**Worker’s Compensation Intake Form**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name  Click or tap here to enter text. | | Social Security Number  Click or tap here to enter text. | Birthdate  Click or tap here to enter text. | | Marital Status: Single Married Widowed Divorce | |
| Address  Click or tap here to enter text. | | Apt. Number  Click or tap here to enter text. | City  Click or tap here to enter text. | State  Click or tap here to enter text. | | Zip Code  Click or tap here to enter text. |
| Phone Number  Click or tap here to enter text. | Email:  Click or tap here to enter text. | | In Case of an Emergency Who should we Contact?  Husband Wife  Friend Other  Name:Click or tap here to enter text. Ph#:Click or tap here to enter text. | | | |

**Claim Number:** Click or tap here to enter text. **Gender (circle): M  F Occupation:** Click or tap here to enter text.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Injury:** Click or tap here to enter text. | **Nature of Injury / Incident:** Click or tap here to enter text. | | | | **Employer Name:**  Click or tap here to enter text. |
| **Employee Status:**  **Active Medical Leave  Terminated Other** | | | **Employer Address:**  Click or tap here to enter text. | | |
| **Workers Compensation Insurance Carrier**  Click or tap here to enter text. | | **Telephone Number:**  Click or tap here to enter text. | |
| **Claimant’s Attorney, Adjuster and Case Manager Information** | | | | | |
| |  | | --- | | **Claimant Attorney’s Name:** Click or tap here to enter text. | | **Phone#:**Click or tap here to enter text. | | **Adjuster’s Name:** Click or tap here to enter text. | | **Phone#:** Click or tap here to enter text. | | **Nurse Case Manager Name:** Click or tap here to enter text. **Phone#:**Click or tap here to enter text. | | **Employer/Carrier Attorney’s Name:** Click or tap here to enter text. | | **Phone#:** Click or tap here to enter text. | | | | | | |

|  |  |  |
| --- | --- | --- |
| **Primary Care Physician:** Click or tap here to enter text. | **Phone Number:**  Click or tap here to enter text. | **Do you currently see a Mental Health Therapist or**  **Psychologist?  Yes No** |

**CLINICAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| **Therapist Name:**Click or tap here to enter text. | **Email:**Click or tap here to enter text. | **PH#:** Click or tap here to enter text. |

I hereby declare all above information is true to the best of my knowledge. I also have read MindHope office policies on their website and/or a copy available in the waiting room area and I agree to the terms established. I authorize my Worker’s Compensation Insurance Carrier to make direct payment to MindHope of Oviedo for services rendered to me. If I settle my case, and continue to attend my scheduled follow-up appointments after my settlement I agree to be financially Responsible to pay MindHope for the visits.

I understand that Failure to fulfill the financial obligation will result in a Legal Action.

**Patient or Guarantor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:**Click or tap to enter a date.

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

**ON HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION**

Our **Notice of Privacy Practices** explains in detail your rights and how we can use and share

your information. A copy of this information is available for your review at the reception desk.

By signing this form, you are acknowledging that we have made this information available to

you and you agree to the terms and conditions therein.

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls

Protected Health Information (PHI) about you. We use this information to decide on what

treatment is best for you and to provide that treatment. There are circumstances when we

may also share this information with others who provide treatment to you or need it to arrange

payment for your treatment or for other business or government functions.

If you do not sign this consent form agreeing to the terms of our Notice of Privacy Practices, **WE**

**CANNOT TREAT YOU**. If you are concerned about some of your information, you have the right

to ask us not to use it for treatment, payment or administrative purposes. You will have to tell

us specifically what you want in writing. Although we will try to respect your wishes, we are

not required to agree to these limitations. However, if we do agree, we promise to comply with

your wish to the extent that the law requires.

**PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

Patients Name: Click or tap here to enter text. Date of Birth: Click or tap here to enter text.

**PRINT NAME**

I acknowledge that **MINDHOPE OF OVIEDO** has made a copy or has provided the office copy for my review of their Notice of Privacy Practices available to me effective: Date:Click or tap to enter a date.

**Signature (patient or authorized representative**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship/Authority (if signed by authorized representative): Click or tap here to enter text.

