Suncoast UR Inc

Arlene M Martínez-Delio, MD

Diplomat of the American Board of Psychiatry & Neurology

Date: _____/_____/_____

Name: _____ Phone: _____ E-Mail: _____
Street: _____ _____City: _____ State: _____ Zip: _____
DOB:_____/_____/_____ Age: ____ Height _____ Weight: _____ Sex : M, F or Transgender (Please circle)
Sexual Preference: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Employer: _____ Job Title: _____ (circle) Disabled, Unemployed, Home Maker, Student
Highest Level of School: (circle), Elementary School, Middle School, GED, High School Degree, Technical Degree, B.A. M.A. PhD, MD, Other _____
Marital Status: (circle one) Single Married Divorced Widow Separated
Number of Children: _____ Sex and Ages: _____ _____ _____ _____ _____
Family Doctor: _____Phone Number:_____ Allergies: _____

Why are you here today? (Circle one or more) Medication Management, Anxiety, Depression, Lack of Focus, Panic Attacks, Stress, Drug/Alcohol Addiction, Suboxone Treatment, Other: _____

Past Medical History: Review of Systems: (Circle one or more) High Blood Pressure, Diabetes, Fibromyalgia, Thyroid, History of Cancer, High Cholesterol Chronic Pain, Headaches, Renal Disease, Lung Disease, other:
_____

Past Surgery History: (CIRCLE) Tonsillectomy, Appendectomy, Hysterectomy, Gallbladder, Prostate, Kidney Stones, Breast Augmentation, Liposuction, Cosmetic Surgery, Gastric Bypass, Lap Band , Cancer (specify) other:
_____

What Medicines are you currently taking? _____

Have you ever been Baker Acted or in a Psychiatry Hospital? (Circle one or more) Yes, No, IOP; PHP, Residential, AA, NA,
If yes, when and where: _____

Have you ever tried to commit suicide? (Circle one) Yes No
If yes, when and how: _____

Past Family History: (Circle one or more) Anxiety, Depression, Lack of focus, Panic Attacks, Stress, Drug/Alcohol Addiction, High Blood Pressure, Diabetes, Fibromyalgia, Thyroid, History of Cancer, High Cholesterol, Chronic Pain, Headaches, other:
_____

Past Substance Use: (Circle one) Smoking, Alcohol, Crack, Cocaine, Marijuana, Heroin, Pain Pills, Acid, LSD, other:
_____

Have you received treatment before? (Circle one or more) Yes No
If yes, which one: Alcoholic Anonymous Narcotic Anonymous Rehabilitation Individual Therapy Counseling

Have you ever been: (Circle one or more) Emotionally Abused Sexually Abused Physically Abused
Past Legal History: (Circle one or more) none probation misdemeanor felony house arrest jail prison DUI
If yes, when: _____ where: _____ Reason: _____
Is the legal matter resolved now? Yes No

********18958 N Dale Mabry Hwy Ste 102 Lutz, FL 33548********
Phone: (813) 839-7390 Fax: (813) 333-5994
Email: arleneoffice@gmail.com

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Insurance and Responsible Party Information

Please present your insurance identification card(s) so that we may make a copy for our files

Name of person responsible for your account: _____

Relationship: (Circle One) Self Spouse Child Step Child

Primary Insurance: _____ Policy Number: _____ Group: _____

Insured Name: _____ Insured DOB: _____/_____/_____

Authorization to Release Information and Acknowledgement of Financial Responsibility

I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependants. I further expressly agree and acknowledge that my signature on this document authorizes my provider of care, and/or my provider's representative, to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I hereby authorize the above insurance company to pay and hereby assign directly to Arlene M Martinez-Delio, MD all the benefits, if any, otherwise payable to me for her services as described on the attached forms. I further acknowledge that my insurance benefits, when received by and pad to the above mentioned provider will be credited to my account, in accordance with the above assignment. I agree to pay my co-pay and/or other patient due amounts as determined by my policy at the time services are rendered.

I understand that while the practice make every effort to ensure all the requirements for claims payment are met, policy limitations or exclusions may result in unpaid charges. I understand that I am financially responsible for all the charges not paid by my insurance coverage and that a finance charge of 1.5% per month will be assessed on all patient due balances over 30 days old.

