Welcome to Solace Behavioral Health

You were born free and happy…

Somewhere along the way that may have changed. We believe in restoring that balance and happiness in your life. We specialize in traditional and non-traditional therapies to engage you in a transformative experience. Unlike other practitioners, who rely exclusively on psychotherapy and pharmaceuticals, we offer an even wider range of therapies and techniques.

What we offer:

- Alcohol & Drug Detox
- Chronic Disease Management
- Counseling
- Court Mandated Services
- Hypnotherapy
- Ketamine Therapy
- Medication Management
- Neuropsychiatric Assessment
- Psychiatric Services
- Shamanic Healing Practices
- Transcranial Magnetic Stimulation (TMS-NeuroStar

What to Expect:

- **The intake**: Our intake process ensures that our providers are able to spend quality time with you during your first appointment with the MD. One of our trained Intake Specialists will complete a social, psych, medical, and family mental health history assessment. The psychiatrist will review this information prior to your intake follow-up appointment with them.
- **The intake follow-up appointment**: is the appointment with one of our Psychiatrists. This visit will focus on creating an individualized treatment plan, which can include a range of treatment resources listed above.
- **The treatment plan:** will be discussed with you, and generally a referral to one of our Nurse Practitioners and/or therapists will be made depending on your needs. The referral to the Nurse Practitioner allows for a closer follow up while medications are being adjusted or renewed.
- If at any time, you feel you would like to review or make changes to your treatment plan, you can always schedule time with a psychiatrist.
- Given the team approach at Solace, our focus is to fulfill the mutually agreed upon treatment plan and your care needs. This may be done under various psychiatrists and supervising MD's and may be reflected in your billing.

We look forward to working with you!

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Please sign below acknowledging that you understand the above-information and the processes of Solace Behavioral Health.

_____

Patient signature Date

Demographics

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Lets get to know you! What is your name?

First: _____

Middle: _____

Last: _____

Nickname: _____

Suffix: _____

DOB: _____

SSN: _____

Gender: ☐ Male ☐ Female

Ethnicity (Optional): _____

Race (Optional): _____

Language (Optional): _____

☐ Other Language: _____

Who is your Primary Care Physician?

_____

Who is your referring physician?

_____

Marital Status: _____

Employed: _____

If employed, who is your employer?

_____

Student Status: _____

Responsible Party Same as Patient: _____

What is your address?

Address: _____

Address: _____

City: _____

State: _____ Zip: _____

How can we reach you?

Home Phone #: _____

Work Phone #: _____

Mobile (Other)#: _____

Email: _____

How would you like to receive your appointment reminder? _____

If you selected phone call reminder, do you want us to leave a message if your voicemail is received? _____

Consent to Obtain External Prescription History

I authorize the providers at Solace Behavioral Heath to view my external prescription history though the RxHub service. I understand that all of my prescription history that have been prescribed by other unaffiliated medical providers may be viewable through the RxHub service. I acknowledge that my prescription history may be viewed by my provider and staff at Solace Behavioral Health.

My signature certifies that I read and understand the above information and that I authorize access to my prescription history.

_____

Patient Signature *Date*

Insurance

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Medical Insurance Coverage

☐ I **DO NOT** have medical insurance and I will be paying out-of-pocket for all costs associated with the services I receive at Solace Behavioral Health, LLC. (Skip to page 4)

☐ I **DO** have medical insurance and I will be providing my insurance information. (Skip to insurance information section below)

Primary Insurance

Primary Insurance Company: _____

Member ID #: _____ Group ID: _____

What type of insurance coverage is this plan: _____

☐ I **AM** the subscriber for my primary insurance. (Skip to Secondary Insurance Coverage)

☐ I **AM NOT** the subscriber for my primary insurance. I am a dependent and will be providing the identifying information for the subscriber on my plan.

Subscriber Information:

Name: _____ _____ _____ Date of Birth: _____
First MI Last

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance

Secondary Insurance Company: _____

Member ID #: _____ Group ID: _____

What type of insurance coverage is this plan: _____

☐ I **AM** the subscriber for my secondary insurance. (Skip to page 4)

☐ I **AM NOT** the subscriber for my secondary insurance. I am a dependent and will be providing the identifying information for the subscriber on my plan.

