# Intake

PATIENT NAME:____________________ LAST NAME:__________________
DOB:________________
Gender:_____________ Sexual Orientation:_________________ Gender Identity:__________________
SSN:______________________
**Race**: ( )White ( )Hispanic or Latino/a ( )Black or African American ( )Asian_________________
( )White Hispanic ( )Black Hispanic ( )Native American ( )Native Hawaiian/Pacific Islander
( )Black Haitian ( )White Haitian ( )Multiracial:_____________________
**Ethnicity**: ( )Cuban ( )Dominican ( )Mexican ( )Puerto Rican ( )Central American:______________
( )South American:___________________ ( ) West Indies________________________
Language: ( ) English ( ) Spanish ( ) Creole ( ) Other:________________________
Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Partnered ( ) Widowed
Do you have children? ( ) Yes ( ) No
Employment: ( ) Working ( ) Unemployed ( ) Retired ( ) Disability ( ) Student
Highest Level of Education: ( ) High School Diploma ( ) GED ( ) Associate's ( ) Bachelor's ( ) Master's
( ) Doctorate's

**Contact Information**
Phone Number: ___________________________________________ ( )Mobile ( )Home ( )Work
Alternate Phone Number: ___________________________________ ( )Mobile ( )Home ( )Work
Address: ___________________________________________City:_______________Zip:____________
Email: ___________________________________**How many people live in your household:**______

**Guardian Information** (Complete if Applicable)

**Name**: _____________________________________________________DOB:________________
Relationship to Client: _________________ **Custody Agreement**:_____________________________
Phone Number: ___________________________________________ ( )Mobile ( )Home ( )Work
Alternate Phone Number: ___________________________________ ( )Mobile ( )Home ( )Work

**Name**: _____________________________________________________DOB:______________________
Relationship to Client: __________________**Custody Agreement**:____________________________
Phone Number: ___________________________________________ ( )Mobile ( )Home ( )Work
Alternate Phone Number: ___________________________________ ( )Mobile ( )Home ( )Work

**Emergency Contact:** ___________________________________Relationship_____________________
Phone number**:** ____________________________

**Insurance Information**
Primary Insurance: ___________________________________Member ID:_______________________
Secondary Insurance:___________________________________ Member ID:______________________
**Pharmacy Information**__________________________________________________________________
__________________________________________________________________________________

**Doctor Information**
Primary Care Physician (PCP):_________________________________________
Physician Group:_______________________ Referral Source:________________________________

**Medical Information**

How often do you see your PCP? ( ) Frequently ( ) Yearly ( ) As Needed ( ) Never ( ) N/A
Vision Problems: ( ) Yes ( ) No
Hearing Problems: ( ) Yes ( ) No
Allergies: ( ) Yes ( ) No
Are there disabilities or health concerns (e.g. head trauma, diabetes, serious illnesses, etc.) that would impact your treatment? ( ) Yes ( ) No
If yes:___________________________________________________________________
**Current diagnosis:**_______________________________________________________________
**Current** Psychiatric Medications: ______________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

**Mental Health**

Presenting Concern(s):_________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Have you addressed these concern(s) before? ( ) Yes ( ) No If yes, what attempts were made?____________________________________________________________
Were they effective? ( ) Yes ( ) No
Are you currently receiving psychiatry services? ( ) Yes ( ) No
What symptoms have you experienced within the last **two weeks**?

- ( ) Depressed mood
- ( ) Unable to enjoy activities
- ( ) Loss of interest
- ( ) Hopelessness
- ( ) Worthlessness
- ( ) Emptiness
- ( ) Crying spells
- ( ) Low self-esteem
- ( ) Grief/bereavement
- ( ) Decreased concentration
- ( ) Forgetfulness
- ( ) Increased irritability
- ( ) Physical aggression
- ( ) Verbal aggression
- ( ) Anger outbursts
- ( ) Temper tantrums
- ( ) Defying authority figures
- ( ) Impulsivity
- ( ) Excessive energy
- ( ) Decreased energy
- ( ) Increased risky behavior
- ( ) Racing thoughts
- ( ) Excessive worry
- ( ) Nervousness
- ( ) Anxiety attacks
- ( ) Trouble relaxing
- ( ) Restlessness
- ( ) Repetitive behaviors
- ( ) Obsessive thoughts
- ( ) Avoidance
- ( ) Social isolation/withdrawal
- ( ) Thoughts of killing yourself
- ( ) Thoughts of harming someone else
- ( ) Self-harming
- ( ) Insomnia
- ( ) Decreased need for sleep
- ( ) Difficulty staying asleep
- ( ) Sleeping too much
- ( ) Poor appetite
- ( ) Increased appetite/overeating

( )Other:______________________________________________________________

Have you ever received the following services?

