Gulf Coast Psychotherapy, LLC
4167 Clark Rd
Sarasota, FL 34233
(941) 219-3111

Patient Registration Form

Date:_____

First Name:_____Last Name:_____MI_____

Home Address:_____ Date of Birth:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

E-mail address:_____ Contact Preference: Home Work Cell E-Mail

Marital Status: M / S / W / D SS #:_____Patient's Employer/School:_____

Spouse's Name:_____ Spouse's Date of Birth:_____

Emergency Contact Name:_____Phone #:_____

Address:_____Relationship to Patient:_____

Patient Referred By:_____ Primary Care Physician:_____

If The Patient is a Child, Please Complete the following:

Biological Father's Name:_____Date of Birth:_____

Address:_____Phone #:_____

City:_____State:_____Zip Code:_____

Father's Employer:_____SS#:_____

Biological Mother's Name:_____ Date of Birth:_____

Address:_____Phone #:_____

City:_____State:_____ Zip Code:_____

Mother's Employer:_____SS#:_____

Medical Insurance Information:

Primary Insurance Name:_____

Cardholder's Name:_____Date of Birth:_____

Relationship to Patient:_____Insurance ID#:_____

Mental Health/Behavioral Health Phone Number on card:_____

1. Secondary Insurance Name:_____

Cardholder's Name:_____Date of Birth:_____

Relationship to Patient:_____Insurance ID#:_____

Mental Health/Behavioral Health Phone Number on card:_____

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to Gulf Coast Psychotherapy, LLC for myself and/or dependents. I understand that I am responsible for any co-payments, co-insurance, and deductibles at the time of visit, or amounts for services not covered by my insurance carrier or managed care company. I understand that I will be charged for canceled or missed appointments unless I give 48 hours advanced notice and I agree to pay said charges. In the event that my account is placed in the hands of an attorney for enforcement of any terms of this agreement, I agree to pay a 33 1/3% attorney's fee on the outstanding balance, plus court costs, constable fees, and miscellaneous expenses. This authority shall remain outstanding until withdrawn in writing by the undersigned.

Patient/Responsible Party Signature:_____Date:_____

Gulf Coast Psychotherapy, LLC
4167 Clark Road
Sarasota, FL 34233
(941)219-3111 Fax: (941) 894-1322

CONSENT FOR THE RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

PATIENT NAME:_____DATE OF BIRTH:_____

I hereby authorize *Gulf Coast Psychotherapy, LLC* to:

- ☐ *RELEASE* the record of my care to:
- ☐ *OBTAIN* the record of my care from:
- ☐ *VERBAL COMMUNICATION* regarding my care to:

_____

(NAME OF PROFESSIONAL, FACILITY OR AGENCY)

_____

(STREET) (CITY) (STATE) (ZIP)

_____

(TELEPHONE NUMBER) (FAX NUMBER) (E-MAIL ADDRESS)

Information pertaining to my identity, prognosis, and/or treatment. The information to be released shall include:

- ☐ All psychotherapy records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, diagnostic evaluations, progress notes, treatment plans, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, photographs, videotapes, telephone messages, e-mail messages.

OR, only the following selected information:

- ☐ Assessments
- ☐ Treatment Plans
- ☐ Treatment Updates
- ☐ Medication Record
- ☐ Discharge Summary
- ☐ STD/HIV/AIDS Information
- ☐ Other:_____

This information is needed for the following purposes:

- ☐ To Provide Ongoing Treatment/Aftercare
- ☐ Other:_____

I understand that my records are protected under FL General Law & HIPAA and cannot be disclosed without my written consent except as otherwise specifically provided by law.

I further release Gulf Coast Psychotherapy, LLC. and it's employees from any liability arising from the release of the information and such persons/agencies, provided the said release of information is done substantially in accordance with applicable law. I understand that any information released or received as a result of this consent will not be further relayed in any way to any person or organization without my additional written consent.

I also understand that I may revoke this consent at any time prior to the release of information herein authorized.