Subscriber Information:

Name: _____ _____ _____ Date of Birth: _____
First MI Last

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Responsible Party

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Who Is The Responsible Party?

☐ I am the *responsible party for pay*ment on this account. (Please skip to Billing Policy section)

☐ I am NOT the *responsible party for payment* on this account and will be providing the information pertaining the responsible individual. *Please note, if you are selection this option, the ID and signature of the responsible individual is required.

Responsible Individuals Name: _____ _____ _____
First MI Last

Relationship to Patient: _____ Birthdate_____

Address: _____

City_____ State_____ Zip_____

Billing Policy

All patient copayments and coinsurance is expected at the time of your visit. If you have an outstanding balance with our office, you will be required to pay the balance in full or will need to reschedule your appointment.

Our office will bill your insurance company for any services rendered toward your care. Any remaining patient responsibility will either be billed to you or collected at the time of your next visit. Our policy requires that all outstanding balances be paid in full and your ledger is clear within thirty (30) days of treatment.

As a patient, you have a right to appeal any payment decisions made by your insurance carrier. As a patient, it is your responsibility to contact your insurance directly regarding any disputes.

It is your responsibility to keep your patient account clear and current. Any delinquent accounts will be sent to collections after 90 days. Additionally, you may be assessed late charges and interest for any outstanding balances.

By signing this form, you agree to office billing policy as it has been explained above.

Patient Signature: _____ Date: _____

If applicable
Responsible Party Signature: _____ Date: _____

Privacy Preferences

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Who Do You Want To Have Access To Your Care?

Please list whom we may discuss your private psychiatric records (e.g. family members or your personal medical doctor). This will include documentation describing diagnosis, treatment, and payment information and may also include personal information.

Primary Contact

Full Name: _____ _____ _____
First MI Last

Relationship to Patient: _____

Home Phone #: _____Work Phone #: _____

Other/Mobile Phone #: _____ Email: _____

☐ Granted Full Patient Health Information Access ☐ May Pick Up Medications

☐ The primary contact listed above also serves as my emergency contact.

Secondary Contact

Full Name: _____ _____ _____
First MI Last

Relationship to Patient: _____

Home Phone #: _____Work Phone #: _____

Other/Mobile Phone #: _____ Email: _____

☐ Granted Full Patient Health Information Access ☐ May Pick Up Medications

☐ The primary contact listed above also serves as my emergency contact.

Privacy Preferences Consent

By signing this form, you acknowledge that the individuals listed above will have access to your Patient Health Information at Solace Behavioral Health, LLC and you consent to release information pertaining to your care to these individuals.

Patient Signature: _____ Date: _____

Privacy Notice

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Privacy Notice

Health information is generated whenever you receive services. We are required by law to maintain the privacy of your protected health information and to provide you a notice of our practices. Below is an overview of how that information can be used and disclosed. This legal disclosure has been simplified for your convenience.

Within The Practice (Solace Behavioral Health, LLC)

- Treatment: Coordination of care with other health care professionals for the purposes of evaluating, diagnosing and treatment of your medical condition.
- Payment: Collecting payment from your health plan or from other sources that may be paying for your services.
- Health Care Operations: To support day-to-day activities and management of The Practice

Outside The Practice

- Law Enforcement: To support audits, inspections, investigations and to comply with mandates.
- Correctional Institutions: Facilitate continuation of your care in the event you are incarcerated.
- Judicial/Administrative Proceedings: In compliance with your request or legal court mandate.
- Victims of abuse, neglect, or domestic violence: As relates under Florida Law to protect at risk individuals or potential victims.
- Public Health Reporting, Oversight Agencies, Coroners, Medical Examiners, Specialized Government
- Agencies and Funeral Directors as required by law.

Third Party Vendors

- Any vendor (not an employee) who, on behalf of Solace Behavioral Health, LLC, (1)Performs a function involving the use or disclosure of individually identifiable health information, PHI, (other than incidental) including claims processing or administration, data collection/analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing or (2)Provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for Solace Behavioral Health, LLC, where the provision of the service involves the disclosure of individually identifiable health information from Solace Behavioral Health, LLC.

