Patient Information

Basic Information

Full Name
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown

Date of Birth / /

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number

Email

Social Security Number

Address Line 1

Address Line 2

City

State

Zip

Marital Status

Maiden Last

Driver's License State

Driver's License #

Demographics

Sexual Orientation

Gender Identity

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify

Ethnicity

Race

Language

Emergency Contact

Relationship to Contact

Full Name
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number

Email

Address Line 1

Address Line 2

City

State

Zip

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact

Full Name
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work Phone Number

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company Policy Number

Insurance Plan Insurance Phone Number

Group Number

Insurance Company Address Address Line 2

City State Zip

Relationship to Primary Policy Holder

If you are not the primary policy holder, please fill out the following:

Full Name
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown Date of Birth / /

Policy ID Number Social Security Number

Policy Holder Address Address Line 2

City State Zip

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company _____ Policy Number _____

Insurance Plan _____ Insurance Phone Number _____

Group Number _____

Insurance Company Address _____ Address Line 2 _____

City _____ State _____ Zip _____

Relationship to Secondary Policy Holder _____

If you are not the secondary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown Date of Birth ___/___/___

Insurance ID Number _____ Social Security Number _____

Policy Holder Address _____ Address Line 2 _____

City _____ State _____ Zip _____

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us? _____

Therapy: Getting to Know You

1. What prompted you to seek therapy now?

---

2. How have you been coping with the problem(s) that brought you into therapy?

---

3. Have you ever done therapy before?

---

4. What was it like growing up in your family?

---

5. Have you ever thought of harming yourself or ending your life?

---

6. What do you hope to accomplish in therapy?

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted expectations are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Please print your name and sign below:

Client (or Guardian) Printed Name: _____

Client (or Guardian) Signature: _____

Date: _____

☐ I am the parent/guardian of this patient

Card on File: Authorization Form

Information to be completed by cardholder: The undersigned agrees and authorizes medical practice to save the credit card indicated below on file.

Medical Practice:

Tranquil Waters Counseling LLC

I authorize the above medical practice to process the credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

Name as it Appears on the Credit Card: _____

Type of Credit Card: _____

Complete Card Number: _____

Expiration Date: _____

CVV Code: _____

Complete Address for this Card including Zip Code:

_____

Please print your name and sign below:

Client (or Guardian) Printed Name: _____

Client (or Guardian) Signature: _____

Date: _____

☐ I am the parent/guardian of this patient

Tranquil Waters Billing Policy Assignment of Benefits/Late Cancel/ No Show Policy

Tranquil Waters Billing Policy

24 Hour Notice Cancellation Policy/Rescheduling Policy

Tranquil Waters Counseling has a 24-hour notice Cancellation Policy/Rescheduling Policy. If an appointment is missed, cancelled or changed with LESS than 24 Business hour's notice, there will be charge of $60. This charge will be charged to the credit card stored on file, provided by you at the intake session. If the Agency must make changes to the scheduled session time that the Patient cannot accommodate, the Cancellation fee will be waived. For all cancellations, you MUST CALL our Main Number (407) 738-9408 and Leave a Voicemail on our Cancellation Line (Option 1) in order to have your cancellation processed as this is Date and Time Stamped. Texts, Emails and Facebook messages will not be processed as a Cancellation. The Voicemail must include Your Name, Date/Time of Appt and the Reason for your Cancellation.

For Monday appointments, a Cancellation must be called in no later than Friday, example: a Monday at 12pm appt must be cancelled Friday before 12pm to be less than 24 hours.

If there are recurring no shows or late cancellations, the Patient will only be able to schedule an appointment on a Same Day Appointment basis until re-establishing a consistent ability to attend at least 3 appointments.

Billing Policy

When our Biller calls or checks online for insurance copay verification, this is most often an ESTIMATE and If the insurance provider does not cover the cost of the session (as Tranquil Waters and the Patient will each receive an Explanation of Benefits mailed) the Patient will be responsible for the Insurance Contracted amount of the session, to be charged to the credit card stored on file after Patient is notified through Kareo Portal (text or email). You will be asked at the initial session to provide your debit/credit card for this policy.

The Agency realizes that there are many things that come up in people's day to day lives. While truly sympathetic, the agency cannot absorb the financial responsibility of last minute cancellations. The Agency does not double book appointment times but rather reserves specific times for each patient affording individualized care. In fairness to all patients, this policy is in effect regardless of the reason for the cancellation.

*A Chargeback to your Bank Card/Debit Card/Credit Card constitutes Fraud if you request such after receiving mental health services or after no showing or late cancelling for a session with Tranquil Waters Counseling. Chargebacks are the act of disputing the charge with your bank to have the fee reversed back to your bank account.

Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with out business office. Necessary Forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier (s) including Medicare, private insurance and any other health/medical plan, to issue payment checks directly to Ann-Marie Miglionico with Tranquil Waters Counseling, rendered to myself and my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Ann-Marie Miglionico, LCSW of Tranquil Waters Counseling to 1) Release any information necessary to insurance carriers regarding my illness and treatments, 2) process insurance claims generated in the course of examination and treatment and 3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Tranquil Waters Counseling on behalf of myself and or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

By signing below, you acknowledge that you have read and understand the this Policy for Tranquil Waters Counseling as described above. Thank you for your understanding and cooperation.

Please print your name and sign below:

Client (or Guardian) Printed Name: _____

Client (or Guardian) Signature: _____

Date: _____

☐ I am the parent/guardian of this patient

TWC No Fly List- Zero Tolerance Policy

In order to maintain the positive atmosphere that exists at Tranquil Waters Counseling, this No Fly List Policy exists to discourage anyone from being disgruntled with any Tranquil Waters Counseling Staff or Patient while in our office, to include phone calls with our Staff. Our Staff do their best in every aspect of their position, but please keep in mind there are often other challenges in our job to include phone issues, Medical Records System issues, as well as other unforeseen events.

Our Staff are valued for the hard work they do and they deserve to be compensated for their time. An area that often causes concerns for Patients are insurance issues/copay issues. The best way to get a resolution on Billing Issues is to please call our Main Line at 407 738-9408 Ext 3 for Billing AFTER you have confirmed the information with your insurance company as they are best able to answer your insurance questions. We do not dictate your Copay Amount, we only confirm the Rate with which your Insurance provides to us, and there are some times that Insurance mis-quotes a copay amount or has a COB (Coordination of Benefits Issue). If this is the case, we will do our best to advocate with you with your insurance company.

Should there be any aggressive behavior (yelling, raising phone, or any other type of behavior that can be perceived as intimidating or threatening), you will be immediately discharged from your treatment at Tranquil Waters Counseling and asked to seek your mental health care elsewhere.

If this should happen, you can seek out another mental health professional through PsychologyToday.com or by calling your Insurance Company for other referrals.

Thank You for Your Help in Maintaining a Positive Environment at Tranquil Waters Counseling.

Your signature below confirms your acceptance on our No Fly Policy.

Please print your name and sign below:

Client (or Guardian) Printed Name: _____

Client (or Guardian) Signature: _____

Date: _____

☐ I am the parent/guardian of this patient

Informed Consent for Telemedicine Services

Introduction
Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,

3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Tranquil Waters Counseling has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Tranquil Waters Counseling of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of Florida and will be present in the state of Florida during all telehealth encounters with Tranquil Waters Counseling.

Patient Consent to the use of Telemedicine
I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize Tranquil Waters Counseling to use telemedicine in the course of my diagnosis and treatment.

As we continue to navigate the current Coronavirus COVID-19 outbreak, we want to assure you that our entire team is here for you and can offer guidance, information and care.

Office Visits
Your health and safety and the health and safety of our staff is our top priority. Therefore, we will continue to follow the below guidelines for all office visits. These guidelines are imperative to the safety of both our medical professionals and other patients.

IF YOU EXPERIENCE ANY OF THE FOLLOWING, PLEASE CALL US AT 407-738-9408
TO RESCHEDULE WITHOUT A LATE CANCEL OR NO SHOW FEE:

1. You have fever, sore throat or difficulty breathing
2. You have had contact with someone with known or suspected COVID-19
3. You live in a community with confirmed ongoing transmission of COVID-19
4. You have travelled within the last 14 days to any location either domestically or internationally with confirmed ongoing transmission of COVID-19

Coming to our Office
For those patients who do come to our offices, we want to share the steps that we are taking to protect the safety of our patients and staff:

1. You are required to wear a mask, before, during and after your visit to the Tranquil Waters Counseling Office or your session will be refused in order to follow the law and safety guidelines set by our Governor.

2. We are carefully monitoring the recommendations and best practices given by the CDC and our local authorities.
3. We have implemented enhanced cleaning and disinfection practices
4. Staff involved with direct patient care will be wearing masks for your protection and theirs.
5. We are reinforcing employee best practices, reminding staff of heightened hygiene practices and to stay home if they are not feeling well.
6. We are monitoring our waiting room so that fewer patients will be sitting together in the reception area.
7. Tranquil Waters Counseling is not held liable for any services refused as a result of patient not willing to wear a mask. Patient will still be charged for the session in the form of a late cancel fee of $60.
8. Tranquil Waters is not liable for any possible spread of Covid 19 as a result of still conducting in office settings as safety precautions are in place.

These are challenging times, but we must prioritize our patients, staff and providers safety. We thank you in advance for your patience and cooperation with our protocols and procedures that may feel unusual, but they are for the protection of all of us.

Telehealth
For those who do not wish to come into the office, we offer Telehealth as an alternative to office visits in some cases. If you are interested in a Telehealth session, please call our office and our staff can assist you.

