WORKERS COMPENSATION INTAKE FORM

2572 West State Rd. *Suite 3056 *Oviedo, FL 32765*Office 407-706-6580*Fax 407-706-6586

Name:	Date of Birth:	**Gender (circle):☐ M ☐ F**	Marital Status: **MARK ONE** ☐Single ☐Married ☐Widowed ☐Divorce
Address:			State: / Zip Code
Phone Number	Email:	**Social Security Number**	In Case of an Emergency Who should we Contact? **☐Husband ☐Wife ☐Friend ☐ Other** Name: Ph#:

Date of Injury	**Nature of Injury / Incident:**	**Employer Name:**
Employee Status: **☐Active ☐ Medical Leave ☐Terminated ☐Other**		**Employer Address:**
Workers Compensation Insurance Carrier	**Telephone Number:**	**Adjuster's Name:** **Phone Number:**

Claimant's Attorney, Adjuster and Case Manager Information

Attorney's Name:
Phone#:
Law Firm Address:
Nurse Case Manager Name: **Phone#:**

CLINICAL INFORMATION

Primary Care Physician	**Phone Number:**	**Fax Number:**	
Do you currently see a Mental Health Therapist or Psychologist? Yes No		**Name:**	**Telephone Number:**

I affirm that all the information provided above is accurate to the best of my knowledge. I have thoroughly reviewed MindHope's office policies, which are accessible on their official website and available within the waiting room area. I hereby give my consent to the stipulated terms.

I authorize my Workers' Compensation insurance carrier and/or my attorney to make direct payments to MindHope of Oviedo for the services rendered to me. If my referral includes treatment as a patient of MindHope, I understand and agree that should my case settle during the course of my treatment, I have the option to continue attending my scheduled follow-up appointments. I also understand and agree that any appointments after my case has been settled will be my sole responsibility, and I will make payments directly to MindHope.

I am fully aware that if my case settles and I choose to continue psychiatric treatment at MindHope, failing to fulfill the financial obligations as mutually agreed may result in legal consequences.

Patient or Guarantor Signature_____**Date**_____

Client's Right: Rules Under Chapter 440, Florida Statutes. "In Florida, an injured worker has the right to select a pharmacy or pharmacist. Florida Law prohibits interference with the right the patient has to choose a pharmacy at any time a patient becomes dissatisfied with their pharmacy or pharmacist's services, they can seek another pharmacy to fill their prescription. The Insurer, Attorney, Adjuster or Case Manager, Physician, or Nurse cannot interfere with their rights to choose which pharmacy they prefer.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
HON HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We would like to bring to your attention our Notice of Privacy Practices, which outlines in comprehensive detail your rights about the usage and sharing of your personal information. A printed copy of this document is conveniently available for your perusal at the reception desk.

By appending your signature to this form, you are expressing your acknowledgment that we have provided you access to the aforementioned information. Furthermore, your signature signifies your acceptance of the terms and conditions outlined therein.

In the course of conducting examinations, diagnoses, treatments, and referrals, we are obligated to gather what is legally referred to as Protected Health Information (PHI) concerning your person. This information is imperative in guiding our decisions regarding your optimal treatment regimen and subsequently providing that treatment. It is important to note that specific circumstances may necessitate sharing this information with other medical professionals involved in your care, or with entities responsible for facilitating payment for the treatments provided or for other pertinent business or governmental functions.

It is crucial to underscore that in the absence of your signature on this consent form, signifying your agreement to the terms outlined in our Notice of Privacy Practices, we are regrettably unable to proceed with providing treatment. We do understand that you might have reservations regarding the use of certain aspects of your information. In such a scenario, you have the prerogative to formally request that we abstain from utilizing your information for treatment, payment, or administrative purposes. This request must be presented in writing, specifying the exact nature of your preferences. While we strive to honor your preferences, it is essential to recognize that adherence to these limitations is not mandated by law. However, should we choose to comply with your stipulations, we assure you that our commitment to adherence will be per the legal framework.

Should you require additional clarification or have any inquiries, please do not hesitate to contact us.