( ) Individual therapy
( ) Family/Couples therapy
( ) Group therapy
( ) Psychological testing (e.g. ADOS, intelligence testing, etc.)
( ) Career counseling
( ) Medication Management

( ) Inpatient in a psychiatric hospital, If yes, what were the reason(s) for admission?_____________________________________________________________
_____________________________________________________________________
______

( ) Past suicidal attempt(s) If yes, number of attempt(s) and last attempt?_____________________________________________________________
_____________________________________________________________________
_______

( ) Residential housing If yes, where and why?________________________________________________________________
_____________________________________________________________________
____

**Family History** (Please indicate if any family members are diagnosed with the following)

| | Mother | Father | Brother | Sister | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Aunt | Uncle |
|---|---|---|---|---|---|---|---|---|---|---|
| Depression | | | | | | | | | | |
| Anxiety | | | | | | | | | | |
| Bipolar | | | | | | | | | | |
| Schizophrenia | | | | | | | | | | |
| OCD | | | | | | | | | | |
| ADHD | | | | | | | | | | |
| Intellectual Disability | | | | | | | | | | |
| Austism Spectrum | | | | | | | | | | |
| Substance Abuse | | | | | | | | | | |
| Victim of Abuse | | | | | | | | | | |
| Suicidal Behavior | | | | | | | | | | |
| Self-harm Behavior | | | | | | | | | | |
| Seizure Disorder | | | | | | | | | | |
| Thyroid Problem | | | | | | | | | | |
| Other: (Please Specify) | | | | | | | | | | |

**Substance Abuse**

Is substance abuse a treatment concern? ( ) Yes ( ) No
Have you been treated for substance abuse before? ( ) Yes ( ) No

How often do you consume alcohol?
( ) Daily ( ) Weekly ( ) Monthly ( ) Infrequently ( ) Never
How often do you use recreational drugs?
( ) Daily ( ) Weekly ( ) Monthly ( ) Infrequently ( ) Never

**Trauma History**

Have you ever experienced a traumatic event or experienced emotional, physical, sexual abuse ,or neglect ? ( ) Yes ( ) No ( ) Unsure
If yes, what was the event and when did it occur_______________________________________________________________

**Legal History**

Are legal problems a current concern? ( ) Yes ( ) No Have you ever been arrested? ( ) Yes ( ) No
Do you have pending legal problems? ( ) Yes ( ) No If yes, please explain_________________________________________________________________

**Minors**

School name: _____________________________________________________________

Grade Level: _____________Grades at school: ____________ Extracurriculars /hobbies:___________________________

Teacher concerns: _____________________________________________________________

Has your child repeated a grade? ( ) Yes ( ) No
History of school suspensions? ( ) Yes ( ) No
Is there an IEP/504 Plan in place? ( )Yes ( ) No
Is bullying a concern? ( ) Yes ( ) No
Was your child bullied in the past? ( ) Yes ( ) No

**Other important information:**

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

# General Consent for Treatment

**Client Name: ________________________________DOB: ____________________________**

I hereby voluntarily give my consent for myself, my child, and/or my family to receive one or more of the following services or treatments provided by **Chrysallís Wellness Center:** mental health and behavioral intervention; This could include school/home visits, and follow-ups, all within the professional medical judgement and discretion of **Chrysallís Wellness Center 's** mental health providers and staff. I further consent to the collection and use of past and current medical and medicine history of the client, the client's family, and the client's providers. I consent to the use of photography for purposes of verifying identification of clients and/or identifying accompanying persons. Because I have the right to refuse services at any time, I understand and agree that my or my family's continued participation in services or treatments offered by **Chrysallís Wellness Center** implies informed consent. If I choose to revoke this consent, I understand that providers and/or staff may not be able to provide me, my child, or family members necessary services and treatments that have been recommended. I further understand that **Chrysallís Wellness Center** participates in educational programs and that students in these affiliated programs may be involved in the care provided.