Prevention
We recommend the following for prevention:

1. Wash your hands with soap and warm water for at least 20 seconds. An alcohol based hand sanitizer is a good alternative when washing isn't possible.
2. Wipe down surfaces and countertops in common areas of your home with disinfecting wipes or sprays.
3. Refrain from going places where you could be in close proximity to people. Avoid being within 6 feet of anyone. And self-quarantine if you have travelled.

For more information, you can visit our website: https://tranquilwaterscounseling.com
or www.cdc.gov for the most current information regarding the Coronavirus outbreak and guidance.

Tranquil Waters Counseling continues to be committed to supporting our patients primary care needs. If you have any questions, please contact our office at 407-738-9408 or contact us through the patient portal.

Please print your name and sign below:

Client (or Guardian) Printed Name: _____

Client (or Guardian) Signature: _____

Date: _____

☐ I am the parent/guardian of this patient

Parent Input Form

At Tranquil Waters Counseling, we love to collaborate with Parents and Caregivers and value your input. Please feel free to request this form from your Child's Therapists to fill your Therapist in as needed.

Your Child's Name: _____

Your Name/ Role: _____

At School: (New Teacher? Received an Honor/Award? Low Grades? Behavior problems at school? Argument with Friends?)

At Home: (Parent working extra long hours, shared toys, completion of chores, birthday, changes with pet or friends?

Environmental Changes: (Change in sleep pattern, appetite, change in support system, moved to new home, relatives visiting?

Physical Changes:(Complaints about body, weight loss/gain, headaches, stomachache, menstruation changes, signs of puberty?

Medication: New or Discontinued?

Assessment of Changes in Child: Any change in child's overall behavior?

Any change in Child's mood/attitude towards life?

Identify any behavioral concerns you would like us to address.

Anything else we should know?

Please print your name and sign below:

Client (or Guardian) Printed Name: _____

Client (or Guardian) Signature: _____

Date: _____

☐ I am the parent/guardian of this patient

Release of Information

Patient's Name and DOB (This should be the client's name and Date of Birth):

Date Authorization Initiated (Date of completion):

Authorization Initiated By (Patient, Provider or other), Role of (who is completing document, parent, guardian, self…):

Information to be released (Clinical, Administrative, or both), and what medium if specified (verbal, written, or both). Be as specific as you would like if necessary:

Purpose of Disclosure (The reason I am authorizing release is couples therapy, court proceedings, continuation of care…):

To Whom is the Disclosure: (Name, Relationship, or Type of Provider to who you are allowing me to communicate the information to be released followed by Address, Phone Number and or Email Address):

This authorization will expire on this date (recommended 1 year of the authorization date):

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Please print your name and sign below:

Client (or Guardian) Printed Name: _____

Client (or Guardian) Signature: _____

Date: _____

☐ I am the parent/guardian of this patient

Coordination of Care

Client Name: _____

Client Date of Birth: _____

TO PRIMARY CARE PHYSICIAN, for coordination of care.

Name of Doctor or group: _____

Phone: _____

Address: _____

Suite #: _____

City: _____

State: _____

Zip Code: _____

Client reports no PCP. Tranquil Waters Counseling recommends finding a regular PCP.

- ☐ Yes
- ☐ No

CLIENT IS BEING TREATED FOR THE FOLLOWING DIAGNOSIS: (DSM 5 code, Name):

_____

And is receiving:

- ☐ Individual/Family Counseling
- ☐ Psychiatric Services
- ☐ Group Counseling

PRIMARY CARE PHYSICIAN:

Please send medical records regarding the following medical condition:

_____

_____

_____

If there is any medical problem or concern that we should be aware of, that would be related or interfere with the above diagnosis, please explain below. You can fax this form back to us:

SELECT ONLY IF YOU DO NOT GIVE PERMISSION TO COORDINATE CARE WITH PCP:

☐ I choose not to give authorization for coordination of care at this time.

Please print your name and sign below:

Client (or Guardian) Printed Name: _____

Client (or Guardian) Signature: _____

Date: _____

☐ I am the parent/guardian of this patient

Request for Records from Tranquil Waters Counseling

Full Name of Requestor: _____

Name of Patient: _____

Address and Phone Number: _____

Email Address: _____

Dear Tranquil Waters Counseling,

The purpose of this letter is to request copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

I was treated in your office. I would like to request copies of my mental health records related to my treatment

I understand you may charge a reasonable fee for copying the records, but will not charge for time spent locating the records. Please send the requested records to me at the specified method.

I look forward to receiving the above records within 30 days as specified under HIPAA. If my request cannot be honored within 30 days, please inform me of this by letter as well as the date I might expect to receive my records*.

Reason for Request: _____

Name, Email and/or Fax to send the Records:

_____

Please print your name and sign below:

Client (or Guardian) Printed Name: _____

Client (or Guardian) Signature: _____

Date: _____

☐ I am the parent/guardian of this patient