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#: ☐**Patient declined to provide Next of Kin information** **For staff use only: Initials:_____ Date:_____**

Date of Injury	**Nature of Injury / Incident:**	**Employer Name:**
Employee Status: ☐**Active** ☐ **Medical Leave** ☐**Terminated** ☐**Other**	**OCCUPATION**	**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 office policies, 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 or my attorney to directly pay MindHope of Oviedo for the service(s) that will be rendered to me.

I understand that referrals to MindHope may be for **psychiatric evaluation only** or for **evaluation and treatment**. If I am referred for evaluation only, I acknowledge that no ongoing doctor-patient relationship is established, and no treatment will be provided unless separately authorized. If my referral includes treatment, I understand that a doctor-patient relationship is established. I further acknowledge that if my workers' compensation claim is formally settled, I will no longer be eligible for workers' compensation benefits, and any continued care or follow-up appointments will be my ***sole financial responsibility***, payable directly to MindHope.

I understand this is legally binding, and any failure to fulfill the agreed-upon financial obligations will be deemed a breach of the financial agreement.

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.

Revised 2024

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

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

We want to bring to your attention our Notice of Privacy Practices, which outlines your rights regarding the use and sharing of your personal information. A printed copy of this document is conveniently available at the reception desk.

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

In conducting examinations, diagnoses, treatments, and referrals, we must gather what is legally Protected Health Information (PHI) concerning you. This information is imperative in guiding our decisions regarding your optimal treatment regimen and providing that treatment. It is important to note that specific circumstances may necessitate sharing this information with other medical professionals involved in your care, entities responsible for facilitating payment for the treatments provided, or 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 understand that you might have reservations regarding using 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, we must recognize that adherence to these limitations is not legally mandated. However, should we comply with your stipulations, we assure you that our commitment to adherence will be in accordance with the legal framework.

Please do not hesitate to contact us if you require additional clarification or have any inquiries.

Patient 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 it. 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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CONSENT FOR ELECTRONIC PRESCRIBING

Patient's Name: **Date of Birth:**

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, enabling them to administer optimal, 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 shall remain in effect for a period of one (1) year and will be renewed annually thereafter.**

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.

Witness Name: **Date:**

_____ **Date:**

Signature of the patient (or authorized representative)

For the Guardian or Caregiver, appropriate supporting documentation will be required.

Benefits of Electronic Prescribing: E-Prescribing eliminates handwriting errors/illegibility and gives physicians and pharmacists access to a patient's prescription history, reducing the risk 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 may 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 the MindHope team to contact me by phone or email regarding my care. For a Guardian or Caregiver, appropriate supporting documentation will be required.

By signing this document, I consent to treatment and to communication regarding my care, including but not limited to phone calls, emails, text messages, and electronic portals. I understand that this consent will remain in effect unless and until I revoke it in writing, treatment is completed, the claim is formally settled, or the claim is transferred to another insurance carrier.

_____ **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:

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 repeatedly?	☐Yes	☐o
Has there ever been a time when you felt so good or so hyper that other people thought you were not your usual 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? enter text. 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 the individuals listed below. It's vital to be aware that any attempts by unlisted parties to initiate contact will, regrettably, prevent us from sharing 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 made in person at our office, as we cannot process them 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. Please do not hesitate to contact us directly if you require any clarification or assistance regarding this matter.

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 for any authorization of medical offices or official requests to release your records.***

By signing this document, I hereby authorize MindHope to disclose and communicate protected health information to the individuals listed on the Family/Friend Authorization Form. I understand that I am responsible for notifying the MindHope team of any request to add or remove authorized individuals, and that all modifications to this authorization **must be made in person**. This authorization shall remain in effect unless and until I submit a written revocation, treatment is completed, the claim is formally settled, or the claim is transferred to another insurance carrier, whichever occurs first.

Patient's Signature: _____ **Date:**

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PHQ-9 DEPRESSION ASSESSMENT FOR

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. Trouble falling or staying asleep, or sleeping too much	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. Feeling bad about yourself or that you are a failure or 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 have noticed. Or the opposite 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				

		+	

= 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**

Patient Signature: **Date:**

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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, including helping you make 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. Whether you take advantage of our services or choose 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. **Please 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 to your medication supply, please let us know promptly about any changes to 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 remain in effect from the date of my endorsement until I submit written notification to MindHope if I decide to change my pharmacy preference. I commit to promptly providing MindHope with updated pharmacy information in the event 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 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 decide to modify my pharmacy preference. I commit to promptly providing MindHope with updated pharmacy information in the event of such changes.

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

Please do not hesitate to contact us if you have 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 essential 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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