_______(initials) I understand that potential benefits of undergoing services offered by **Chrysallís Wellness Center** may include improvement in functioning of myself or child and/or an increased understanding of myself and/or child. I understand the potential risks may include possible disagreement with opinions offered to me, and possible emotional distress concerning my situation. I understand that alternative procedures may include services provided by other psychologists, psychiatrists, or mental health professionals.

_______(initials) I understand that while the evaluation and/or treatment will be based upon known principles and research, the practice is not an exact science. I acknowledge that no guarantees have been made to me concerning the results of evaluations and/or treatments or services provided by **Chrysallís Wellness Center**

_______(initials) I verify that I am the client OR client's legal guardian per Florida State Statute Chapter 744 for the above and furthermore certify that the information, records, and other documents I have provided to **Chrysallís Wellness Center** (either verbally or in writing) are accurate to the best of my knowledge.

_______(initials) I hereby acknowledge that I have reviewed the Notice of Privacy Practice (NPP) and the Patients' Rights and Responsibilities documents. I can request copies. **Chrysallís Wellness Center** must post NPPs. Signed copies of consents, agreements, and authorizations can be used in place of original scanned into medical record chart.

By signing below, I am agreeing to consent for treatment and my understanding of the information described in this document. I have read this consent and have been able to ask questions.

______________________________________________________________________

**Client Printed Name** **Signature** **Date**

______________________________________________________________________

**Guardian Printed** **Signature** **Date**

______________________________________________________________________

**Witness Printed** **Signature** **Date**

11932 FAIRWAY LAKES DR. FORT MYERS, FL 33913 OFFICE 239-237-2801 FAX 239-771-8327

Chrysallís Wellness Center
GROWTH ❖ TRANSFORMATION ❖ EMPOWERMENT

## General Policies

Client Name: _______________________________________________DOB: ______________

**General Policies**

_______(initials) **Emergency Services- Chrysallís Wellness Center provides** mental health crisis intervention. For life threatening emergencies call 911 or go to the nearest emergency room. For mental health crisis situations during regular business hours, please call 844-395-4432 CPE mobile crisis team and you will immediately be communicated to a dispatcher.

_______(initials) **Communications-** You understand that you may receive calls from **Chrysallís Wellness Center or** third-party business associates for purposes of including, but not limited to, results, communication, patient surveys, and debt collection using phone numbers, including wireless numbers you have provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

_______(initials) **Confidentiality and Release of Protected Healthcare Information (PHI)-** All information disclosed within sessions is confidential and may not be revealed to anyone outside of **Chrysallís Wellness Center without** written permission, except for disclosures as required by law. The law does require clinicians to report to the authorities any reasonable suspicions of child or elder abuse, danger of harm to self and/or to others unless protective measures are taken. To the extent necessary to determine insurance benefits or liability for payment and to obtain reimbursement, **Chrysallís Wellness Center may** disclose portions of the client's medical record and account file to any person or corporation that may be liable for all or any portion of the client's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers. **Chrysallís Wellness Center may** disclose information to referring provider following the minimum necessary rule.

**The signatory certifies that he or she has read, understands, and accepts these terms and conditions of this document and is either the patient or is duly authorized by the client as clients' general agent to execute the above agreement and may receive a copy upon request.**

___

**Client Printed Name** **Signature** **Date**

___

**Guardian Printed Name** **Signature** **Date**

___

**Witness Printed Name** **Signature** **Date**

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# Patient's Bill of Rights and Responsibilities

**Section 381.026, Florida Statutes**

**A patient has the right to:**

- Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy. Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and is responsible for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill and, if requested, to have the charges.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
- Express complaints regarding any violation of his or her rights.

**A patient is responsible for:**

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

**Agency for Health Care Administration – Visit us at [www.FloridaHealthFinder.gov](www.FloridaHealthFinder.gov)**
If you have questions or concerns, please contact or office.

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**Notice of Privacy Practices**
**Our Commitment to Your Privacy**

Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI) or Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. At **Chrysallís Wellness Center,** the privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it.
We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. Our practice will also post a copy in our office in a visible location always.

**Understanding Your Health Record/Information**

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record.

**Your Health Information Rights**

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you.

**Right to A Copy of Your Medical Records**

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. To inspect and copy medical information that may be used to make decisions about you, you must contact the office to obtain an Authorization Form. Once you have received this form, please fill it out thoroughly and send the form back to the office.
Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed.