PATIENT/PARENT/GUARDIAN
SIGNATURE:_____DATE:_____

WITNESS SIGNATURE:_____DATE:_____

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Gulf Coast Psychotherapy, LLC. Policy Agreement And Consent

TO THE PATIENT: You have the right, as a patient, to be informed about the policies of the practice of Gulf Coast Psychotherapy, LLC, so you can make an informed decision whether or not to undergo the therapy that your physician and/or others have recommended for your well-being. This information is simply an effort to help you become better informed so that you may give or withhold your consent to the policies of the practice.

1. **Co-payment:** The *full* amount due according to your health insurance policy coverage is due and payable *at the time* of your therapy appointment.
2. **Refund:** Any co-payment overcharges will be refunded to you.
3. **Underestimation of Co-payment, Deductible, and Gaps in coverage:** Should you misunderstand your insurance coverage and later find that you are required to pay a higher percentage co-payment than you initially understood, you will be expected to pay the difference and will be billed for that amount. Additionally, should there be a lapse in insurance coverage the patient will be responsible for full fee of all sessions scheduled during those periods.
4. **48-Hour Notice of Cancellation** is required for all therapy sessions. If 48-hour notice is not received, *the patient will be billed the full session fee of $85.00, not just the co-payment*, as insurance companies will not pay for missed visits. Examples of late cancellations are, but not limited to, cancellations the same morning of your appointment or during the time of your scheduled therapy appointment. See Gulf Coast Psychotherapy, LLC Cancellation and Fail To Keep Policy.
5. **Failure to Cancel or Keep Appointment:** If a scheduled appointment is not cancelled, or if 48-hour notice is not received, *the patient will be billed the full session of $85.00, not just the co-payment,* as insurance companies will not pay for missed visits. See Gulf Coast Psychotherapy, LLC Cancellation and Fail To Keep Policy.
6. **Returned Check Fees:** A *$35.00* processing fee will be charged for all checks returned for insufficient funds. It is *your* responsibility to pay the processing fee prior to, or at the time of, your next therapy session. In the event that more than one check is returned, cash payment will be required prior to scheduling subsequent appointments.
7. **Late Fees:** If your account becomes past due, *the unpaid balance carried to the first day of the next calendar month will be charged an interest rate of 1 ½% per month or 18% per annum.*
8. **Collection Fees:** If your account becomes past due and sent to a collection agency, you will be responsible for the costs incurred as well as the balance due.
9. **Termination of Treatment:** You are expected to communicate your wish to end therapy prior to your last visit with your therapist. In doing so, you will have one final session for the purpose of *"closure"*. You may choose to end therapy at any time, but it is best to discuss this with your therapist prior to deciding. This is an important part of the therapy process, and it is in your best interest to end therapy in this way.
10. **Keeping Track of your benefits:** It is best for you to call your insurance company or benefits department and to *keep track of the number of visits yourself.* Also, keeping track of your annual deductibles, if any, is very important. If you have seen another mental health professional or psychiatrist outside of this practice, be aware that those sessions can be counted against your annual allowance given by your insurance company.
11. **Preauthorizations:** If my insurance or managed care company requires preauthorization (informing them of treatment), I understand that I am responsible for obtaining this authorization.
12. **Patient Insurance Waiver:** Due to insurance and managed care companies giving a limited time to get our claims processed, it is imperative that we maintain up to date insurance information in your file. I acknowledge that it is my obligation to make this office aware of any changes to my insurance coverage information. If I am issued a new insurance card, I am to report this to your office, should the information be requested of me through either a phone call or billing correspondence. Should I fail to provide the information necessary to have my claim properly adjudicated within the filing limits of my insurance or managed care company, I agree to assume financial responsibility for services rendered by my doctor or therapist.
13. **Therapy Session:** I understand that an intake evaluation and full therapy session is 45 minutes.

14. **Out-of-pocket Expenses:** I am aware that my insurance may not reimburse for all services provided by Gulf Coast Psychotherapy, LLC. The following fee schedule lists uncovered expenses that may be provided by Gulf Coast Psychotherapy, LLC.