Authorization to Release Information to a Third Party

I hereby authorize Arlene M Martinez-Delio, MD to release any and all information pertaining to my mental health records and treatment to the individuals listed below. I further more authorize the individuals listed below to disclose any and all information assist with my treatment. I understand that by authorizing the individuals below I am aware and consent that the provider and the individual can discuss my treatment or record without my presence. I can revoke the authorization at anytime upon written notification for each individual listed below. I further understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected by Federal Regulations and Florida Statues.

_____ _____ _____

Printed Name: _____ Date: ___/____/_____

Signature: _____ Relationship: _____

Signature of Patient/Guardian

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Informed Consent for Treatment

I, _____ hereby voluntarily request diagnostic evaluation and medical treatment, which may include individual, family, couples, and group therapies, medication management, consultation, education, and referral to other community resources, provided by Arlene M Martinez-Delio, MD.

I understand:

- □ The purpose of treatment.
- □ Possible alternative treatment exists.
- □ Treatment includes potential risk and benefits. The risks may be irreversible and may include increased suicide risk and death, when treated with psychotropic medications.
- □ No diagnostic or therapeutic guarantees have been made.
- □ My participation in treatment is voluntary and I may stop at any time.
- □ I agree not to sue Dr. Martinez-Delio in a Civil or Medical Malpractice Lawsuit. I agree to seek Legal Mediation if there is a disagreement with my treatment plan, which is, if after both parties try to resolve the issue between us without attorneys involved. I agree to pay all my attorney fees and do not expect Dr. Martinez-Delio or Suncoast UR, Inc. to cover these expenses. I understand that Dr. Martinez-Delio has my health as her main priority. I also understand the risk and benefits of using psycho tropic medications. These may have permanent, irreversible side effects and even cause death. I legally waive Dr. Martinez-Delio for these risks and agree to try to resolve any issue with Legal Mediation and not a Civil or Medical Lawsuit**. If I do not agree with these terms, I will not sign this agreement and I will seek help elsewhere.**
- □ I understand that I may be discharged from the practice if my behavior is considered non compliant and not safe by the providers. This may include, missing appointments, unpaid balances, being disrespectful to staff and other patients, being loud and inappropriate, threatening to others, lying, drug seeking behavior, over using medications, doctor shopping, stealing, and other reasons that the provider may think it is not a good therapeutic rapport with the patient. You shall be given 30 days written notice as stated by the State of Florida, to get another Physician.

My signature below certifies my understanding and acceptance of the intent of this informed consent.

Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- □ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- □ Obtain payment from third party payors
- □ Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Arlene M Martinez-Delio, MD has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to y request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____/_____/_____

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CONTROLLED MEDICATION TREATMENT PLAN

I freely and voluntarily agree to accept this treatment agreement as follows:

1. I agree to keep and be on time to all my scheduled appointments with the doctor.
2. I agree to conduct myself in a courteous manner in the physician's or clinic's office.
3. I agree to pay all office fees for this treatment at the time of my visits. I will be given a receipt that I can use to get reimbursement from my insurance company if the treatment is not a covered service.
4. I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me and I will not be given any medications until my next scheduled appointment. This may result in my discharge from my care. I may not get medications, for my own protection, per the doctor's discretion.
5. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
6. I understand that the use of controlled medication by someone who is addicted to drugs could cause them to experience severe withdrawal. I may have to go to the ER or Hospital for detox since doing this in an OP setting may be dangerous. It is not the doctors responsibility if I voluntary got myself in this predicament of abuse and intoxication and the doctor will guide me to Community detox centers for my safety. I do not hold Dr. Martinez liable for my irresponsible behavior since it has been explained to me the nature of addiction of these medications.
7. I agree not to deal, steal, or conduct any other illegal or disruptive activities in or in the vicinity of the doctor's office or anywhere else. If the doctor finds out, I will be discharged from her care.
8. I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
9. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
10. I agree not to obtain medications from any other physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing controlled medicine with other medications especially benzodiazepines such as Valium (Diazepam), Xanax (Alprazolam), Librium (Chlordiazepoxide), Ativan (Lorazepam), and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing controlled medications with benzodiazepines, hypnotics like Ambien and Lunesta, and /or alcohol. I waive Dr. Martinez-Delio of any liability, if I decide to mix alcohol with prescribed or not prescribed medications without written consent from the doctor. I agree not to sue, (personally or let my Estate sue), Dr. Martinez-Delio, if I eventually break this treatment plan and I end up with medical consequences, including permanent physical or mental damages and even death. I take full responsibility for the use and/ or misuse of these Controlled substances.
11. I understand that medication treatment may be discontinued and I may be discharge from the clinic if I violate this agreement.