**Right to Request Restrictions**

You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in

this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

**Right to Amend**
This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a

statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to obtain the "Health Record Amendment Form". This form must be submitted to our office.

**Right to Receive Certain Accounting Disclosures**
This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes.

The right to receive this information is subject to certain exceptions, restrictions and limitations.

**Right to Obtain A Paper Copy**
You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, please contact the Office.

**Our Responsibilities Chrysallís Wellness Center** is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

**Appointment Reminders**
We may contact you by phone or leave a message on your home, work or cell phone as a reminder that you have a follow up appointment scheduled. Please notify us if you do not wish to be contacted for appointment reminders.

**Notification**
We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

**Communication with Family Members**
Health professionals, using their best judgment, may disclose to a family member, other relative, close friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**Research**
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**Disclosures Required by Law**

We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

**Military and National Security**
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for a determination by the Department of Veterans Affairs of your eligibility for

benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Lawsuits and Disputes**
If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose your medical information in response to a subpoena.

**Coroners, Medical Examiners and Funeral Directors**
We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death.

**Other Uses and Disclosures of Health Information**
We will not use or disclose your Protected Health Information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization in writing at any time. If you revoke the Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. We cannot release you're your Psychotherapy Notes without a special signed, written authorization (different than the Authorization mentioned above) from you.

**Food and Drug Administration (FDA)**
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Correctional Institution**
Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

If have questions and would like additional information, you may contact our Office.

If you believe your privacy rights have been violated, you can file a complaint with our Office.
OR with the Secretary of Health and Human Services by using
the information below:
Timothy Noonan, Regional Manager
Office for Civil Rights. U.S. Department of Health and Human Services Sam Nunn Atlanta Federal Center, Suite 16T70 61 Forsyth Street, S.W. Atlanta, GA 30303-8909 Customer Response Center: (800) 368-1019 Fax: (202) 619-3818 TDD :(800) 537-7697 Email:ocrmail@hhs.gov

# Attendance Policy for Counseling

To obtain the most effective treatment from Chrysallís Wellness Center Inc., it is critical to consistently attend appointments. We understand that emergencies and rescheduling occur. However, the following attendance policy is in place to help maintain participation and achieve success in you or your child's mental health services.

Our staff will assist you to maintain consistency in attendance, but ultimately, it is your responsibility to keep the scheduled appointments and/or communicate hardships impairing you to attend scheduled appointments. The first intake assessment as well as the first counseling session are critical to your or your child's treatment. Treatment will be consisting of, but not limited to, 10-12 weeks. Continuation of appointments and termination of services will be at the discretion of Chrysallís Wellness Center.

- Three (3) **Cancellations** and/or **No Call/No Show** appointments within a 60–90-day period may result in discharge from treatment.

  Cancellations: Cancelling appointments via telephone call or in person less than 24hrs in advance with or without a reschedule. Voicemails to our office telephones will not constitute as a valid cancellation. Cancellations without a 24-hour notice will be charged an **automatic fee of $40.00**

  No Call/ No Show: Missing appointments without providing telephone call or in person cancellation or reschedule. Any no show appointment will be charged an **automatic fee of $40.00**

- **Termination**: After 30 days of no therapeutic contact, you will be subject to discharge.

- **Lateness,** Please note that if you are more than **15 minutes** late for an appointment it may be shortened or rescheduled at the discretion of the provider. Consecutive tardiness may result in discharge from services.

PLEASE READ AND SIGN

I agree with the above statements regarding attendance of myself or my child's mental health outpatient services in Chrysallís Wellness Center Inc. I understand that if I or my child am non-compliant with the above statements regarding attendance I or my child may or may not be discharged or have services terminated at the discretion of the provider and Chrysallís Wellness Center Inc. I understand if I have any questions regarding this policy they will be answered by my provider upon communication.

**SIGNATURE: ___________________________________ DATE: _______________**

# FINANCIAL INFORMATION

**CREDIT CARD ON FILE REQUIREMENT**:

As a courtesy to you, we will bill your insurance company for services rendered. If for any reason your insurance company denies the claim, you will be personally responsible for the charges. Any copay and co-ins are collected up front at time of service. **A CREDIT CARD IS REQUIRED TO BE KEPT ON FILE for any charges not covered by insurance.** ***Due to thousands of insurance plans available it is impossible for us to know the coverage details of all the policies. It is your responsibility to know what type of coverage, benefits, deductibles, and co-payments you have with your insurance plan.***

**TELHEALTH SERVICES PAYMENT:**

Method of payment must be provided to the office 24 hours before the scheduled appointment. No appointments will be kept if method of payment is not provided to the office prior to the scheduled appointment.