    - Late cancellation or failure to keep appointment: The full session fee of $85.00 is due, not just the co-payment.
    - Medical record copy fees: $15.00 Retrieval Fee plus .25 per page up to 100 pages, .15 per page after 100 pages, $10.00 additional fee for 24-hour service.
    - Telephone Consultation: If a therapist is required to speak with you on the telephone, you will be billed for this service. $85.00/45 min., pro-rated, including time spent on the telephone and documentation of the consultation. If a therapist is required to speak with a doctor, employer, family member, EAP personnel, attorney, school department professionals, social agencies, nursing home, etc., on your behalf, you will be billed for this service. $85.00/45 min., pro-rated, including time spent on the telephone and documentation of the consultation.
    - Letter/Report Preparation: If you require a letter or report to any employer, attorney, social agency, insurance company, etc., you will be billed for this service. $85.00/45min., pro-rated.
    - Collection Fees: If your account is sent to a collection agency, you are responsible for paying the fees incurred as well as your balance due.
    - Legal Fees: These fees will be charged to the requesting party (i.e. an attorney). Be aware that these fees may be passed along to you through your attorney:

      Preparation for Court Appearance.....$110.00/hour*
      Court Appearance.....$250.00/hour*
      Deposition (in our office, 1 hour minimum.).....$200.00/hour*
      Deposition (out of this office, 1 hour minimum).....$250.00/hour*

      *All fees must be prepaid and are non-refundable.

Limits of Confidentiality

To The Patient: You have the right, as a patient, to be guaranteed the protection of the confidentiality of your relationship with your mental health professional. Mental health professionals disclose confidential information without the consent of the individual only as mandated by law, or where permitted for a valid purpose such as:

1. To provide needed professional services to the patient or the individual or organizational client.
2. **Dangerous Situations**: If a patient presents a danger to harm themselves, or others.
3. **Suspected Child, Elderly Person, And Disabled Person Abuse**: All mental health professionals are mandated by law to report cases where abuse is suspected or disclosed.
4. **To obtain payment for services,** in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.
5. **To obtain appropriate professional consultations.** When consulting with colleagues, your mental health professional(s) do not share confident information that reasonably could lead to the identification of a patient, client, research participant, or any other person or organization with whom they have a confidential relationship unless they obtain prior appropriate consent of the person or organization or the disclosure cannot be avoided. Your mental health professional can share information only to the extent necessary to achieve the purpose of the consultation.

Mental health professionals may disclose confidential information with appropriate consent of the patient or the individual or organizational client (or of another legally authorized person on behalf of the patient or client), unless prohibited by law. While this written summary demonstrates some exceptions to confidentiality, it is important to discuss any questions or concerns that you may have with your mental health professional at your next meeting. Law governing these issues are quite complex. Should you need specific advice, formal legal consultation with your attorney may be desired.

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Patient Rights and Responsibilities

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Patients have the right to have their treatment and other patient information kept private.
- Only in an emergency, or if required by law, can records be released without patient permission.
- Patients have the right to have an easy to understand explanation of their condition and treatment.
- Patients have the right to information from staff/providers in a language they can understand.
- Patients have the right to know all about their treatment choices. This would mean no matter of cost or if they are covered or not.
- Patients have the right to get information about their insurance services and role in the treatment process.
- Patients have the right to information about providers.
- Patients have the right to know the clinical guidelines used in providing and/or managing their care.
- Patients have the right to provide input on their insurance policies and services.
- Patients have the right to know about the complaint, grievance and appeal process.
- Patients have the right to know about State and Federal laws that relate to their rights and responsibilities.
- Patients have the right to know of their rights and responsibilities in the treatment process.
- Patients have the right to share in the formation of their plan of care.

I fully understand the above information. This information has been explained to me and all my questions have been answered. My signature below indicates my informed consent to the above practice policies and patient information and to proceed with the recommended therapy.

➢ _____

Patient's Signature Date

➢ _____

Signature of Parent and/or Guardian Date

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Gulf Coast Psychotherapy, LLC. Cancellation and Fail To Keep Policy

Cancellations:

It is the policy of Gulf Coast Psychotherapy, Inc. to charge the **full fee** to patients for any cancellations that are made less than 48 hours in advance of the scheduled appointments. The full fee for cancellations that are not made within 48 hours is **$85.00** per session scheduled. If late cancellations are billed to you, this fee must be paid before another appointment can be scheduled. If a late cancellation occurs more than two times for appointments scheduled on Saturdays or evening appointments (after 4pm), future appointments will need to be scheduled during weekday hours (between the hours of 9am and 4pm, Monday through Friday). ***Parents, please be aware that the parent making the appointment for their child is financially responsible for those appointments if they are not cancelled within the time frame outlined above.*** For example, if a mother makes an appointment knowing she will not be bringing her child to the appointment and the spouse or ex-spouse bringing the child doesn't cancel in time, the mother would be responsible for paying the $85.00 fee.