Other Uses

- Appointment Reminders, Workers Compensation, Your Legal Representatives and Workers Compensation
- Research: Only when approved by an IRB and protocols have been followed.
- Other Uses: Requires specific written authorization. You can change your mind but this may not undo disclosures made during the period of authorization.

BY SIGNING BELIOW, I CERTIFY THAT I HAVE READ AND REVIEWED THE ABOVE PRIVACY NOTICE.

✗ _____

Signature of Patient or Legal Representative Date

Know Your Rights

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Rights

Individual rights under Federal Privacy Standards include:

- Use and disclosure of protected health information
- Confidential communications about your treatment with your provider
- To inspect, amend, submit corrections to and copy your protected health information. Filling out a form available at our office can do this.
- Tracking of disclosure of your protected health records
- Provided a copy of this notice

Your may submit any concern or complaint about our privacy practices. If you believe that your privacy rights have been violated, please send a letter or email to the address above. You will not be penalized or otherwise retaliated against for filing a complaint.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may reflect changes in state and federal regulations. Only the latest policies and practices will be applied and available for your review at our office. If you wish to see the actual legal language, please contact us.

☐ I have reviewed/received a copy of the Solace Behavioral Health, LLC Privacy Practices.

☐ I understand that correspondence will be sent from this office marked confidential.

☐ Confidential messages may be left on my phone including voicemail or answering machine.

☐ I am fully aware that a cell phone is not a secure and private line.

BY SIGNING BELIOW, I CERTIFY THAT I HAVE READ AND REVIEWED THE ABOVE PRIVACY NOTICE.

✗ _____

Signature of Patient or Legal Representative Date

Informed Consent Assignment if Benefits & Cancellation Policy

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Informed Consent

I, the undersigned, voluntarily give consent to my Solace Behavioral Health, LLC medical professional to provide and perform diagnostic procedures and treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Assignment of Benefits

I hereby authorize my Solace Behavioral Health, LLC practice location to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Solace Behavioral Health, LLC (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a copy of this agreement shall be considered as effective and valid as the original.

Cancellation Policy

Our providers only see one patient at a time so that each patient has their full attention, and only see a limited number of patients per day.

Cancellations or rescheduling of appointments made over 24 hours in advance will be appreciated, even if you do this through our messaging services. - Cancellations made less than 24 hours and No – Shows are subject to a fee as below:

- 1st Missed Appointment: $25.00
- 2nd Missed Appointment: $50.00
- 3rd Missed Appointment: Automatic Discharge

In the event of a true emergency, the cancellation policy does not apply. Documentation will be required.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

✗ _____

Signature of Patient or Legal Representative Date

Lets Communicate With Your Healthcare Team

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Release of Patient Health Information (PHI)

We at Solace Behavioral Health want you to know how your Patient Health Information (PHI) is going to be used in this office. As your mental health provider, it is our goal to communicate with your referring and primary care physician in order to keep them actively involved in your care. In some cases, we may release your Patient Health Information (PHI), such as your demographics, progress notes, diagnosis, lab results, treatment plans, billing history, and prescription information. Provide your referring and/or primary care physician down below that you would like involved in your care.

If you listed a referring and primary care physician on your registration form, please sign below indicating that you approve Solace Behavioral Health, LLC to release your PHI to your referring and primary care physician.

BY SIGNING BELIOW, I CERTIFY THAT I HAVE READ, REVIEWED, AND AGREE TO THE ABOVE PHI NOTICE.

✗ _____

Signature of Patient or Legal Representative Date

Select the services your interested in receiving at Solace Behavioral Health:

- ☐ Alcohol & Drug Abuse Treatment
- ☐ Chronic Disease Management
- ☐ Counseling
- ☐ Hypnotherapy
- ☐ Transcranial Maganetic Stimulation (TMS) for Depression
- ☐ Medication Management
- ☐ Neuropsychological Testing
- ☐ Shamanic Healing Practices
- ☐ Ketamine Therapy for Depression

PHQ-9 Depression Scale

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Patient Name _____ **Date** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

If you checked off any problem on this questionnaire so far, 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
0	1	2	3
Total Score from both tables:_____			

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

✗ _____

Signature of Patient or Legal Representative Date