**NO SHOW/CANCELLATION FEE**:

An automatic **fee of $40** will be charged to you credit/debit card for any no shows or cancellations with less than 24 hours' notice.

**ASSINGMENT TO PAY FOR SERVICES**:

I agree to pay Chrysallis Wellness Center for all charges for services rendered today, or any future date of service in this practice. I understand that any unpaid charges will be billed to my credit card. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all collection fees, attorney's fees or and/or court costs.

**SIGNATURE:** ______________________________ **DATE**:_________________________

# MEDICATION MANAGEMENT POLICY

**It is CHRYSALLIS WELLNESS CENTER policy that ALL medication management patients are required to be seen every 28-30 days for prescription renewals. Under no circumstances will Chrysallis Wellness Center send any refills to the pharmacy if patients have not kept their routine monthly appointments.**

Every patient is responsible to schedule appointments before running out of medication to secure medication refills on a timely manner. It is not the practice responsibility to remind you when you are due for a refill. All follow up appointments need to be scheduled at the conclusion of the visit at the check-out counter. If you are being seeing telehealth, then it is your responsibility to call the office at the conclusion of your visit to schedule your follow up. **All patients will be held accountable and responsible to keep up with their appointment for medication refills!**

**Do not wait until you are out of medication to call the office for a refill as there will be no refills sent until you are seen by the doctor or physician assistant. Appointments are scheduled based on availability therefore we will not be able to add anyone to the schedule on a last-minute request.**

All medications will be sent to the pharmacy at the conclusion of our business day. It will be available for pickup at the pharmacy on the following day. Please check with your pharmacy if your prescription is ready for pick up prior to calling our office to inquire.

**All communication must be done directly with the practice not via email!!!**

**SIGNATURE:** ______________________________ **DATE:**___________________

**Chrysallís Wellness Center**

**Permission to Discuss Protected Health Information (PHI)**
**With Others Who are Involved in Your Healthcare**

**I hereby permit Chrysallís Wellness Center to share specific information described below, only for the purposes and persons involved in my healthcare.**

Description of the specific information to be discussed:

( ) **Billing Summary**
( ) **Diagnosis Letter**
( ) **Medications List**
( ) **Lab Tests/Results**
( ) **Psychiatry Notes**
( ) **Therapy Letter**
( ) **Genetic Testing Results**

Indicate Confidential Information you **<u>don't</u>** want discussed:

( ) **Mental Health** ( ) **HIV Information** ( ) **Alcohol/Drug Information**

**Patient Information:**

Full name:____________________________________ Date of Birth:_______________________

Address:_________________________________________________________________________

Phone number:______________________________ Email:_______________________________

**AUTHORIZE**:

_______________________________________
Name of Provider/Healthcare Facility

_______________________________________
Street Address

_______________________________________
City, State, Zip

**RELEASE RECORDS TO:**

_______________________________________
Name of Provider/Healthcare Facility

_______________________________________
Street Address

_______________________________________
City, State, Zip

It is my responsibility to inform **Chrysallís Wellness Center** of changes and to revoke and complete another form. I understand that:

- This document does not dictate that our providers will initiate conversations or other methods to share information with persons listed above. If those persons wished to be involved, then it is their duty to initiate involvement, and if time and circumstances permit, then **Chrysallís Wellness Center** will do our best to comply to your wishes.
- I may revoke this permission in writing by contacting our Privacy Officer.
- Information shared may be subject to re-disclosure by the recipient and no longer be protected under HIPAA. This document is intended to relieve burden of our staff to know to whom you want to involve in this patient's care. It is not mandatory to complete.
- This document is not an authorization to release protected health information (PHI).
- This document allows staff the right to visit on school premises, unless otherwise indicated.

**<u>There is a $35 fee for medical records and/or therapy letters, animal support letters, disability letters and work letters</u>**.

_______________________________________________________________________________
Client Printed Name Signature Date

Guardian Printed Name Signature Date