**TREATMENT AND COMMUNICATION CONSENT FORM**

**I** Click or tap here to enter text., do hereby voluntarily consent to **care** and **treatment** by **MindHope of Oviedo**. I acknowledge that no guarantees have been made as to the result of evaluation or treatment. I also understand that some medication might cause adverse reactions or side effects. My provider will not be liable for any such untoward short or long-term effects (adverse effects/ Side effects etc). I am aware that I am an active participant in the treatment/counseling process and that I share responsibility for my treatment. I hereby authorize the Providers (physicians/therapists/nurses assigned), to provide psychiatric/psychological care which includes Psychotropics (Medications: oral/injections etc). It is my sole responsibility to maintain compliance or to take the necessary steps to remain complaint. I understand this treatment contract can be terminated any time from either party for any reason. **I understand that my initial Psychiatric Evaluation visit does not guarantee the continuation of care at MindHope of Oviedo. *If is determine that I continue treatment I Agree to comply with the doctor’s treatment plan.***

**COMMUNICATION: I** also understand that **MindHope** staff is not obligated to receive or return any phone call after hours. In the event of an emergency, it is imperative that I or someone next to me call **911** immediately**.** I authorized **MindHope of Oviedo** Psychiatric team to call my cell or home phone number to leave messages of appointment reminders or any other messages that do not include any personal information. For messages that need to disclose personal information I authorize MindHope Team to communicate with me via phone or email in regards to my care. In case of a Guardian or Caregiver, we need related supportive documents.

***By Signing this document, I agree to consent Treatment and ways of Communication.***

Click or tap here to enter text.

Patient/ Guardian **Print Name**

Click or tap here to enter text.

Patient/Guardian **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** Click or tap to enter a date.

**CONSENT FOR ELECTRONIC PRESCRIBING**

**Name:** Click or tap here to enter text.**DOB:** Click or tap here to enter text.**SSN:**Click or tap here to enter text.

MindHope of Oviedo is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to give them the best possible treatment.

***By signing this form***, you consent to MindHope of Oviedo retrieving electronic prescribing information. This consent will only be valid for one year. A new consent will be required every year. I agree that MindHope of Oviedo may request and use my prescribing medication history from other healthcare providers.

Click or tap here to enter text.

Print name of patient (or authorized representative)

Click or tap here to enter text.

Signature of patient (or authorized representative) Date: Click or tap to enter a date.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:

**Witness**

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient:

Click or tap here to enter text.

**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.**

**PATIENT HEALTH QUESTIONNAIRE**

**All questions contained in this form are strictly Confidential and will be part of you record**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Patient Name** | **Date of Birth** | **Claim Number** | **Date of Accident** | **Adjuster’s Name** | | Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | | | |
| All questions contained in this form(s) are strictly confidential  and will become part of your medical record. | | |
| **Health HISTORY/Mental health history** | | |
| **List any medical problems that other doctors have diagnosed:** | | |
| **1.Click or tap here to enter text.** | | |
| **2.Click or tap here to enter text.** | | |
| **3.Click or tap here to enter text.** | | |
| **4.Click or tap here to enter text.** | | |
| **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:** Click or tap here to enter text. | | |
| **Surgeries:** | | |
| Year | Reason | Hospital |
| Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Other hospitalizations** | | |
| Year:Click or tap to enter a date. | Reason:Click or tap here to enter text. | Hospital:Click or tap here to enter text. |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** | | | | | | | |
| Medication Name | | Strength | Frequency Taken | | | | |
| Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | | | | |
| Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | | | | |
| Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | | | | |
| Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | | | | |
| Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | | | | |
| Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | | | | |
| **Allergies to medications** | | | | | | | |
| Name the Medication | | Reaction You Had | | | | | |
| Click or tap here to enter text. | | Click or tap here to enter text. | | | | | |
| Click or tap here to enter text. | | Click or tap here to enter text. | | | | | |
| **Personal Safety** | Do you live alone? | | |  | Yes |  | No |
| Do you have frequent falls? | | |  | Yes |  | No |
| Do you have vision or hearing loss? | | |  | Yes |  | No |

