkbox"/> Paper

This authorization allows UF Health to use and disclose (release) certain PHI, which includes medical records, as I have directed.

I understand that:

- The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and STDs.
- This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.
- This authorization will remain in effect for one (1) year or until I revoke it in writing (i.e., tell UF Health to cancel it).
- I have the right to revoke this authorization at any time, if I do so in writing to the Health Information Management Department at the organization named above and that the revocation will not apply to action already taken as a result of this authorization.
- I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- I understand that PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.
- I am aware that I may be charged a fee for this request as allowed by law, which may include up to \$1.00 per page (plus applicable tax and handling) for Paper Records and fees associated with labor, supplies (i.e. cost of a computer disk), and postage for Electronic Records. Fees are waived when PHI is released to a health care provider for treatment purposes.

Signature of patient / patient representative \_\_\_\_\_ Date \_\_\_\_\_