By signing below you agree to the office policy and understand that no matter what the situation is, you will be responsible for the fee. You also agree to be discharged for non compliance if you do not abide to the controlled substance agreement.

X _____ _____

Signature of Patient/ Parent Date

X _____ _____

Signature of Witness Date

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Policies and Fees

Fees for Service are due AT THE TIME of your appointment. If you have insurance benefits with a company with which Arlene M Martinez-Delio, MD is a participating provider, we will make every effort to obtain benefits information prior to your appointment and let you know in advance the amount you will need to bring with you. We will submit claims for your services and your insurance company will pay your benefits directly to Arlene M Martinez-Delio, MD . However, you are responsible for paying your portion at the time of your appointment. If in any case you are unable to then your appointment will be rescheduled

Some Insurance Companies only cover services for a medicine management check up. If you need more time to discuss personal issues, disability claims, FMLA, Immigration paper work, etc, your insurance does not cover these services. We will be charging our *customary rate for blocks of 15 minutes extra*, if you need extra time. Paperwork will be filled out, only on patients who clinically need it, at the hourly rate. Please ask ahead to the front staff, if you need extra time, so we can give you a longer visit and so that other patients don't have to wait.

If prior authorization is required by your insurance carrier, please contact them prior to your appointment to obtain the necessary authorizations. If your insurance company has not issued the necessary authorizations before the time of your appointment, your appointment will be rescheduled or you will be considered a self pay patient.

Refills and appointment requests are handled during regular business hours ONLY. (Monday-Wednesdays 9AM-5PM, Thursdays 12 noon-5PM, and Fridays 9AM-4PM). Please DO NOT call the afterhours line for these services. ALL refill requests and/or exchange in medications are done during your appointment. We will not call in prescriptions or accept call or faxes from the pharmacy for refills.

Arlene M Martinez-Delio, MD will not make calls to your insurance company for medications that are not in your insurance formulary list. However, she will gladly substitute any medication prescribed for an equivalent one in your insurance formulary list. If a prior authorization is requested by you, there will be a fee for the service.

If you are in an emergency situation, please go to the nearest emergency room or call 911. If you have an urgent need afterhour, please call the afterhour's line at (813) 500-0200. LEAVE A CLEAR MESSAGE with your name, date of birth, and reason for your emergency. Calls for refills and appointments are not accepted on this line. This line is intended for urgent needs, as long as they are not life threatening. You can get a Virtual Consult, HIPPA protected email or text at www.arlenemd.com and click on the link if you need refills after hours only. A fee applies to these services since it's managed by another company, not Suncoast UR Inc. These services are not covered by your insurance.

The fees below apply to self pay patients and patients needing additional services not covered by their insurance.
Effective January 1, 2016

Initial Diagnostic Interview	$320.00
Individual Psychotherapy w/Med Management (40-50min)	$280.00
Individual Psychotherapy w/Med Management (20-30min)	$160.00
Med Management Only (15-20min)	$120.00
*Phone Consultation	$110.00
Late Cancellation & No Show	$ 50.00
Prior Authorization for Medication	$ 30.00
Testing and or UDS	$ 60.00
*Paper Work:	a fee may apply if Doctor decides is medically necessary to do paper work.

***Most services cannot be handled over the phone. Arlene M Martinez-Delio, MD reserves the right to determine the service you are requesting can be handled over the phone or you need to be seen. I have read and understand these policies and have been notified of all applicable fees for service.**

Signature: _____ **Date:** _____/_____/_____

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