|  |  |  |
| --- | --- | --- |
|  |  | **HISTORY OF MENTAL HEALTH PROBLEMS** |

|  |  |  |
| --- | --- | --- |
| Is stress a major problem for you? | Yes | No |
| What stresses you the most?Click or tap here to enter text. |  |  |
| Do you feel depressed? YES NO How long have you been feeling depressed?Click or tap here to enter text. |  |  |
| 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 really lose your temper? | Yes | No |
| Have you experienced repeated or unexpected “attack” 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 period of 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 |
| Have you ever spent money on things you didn’t need and got your or your family into trouble? | Yes | No |
| Do you cry frequently? | Yes | No |
| Have you ever attempted suicide? **YES NO** How long agoClick or tap here to enter text.  Was this your first time **YES NO** If No how many other times have you attempted suicide?Click or tap here to enter text.  What made you change your mind?Click or tap here to enter text. |  |  |
| Have you ever seriously thought about hurting yourself? YES NO Please explain:Click or tap here to enter text.  Have you ever thought of hurting someone else?  Any mental health hospitalization or Rehabilitation in the last 2 years? Yes No How long ago?Click or tap here to enter text. | Yes | No |
| Do you have trouble sleeping? | Yes | No |
| Have you ever been treated at a methadone clinic or receive Suboxone treatment in the last two years? | Yes | No |
| Have you ever been to a counselor? **YES  NO** How long ago?Click or tap here to enter text. |  |  |
| Have you ever seen a psychiatrist before?  **YES NO** How Long?Click or tap here to enter text. |  |  |

**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**

|  |
| --- |
| Are currently under a Psychiatric Care?  **YES  NO** Who is your Psychiatrist? Click or tap here to enter text. |
| When was the last time you saw your Psychiatrist?Click or tap here to enter text. |

**WE RECOMMEND THAT WHEN YOU ARE DONE COMPLETING THIS FORM TO SAVE IT.**

**PRINT COMPLETED FORM, SIGN IT AND BRING IT TO YOUR APPOINTMENT**

**Patients Name:** Click or tap here to enter text.

**PATIENT FAMILY/FRIEND AUTHORIZATION FORM**

**Patient Name:**Click or tap here to enter text. **DOB:**Click or tap here to enter text.

The purpose of this form is to give **MindHope of Oviedo** authorization to speak to a family member or a friend that may call on your behalf to request information regarding your medical history (mental health related ONLY) or to confirm or cancel an appointment. Please understand that for your security and for you own protection we have established a strict policy regarding family members or friends that will call on your behalf. Please be advise that when you sign this form you are authorizing us to **ONLY** provide information to those individuals that you have listed below. If any other person calls on your behalf and is NOT listed below, **WE WILL NOT PROVIDE THEM WITH ANY INFORMATION.** If after you signed this form, you realized that you want to add another person to this list you need to personally come by the office to add this person to the existing form. We will NOT take any phone calls with instructions regarding this matter.

**Print Name Phone Number Relation to Patient**

|  |  |  |
| --- | --- | --- |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

***Note: This authorization form is Only to be used related to family and/or friends requests. You will be completing a different Authorization form to Authorized Medical Offices or any other official requests of your records.***

**Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**Click or tap to enter a date.

|  |
| --- |
| **PHARMACY PREFERENCE**  **MindHope is a Certified Medication Dispensing Facility.** **Dr.Figueroa** is a ***Certified Dispensing Physician*** that can dispense medications at this location. For your convenience we can dispense your medications here, however the prescription may be filled at any pharmacy of your choice and/or authorized by Workers Compensation.  **If you have a pharmacy of preference**, MindHope will be send your medication prescriptions to the Pharmacy of your choice or the pharmacy on the back of the card you may have. This will be electronically sent via the e-prescribing method.  **You understand that it is your responsibility** to notify MindHope team immediately if you change pharmacy preference or if they send you a new card with new pharmacy information. A new pharmacy preference form will need to be completed and signed so that MindHope Team can update your records.  **You also understand that failure to notify MindHope Team** of any change of Pharmacy may result in a **delay** in obtaining your medications.  Name of Preferred Pharmacy: Click or tap here to enter text.  Address: Click or tap here to enter text.  Phone Number: Click or tap here to enter text.  Fax Number: Click or tap here to enter text.  **Patient Signature:** I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and understand the options regarding pharmacy preference.    **"In Florida, an injured worker has the right to select a pharmacy or pharmacist.**[**Florida Law**](https://www.myfloridacfo.com/division/wc/employee/faq.htm#23)**prohibits interference with your right to choose a pharmacy or pharmacist. However, a pharmacy is not required to participate in the workers’ compensation program. If at any time, you become dissatisfied with your pharmacy or pharmacist’s services, you can seek another pharmacy to fill your prescription. Your insurer, Attorney, Adjuster or Case Manager cannot interfere with your right to choose which pharmacy you prefer.** |

**PHQ-9 DEPRESSION ASSESSEMENT FORM**

**PATIENT NAME:** Click or tap here to enter text. **DATE:**Click or tap to enter a date.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mark with an “X” to indicate your answer**  1. Little interest or pleasure in doing things | Not at all | Several days | More than half the days | Nearly every day |
| 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**:Click or tap here to enter text.

**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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