Failure To Keep Scheduled Appointments:

It is the responsibility of the patient to remember their appointments. This office attempts to confirm future appointments one day prior to visits as a courtesy to patients. It is the policy of Gulf Coast Psychotherapy, LLC. to charge the **full fee** to patients for any failed to keep appointments (no notice given for a cancellation). The full fee for missed sessions is **$85.00** per session missed. If a failure to keep appointment charge is billed to you, this fee must be paid before another appointment can be scheduled. If more than 2 scheduled sessions are missed for appointments scheduled on a Saturday or evening appointments (after 3 pm), future appointments will need to be scheduled during weekday hours (between the hours of 9am and 3 pm, Monday through Friday). ***Parents, please be aware that the parent making the appointment for their child is financially responsible for those appointments if they are not kept.*** For example, if a mother makes an appointment knowing she will not be bringing her child to the appointment and the spouse or ex-spouse bringing the child doesn't bring the child to the session, the mother would be responsible for paying the $85.00 fee.

I have read and understand Gulf Coast Psychotherapy, LLC.'s policy regarding cancellations and failure to keep appointments.

_____

Patient/Parent Signature Date

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Animal Interaction Waiver

In signing this release of liability, I acknowledge that animals are present in this facility and utilized in treatment. I am aware that I am responsible for determining any health risks involved in being on the premises including allergic reactions to animals on the premises. I understand and agree to the following:

1. I am releasing Gulf Coast Psychotherapy, LLC, all of its clinicians and staff harmless of any and all liability related to but not limited to animal assisted therapy and any interaction that I or my family have with any animals in or around the office of Gulf Coast Psychotherapy, LLC.
2. If I participate in animal assisted therapy, I am participating at my own risk.
3. I accept full responsibility for any injuries, destruction of property, or illness incurred as a direct or indirect result of pet assisted therapy or interaction with any animals on the premises.
4. I acknowledge that this hold harmless agreement applies even if the injury or illness is a direct result of aggressiveness or illness of the animal or of my unauthorized interaction with an animal.
5. This release of liability applies to me, all family members or guests entering the premises and all of my minor children.
6. I waive all of my rights to any type of legal action involving destruction of property, bodily injury or illness as a result of interaction with all animals present in the office of Gulf Coast Psychotherapy, LLC.

I have read, understand, and agree to all statements written and implied by this waiver. I am signing this waiver of my own free will.

_____ DOB_____
Patient Name

_____ Date_____
Patient or Guardian Signature

_____ Date_____
Signature of Witness

Gulf Coast Psychotherapy, LLC
4167 Clark Road
Sarasota, FL 34233
(941) 294-1322
gulfcoastpsych@yahoo.com

Credit Card on File Authorization

Please complete this form if you would like *Gulf Coast Psychotherapy, LLC* to keep your credit card on file for future payments.

Patient Name:_____Patient Date of Birth:_____

Information to be completed by the cardholder:

Cardholder Name:_____

Card Number:_____

Card Type: (circle one)

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Expiration Date:_____

CVV Code (3 DIGIDTS ON BACK OF CARD):_____

E-Mail Address:_____

I, _____, authorize *Gulf Coast Psychotherapy, LLC* to charge the above credit card account for payments owed to my account for services rendered, late cancelation fees or failure to keep my appointment fees. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature:_____Date:_____

Witness:_____Date:_____

Gulf Coast Psychotherapy, LLC.
4167 Clark Road
Sarasota, FL 34233

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully and sign your name with today's date on the final page.

- Our Commitment To Protecting Health Information About You

Federal law requires that we provide you with this detailed written notice of our privacy practices. In this notice, we describe the ways that we may use and disclose your health information. We are required by law to protect the privacy of health information that identifies, or can be used to identify, a patient. This information is called "protected health information" (or "PHI").