Patients Name: **Date of Birth**:

I acknowledge that **MINDHOPE OF OVIEDO** has provided a copy of their Notice of Privacy Practices, which is available for review in the waiting room area. I can also request a copy of the same. Additionally, it is available on their website at www.mindhopehealth.com. **Effective: Date**:

Signature (patient or authorized representative): _____
Relationship/Authority (if signed by authorized representative):

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We Specialize in Psychiatric Evaluations and Treatment of Adults 21 and older

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CONSENT FOR ELECTRONIC PRESCRIBING

Patients Name: **DOB:**

MindHope of Oviedo's Enrollment in Electronic Prescribing Program
MindHope of Oviedo is enrolled in an electronic prescribing program to enhance the efficacy of our healthcare services. This program is designed to help our healthcare providers gain insights into our patients' current medication regimens, thus enabling them to administer optimal and personalized treatment plans.

By signing this form, you grant informed consent to MindHope of Oviedo to retrieve electronic prescribing information pertinent to your medical history. Please note that this consent will remain in effect for one year. After this period, the renewal of consent will be required annually.

This consent authorizes MindHope of Oviedo to obtain and use your prescription medication history from other healthcare providers as necessary to provide you with comprehensive and well-informed medical care.

Your cooperation in this matter is greatly appreciated. Please do not hesitate to contact us if you require further clarification or have any inquiries.

_____ **Date:**
Signature of the patient (or authorized representative)

Witness: **Date:**
If signing on behalf of the patient please provide your relationship to the patient:_____ Guardian or Caregiver, appropriate supporting documentation will be required.
Benefits of Electronic Prescribing E-Prescribing eliminates handwriting errors/illegibility and gives both physicians and pharmacists access to a patient's prescription history to reduce the chance of the wrong drug being dispensed.

TREATMENT AND COMMUNICATION CONSENT FORM

I_____ voluntarily consent to receive care and treatment from MindHope of Oviedo. I acknowledge that no guarantees have been made regarding my evaluation or treatment outcomes. I understand that some medications may cause adverse reactions or side effects, and I agree that my provider will not be liable for any such short or long-term effects. I will actively participate in the treatment and counseling process and share responsibility for my care. I authorize the assigned providers, including physicians and nurses, to deliver psychiatric care, which may include prescribing and or administering psychotropic medications (oral, injections, etc.), and when applicable, authorize Licensed Mental Health Therapist(s) to provide psychotherapy services. I understand that it is my responsibility to maintain compliance with the treatment plan or to take the necessary steps to remain compliant.

I understand that either party can terminate this treatment contract at any time for any reason. I also acknowledge that my initial psychiatric evaluation does not guarantee continued care at MindHope of Oviedo. If it is determined that I will continue treatment, I agree to comply with the doctor's treatment plan.
Communication: MindHope staff is not obligated to receive or return phone calls after hours. In an emergency, I or someone nearby must call **911** immediately. I authorize MindHope of Oviedo psychiatric team to contact me via cell or home phone for appointment reminders or other non-personal messages. For communications that involve personal information, I authorize MindHope team to use phone or email to contact me regarding my care. In the case of a Guardian or Caregiver, appropriate supporting documentation will be required.
By Signing this document, I agree to consent to Treatment and ways of Communication.
_____ **Date:**
Patient/Guardian **Signature**

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PATIENT HEALTH QUESTIONNAIRE

All questions contained in this form(s) are strictly confidential

Patient Name	Date of Birth	Claim Number	Date of Accident	Adjuster's Name

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED:
1.
2.
3.
Do you have any pain in your body? ☐YES ☐NO rate your pain 10 been extremely painful: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Is this pain interfering with your work and/or personal life? ☐YES ☐NO
Have you ever had a blood transfusion? ☐Yes ☐No When:

Surgeries:		
Year	Reason	Hospital
Other hospitalizations		
Year:	Reason:	Hospital:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Medication Name	Strength	Frequency Taken
Allergies to medications		
Name the Medication	Reaction You Had	

Patient Initials:

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HISTORY OF MENTAL HEALTH PROBLEMS