We are required by law to:

- Maintain the privacy of your PHI
- Give you this Notice of our legal duties and privacy practices with respect to PHI
- Comply with the terms of this Notice of Privacy Practices

We reserve the right to make changes to this notice and to make such changes effective for all PHI we may already have about you. If and when this notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised notice upon your request made to our Privacy Officer.

- How We May Use And Disclose Protected Health Information About You

Treatment: We may use and disclose your PHI to provide, coordinate or manage your health care and related services; consult with other health care providers regarding your treatment or to coordinate and manage your health care; when you need a prescription, lab test, x-ray, or other health care service; or when referring you to another health care provider for treatment. For example, we may disclose your PHI to a physician we refer you to regarding whether you are allergic to any medications, or we may send a report about your care from us to a physician that we refer you to so that the other physician may treat you.

Payment: We may use and disclose your PHI so that we can bill and collect payment for the treatment and services we provide to you. For example, before providing treatment or services, we may share details with your health plan concerning the services you are scheduled to receive, or we may ask for payment approval from your health plan before we provide care or services. We may also use and disclose your PHI to find out if your health plan will cover the cost of care and services we provide; to confirm you are receiving the appropriate amount of care to obtain payment for services; for billing, claims management, and collection activities; or to insurance companies providing you with additional coverage. We may also disclose limited PHI to consumer reporting agencies relating to collection of payments owed to us, or to another health care provider for the payment activities of that health care provider.

Health Care Operations: We may use and disclose your PHI in performing routine business activities ("health care operations"). Health care operations include practices that allow us to improve the quality of care we provide and to reduce health care costs. For example, we may use and disclose your PHI to review and improve the quality, efficiency and cost of care that we provide; to improve health care and lower costs for groups of people who have similar health problems and help to manage and coordinate the care for these groups of people; to review and evaluate the skills, qualifications, and performance of health care providers taking care of you and our other patients; to provide training programs for students, trainees, health care providers, or non-health care professionals (for example, billing personnel) to help them practice or improve their skills; to cooperate with outside organizations that assess the quality of the care that we provide; to

cooperate with outside organizations that evaluate, certify, or license health care providers or staff in a particular field or specialty; to cooperate with various people who review our activities, including doctors that review the services provided to you, accountants, lawyers, and others who assist us in complying with the law and managing our business; to assist us in making plans for our practice's future operations; to resolving complaints within our practice; for business planning and development, such as cost-management analyses. We may also call you by name in the waiting room when your doctor is ready to see you, and call you to remind you of an appointment.

- Uses And Disclosures For Which You Have The Opportunity To Agree Or Object

Disclosures to Family, Friends or Others: We may disclose your PHI to a family member, close friend, or any other person that is involved in your care or the payment for your health care, unless you object.

- Other Uses And Disclosures We Can Make Without Your Written Authorization Or Opportunity To Agree Or Object

We may use and disclose your PHI in the following circumstances without your authorization or opportunity to agree or object, provided that we comply with certain conditions that may apply:

Required By Law: We may use and disclose PHI when we are required to do so by federal, state, or local law.

Public Health Activities: We may use or disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following activities:

- To prevent or control disease, injury, or disability.
- To report disease, injury, birth, or death.
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities.
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease.

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.

Health Oversight Activities: We may disclose PHI to a health agency for oversight activities such as audits, investigations, inspections, licensure or disciplinary activities.

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court or administrative order. We may also disclose PHI in response to subpoenas, discovery requests, or as otherwise required by law.

Law Enforcement: Under certain conditions, we may disclose PHI to law enforcement officials. These law enforcement purposes include legal processes required by law; limited requests for identification and location purposes; suspicion that death has occurred as a result of criminal conduct; in the event that a crime occurs on the premises of the practice; pertaining to victims of a crime; in response to a medical emergency not occurring at the office, where it is likely that a crime has occurred.

Coroners, Medical Examiners, Funeral Directors: We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death, or to funeral directors so that they may carry out their jobs.

Organ and Tissue Donation: If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation and transplantation.

Research: We may use and disclose PHI for research purposes under certain limited circumstances. We must obtain your written authorization to use and disclose your PHI for research purposes except in situations where a research project meets specific, detailed criteria established by law.

To Avert a Serious Threat to Health or Safety: We may use or disclose PHI in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public. This disclosure can only be made to a person or organization that is able to help prevent the threat.

Specialized Government Functions: We may disclose PHI under the following circumstances:

- Per certain military and veteran activities, including determination of eligibility for veterans benefits and where deemed necessary by military command authorities.
- For national security and intelligence activities.
- To help provide protective services for the President and others.
- For the health and safety of inmates and others at correctional institutions.

Disclosures Required by Law: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services, upon request, to review our compliance with the privacy regulations.

Worker's Compensation: We may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

➢ Other Uses And Disclosures Of Protected Health Information Require Your Authorization

All other uses and disclosures of your PHI will only be made with your written authorization. If you have authorized us to use or disclose your PHI, you may revoke your authorization at any time, except to the extent we have taken action based on the authorization.

➢ Your Rights Regarding Protected Health Information About You

Under federal law, you have the following rights regarding PHI about you:

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use for treatment, payment and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care that otherwise are permitted by the Privacy Rule. We are *not required to agree to your request*. If we agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency. To request restrictions, you must make your request in writing to our Privacy Officer. In your request, please include (1) the information that you want to restrict; (2) how you want to restrict the information (for example, restricting use to this office, only restricting disclosure to persons outside this office, or restricting both); and (3) to whom you want those restrictions to apply.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. You must make your request in writing to our Privacy Officer. You must specify how you would like to be contacted (for example, by e-mail instead of regular mail). We are required to accommodate reasonable requests.

Right to Inspect and Copy: You have the right to inspect and receive a copy of your PHI in certain records that we maintain. This includes your medical and billing records but does not include psychotherapy notes. Please contact our Privacy Officer if you have questions about access to your medical record. If you request a copy of your PHI, we may charge you a reasonable fee for the copying, postage, labor and supplies used in meeting your request.

Right to Amend: You have the right to request that we amend your PHI, as long as such information is kept by or for our office. To do so, you must submit your request in writing to our Privacy Officer. You must also give

us a reason for your request. We *may deny your request* in certain cases. For example, if the request is not in writing or if you do not give us a reason for the request.

Right to Receive an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures that we have made of your PHI. This is a list of disclosures made by us other than disclosures made for treatment, payment, and health care operations. It excludes disclosures made to you or to family members and friends involved in your care. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The firs list that you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.

Right to a Paper Copy of this Notice: You have a right to receive a paper copy of this notice at any time. You are entitled to a paper copy of this notice even if you have previously received this notice electronically. To obtain a paper copy of this notice, please contact our Privacy Officer.

- Complaints

If you believe your privacy rights have been violated, you may file a complaint with us, or with the Secretary of the United States Department of Health and Human Services. To file a complaint with our office, please contact our Privacy Officer at the address and number listed below. We will not retaliate or take action against your for filing a complaint.

Privacy Official Contact Information

You may contact our Privacy Official at the following address and phone number:

Debra Octeau
4167 Clark Road
Sarasota, FL 34233

e-mail address: gulfcoastpsych@yahoo.com

Form 10/1/11

Gulf Coast Psychotherapy, LLC
4167 Clark Road
Sarasota, FL 34233
(941) 219-3111
www.gulfcoastpsych.com

Acknowledgement of Receipt of HIPAA Privacy Practices

I acknowledge that I have read and understand the HIPAA Privacy Policy of Gulf Coast Psychotherapy, LLC.

I am aware that if I have any questions or concerns regarding this policy, I may contact Debra Octeau, Practice Manager & Privacy Official at Gulf Coast Psychotherapy, LLC.