Is stress a major problem for you?	☐Yes	☐No
What stresses you the most?		
Do you feel depressed? ☐YES ☒NO How long have you been feeling depressed?		
Do you panic when stressed?	☐Yes	☐No
Do you dislike yourself?	☐Yes	☐No
If you feel angry, do you tend to keep quiet about it initially, but later erupt and lose your temper?	☐Yes	☐No
Have you experienced repeated or unexpected "attacks" during which you suddenly are overcome by fear for no apparent reason	☐Yes	☐No
Do you have upsetting or distressing thoughts, impulses, or images that happen in your mind over and over again?	☐Yes	☐No
Has there ever been a time when you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐Yes	☐No
Do you cry frequently?	☐Yes	☐No
Have you ever attempted suicide? ☐**YES** ☐**NO** How long ago Was this your first time ☐**YES** ☐**NO** If No how many other times have you attempted suicide? What made you change your mind?		
Have you ever seriously thought about hurting yourself? ☐YES ☐NO Please explain: Have you ever thought of hurting someone else? Any mental health hospitalization or Rehabilitation in the last 2 years? ☐Yes ☐No How long ago?	☐Yes	☐No
Do you have trouble sleeping?	☐Yes	☐No
Have you ever been treated at a methadone clinic or received Suboxone treatment in the last two years?	☐Yes	☐No
Have you ever been to a counselor? ☐**YES** ☐ **NO** How long ago?		
Have you ever seen a psychiatrist before? ☐ **YES** ☐**NO** How Long?		
When was the last time you saw your psychiatrist?		

PLEASE CHECK ALL THAT APPLIES TO YOU

☐ Depressed ☐ Sadness ☐Crying Spells ☐Loss of Interest ☐Anxiety ☐Panic Attack
☐ Irritability ☐Rages ☐Fearfulness ☐Feelings of hopelessness ☐Insomnia
☐Feelings of helplessness ☐Hypersomnia ☐Fatigue ☐Forgetfulness
☐Poor concentration ☐Headaches ☐Weight loss ☐No appetite
☐ Increased appetite ☐ Bingeing ☐Thoughts of Suicide

Smoking/Alcohol History

Have you ever smoked tobacco products? (e.g., cigarettes, cigars, pipes)
☐Yes ☐ No
If yes, please specify: How many years did you smoke?
How many cigarettes per day did/do you smoke?
Have you quit smoking?
☐ Yes ☐ No
Do you consume alcoholic beverages?
☐ Yes ☐ No
How often do you drink alcohol?
☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐ Never
Have you ever used recreational or illicit drugs? **☐ Yes ☐ No**
Please note that all information provided is confidential and will be used solely to assist in your care and treatment

Patient Initials:

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PATIENT FAMILY/FRIEND AUTHORIZATION FORM

Patient Name: **DOB:**

We've formulated this form to address a crucial aspect of our communication protocol. At MindHope of Oviedo, we recognize the importance of permitting a family member or friend to connect with us on your behalf for matters related to your mental health history and appointment management. However, we wish to emphasize that your explicit authorization is paramount. Safeguarding your confidentiality is of the utmost significance to us. Hence, we've established a stringent policy governing interaction with individuals representing your interests.

By endorsing this form, you grant us the authority to disclose information exclusively to those individuals enumerated below. It's vital to be aware that any attempts from unlisted parties to initiate contact will regrettably lead to our inability to share any information. If you find it necessary to extend the list of authorized individuals after signing this form, we'd be more than willing to accommodate the change. However, we kindly request that such modifications be conducted in person at our office, as we're unable to process such requests over the phone.

We greatly appreciate your understanding and cooperation in adhering to these guidelines. This approach is pivotal in ensuring the sanctity of your sensitive medical information. Should you require any clarifications or assistance regarding this matter, please do not hesitate to reach out to us directly.