Patient/Parent Signature Date

Developmental and Medical History

Your Child's Name:_____Date of Birth:_____

Name of Person completing this form/relationship to patient:_____

Pregnancy and Delivery

A. Length of pregnancy (e.g.: full term, 40 weeks, 32 weeks, etc) _____

B. Length of delivery (number of hours from initial labor pains to birth) _____

C. Mother's age at child's birth _____

D. Child's birth weight _____

E. Did any of the following conditions occur during pregnancy/delivery?

1. Bleeding.....No Yes
2. Excessive weight gain (more than 30 lbs.).....No Yes
3. Toxemia/preeclampsia.....No Yes
4. Rh factor incompatibility.....No Yes
5. Frequent nausea or vomiting.....No Yes
6. Serious illness or injury.....No Yes
7. Took prescription medications.....No Yes
   a. If yes, name of medication_____
8. Took illegal drugs.....No Yes
9. Used alcoholic beverage.....No Yes
   a. If yes, approximate number of drinks per week_____
10. Smoked cigarettes.....No Yes
    a. If yes, approximate number of cigarettes per day_____
11. Was given medication to ease labor pains.....No Yes
    a. If yes, name of medication_____
12. Delivery was induced.....No Yes
13. Forceps were used during delivery.....No Yes
14. Had a breech delivery.....No Yes
15. Had a cesarean section delivery.....No Yes
16. Other problems: please describe.....No Yes

F. Did any of the following conditions affect your child during delivery or within the first few days after birth?

1. Injured during delivery.....No Yes
2. Cardiopulmonary distress during delivery.....No Yes
3. Delivered with cord around neck.....No Yes
4. Had trouble breathing following delivery.....No Yes
5. Needed oxygen.....No Yes
6. Was cyanotic, turned blue.....No Yes
7. Was jaundiced, turned yellow.....No Yes
8. Had an infection.....No Yes
9. Had seizures.....No Yes
10. Was given medications.....No Yes
11. Born with a congenital defect.....No Yes
12. Was in the hospital for more than 7 days.....No Yes

Infant Health and Temperament

G. During the first 12 months, was your child:

1. Difficult to feed.....No Yes
2. Difficult to get to sleep.....No Yes
3. Colicky.....No Yes
4. Difficult to put on a schedule.....No Yes
5. Alert.....No Yes
6. Cheerful.....No Yes
7. Affectionate.....No Yes
8. Sociable.....No Yes
9. Easy to comfort.....No Yes
10. Was given medications.....No Yes
11. Born with a congenital defect.....No Yes
12. Very stubborn, challenging.....No Yes

Early Developmental Milestones

H. At what age did your child first accomplish the following:

1. Sitting without help....._____
2. Crawling....._____
3. Walking alone, without assistance....._____

4. Using single words (e.g.: "mama", "dada", "ball", etc.)..... _____
5. Putting two or more words together (e.g.: "mama up")..... _____
6. Bowel training, day and night..... _____
7. Bladder training, day and night..... _____

Health History

I. Date of child's last physical exam..... _____

J. At any time has your child had the following:

1. Asthma.....	Never	Past	Present
2. Allergies.....	Never	Past	Present
3. Diabetes, arthritis, or other chronic illnesses.....	Never	Past	Present
4. Epilepsy or seizure disorder.....	Never	Past	Present
5. Febrile seizures.....	Never	Past	Present
6. Chicken pox or other common childhood illnesses.....	Never	Past	Present
7. Heart or blood pressure problems.....	Never	Past	Present
8. High fevers (over 103 degrees).....	Never	Past	Present
9. Broken bones.....	Never	Past	Present
10. Severe cuts requiring stitches.....	Never	Past	Present
11. Head injury with loss of consciousness.....	Never	Past	Present
12. Lead poisoning.....	Never	Past	Present
13. Surgery.....	Never	Past	Present
14. Lengthy hospitalization.....	Never	Past	Present
15. Speech or language problems.....	Never	Past	Present
16. Chronic ear infections.....	Never	Past	Present
17. Hearing difficulties.....	Never	Past	Present
18. Eye or vision problems.....	Never	Past	Present
19. Fine motor/handwriting problems.....	Never	Past	Present
20. Gross motor difficulties, clumsiness.....	Never	Past	Present
21. Appetite problems (overeating or under eating).....	Never	Past	Present
22. Sleep problems (falling asleep, staying asleep).....	Never	Past	Present
23. Soiling problems.....	Never	Past	Present
24. Wetting problems.....	Never	Past	Present

25. Other health difficulties: please describe:

_____