Print Name	Phone Number	Relation to Patient

Important Notice: ***This authorization form is exclusively intended for use in response to inquiries made by family members and/or friends. It is imperative to recognize that a distinct Authorization form must be completed in cases involving the authorization of medical offices or any official requests for the release of your records.***

Patient's Initials **Date:**

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PHQ-9 DEPRESSION ASSESSEMENT FORM

Patient Name(Print): **Date of Birth:**

Mark with an "X" to indicate your answer	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0☐	1☐	2☐	3☐
2. Feeling down, depressed, or hopeless	0☐	1☐	2☐	3☐
3.Troublefallingorstayingasleep,orsleepingtoomuch	0☐	1☐	2☐	3☐
4. Feeling tired or having little energy	0☐	1☐	2☐	3☐
5.Poor appetite or overeating	0☐	1☐	2☐	3☐
6.Feelingbadaboutyourself orthatyouareafailureor have let yourself or your family down	0☐	1☐	2☐	3☐
7.Trouble concentrating on things, such as reading the newspaper or watching television	0☐	1☐	2☐	3☐
8.Moving or speaking so slowly that other people could havenoticed.Ortheopposite being so fidgety or restless that you have been moving around a lot more than usual	0☐	1☐	2☐	3☐
9.Thoughts that you would be better off dead, or of hurting yourself	0☐	1☐	2☐	3☐
After you have added each individual column then add the total of the three columns and write that total number in the TOTAL SCORE SECTION				

Patients Signature: **Date:**

		+	

= TOTAL SCORE:

If you checked off any problems, 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** ☐

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PHARMACY PREFERENCE

Your Pharmacy Options and Prescription Process

Dear Patient

We are here to ensure you receive the best possible care, which includes making informed decisions about your medications and pharmacy preferences. We want you to know that our primary goal is to provide you with essential information regarding your medication options and rights when selecting a pharmacy. This is especially important in the context of your workers' compensation case. At MindHope, we are delighted to offer you the convenience of receiving your prescribed medications either during your appointment or, in some instances, having them delivered to your home at no cost.

We want to ensure you are fully informed – you can choose any pharmacy that suits your preferences. Your comfort and choices matter to us. So, whether you take advantage of our services or opt for a different pharmacy, we are here to support you every step of the way. We wish to highlight that MindHope is registered as a fully compliant pharmacy-dispensing facility. Additionally, our registered physician, Dr. Figueroa, possesses the legal authority to prescribe and dispense medication within our establishment.

If you have a preferred pharmacy in mind, we are fully committed to accommodating your choice. Our team will ensure that your medication prescriptions are electronically transmitted to your specific pharmacy. This process will be facilitated through the e-prescribing method to ensure efficiency and accuracy. You must promptly inform the MindHope team of any alterations to your pharmacy preference. This procedural step is crucial to maintaining accurate and up-to-date records. To avoid any disruption in your medication supply, we ask that you please let us know promptly about any shifts in your pharmacy preference.

Indicate your pharmacy preference below by checking the appropriate box:

☐ **I PREFER TO OBTAIN MY MEDICATIONS AT MINDHOPE**

By placing my signature below, I confirm that I have thoroughly reviewed and understood the information outlined concerning pharmacy preference options. I willingly grant my consent to designate MindHope as my chosen pharmacy. I am aware that this authorization will still be effective from the date of my endorsement until I submit written notification to MindHope should I decide to change my pharmacy preference. I commit to quickly providing MindHope with the updated pharmacy information in case of such changes.

Print Name: **Patient Signature:** **Date:**

☐ **I PREFER TO OBTAIN MY MEDICATIONS AT THE PHARMACY BELOW**

Name of preferred pharmacy:

Address:

Phone Number: **Fax Number:**

By placing my signature below, I confirm that I have thoroughly reviewed and understood the information outlined regarding pharmacy preference options. I would like to grant my consent to designate the pharmacy identified above as my chosen pharmacy. I am aware that this authorization remains effective from the date of my endorsement until I submit written notification to MindHope should I choose to modify my pharmacy preference. I commit to quickly providing MindHope with the updated pharmacy information in case of such changes.

Print Name: **Patient's Signature:** **Date:**

Please reach out to us if you have any questions or need further clarification. Your well-being is our top priority, and we are honored to be part of your healthcare journey. Your comfort and peace of mind are important to us.

Please ensure all fields are completed before saving and printing these documents.
An original handwritten signature is required. Please bring the completed form with you on the day of the appointment.

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