



## WHAT NEW PATIENTS SHOULD KNOW ABOUT SARKIS FAMILY PSYCHIATRY

529 NW 60<sup>th</sup> Street, Gainesville FL 32607  
Phone (352) 331-5100 Fax (352) 332-9607

Sarkis Family Psychiatry was started in 1991 by Elias Sarkis, MD. Since then, it has grown to include Nurse Practitioners, Mental Health Counselors, and Licensed Clinical Social Workers.

We are a group practice, which means we work closely together to provide evaluation, education, and treatment for a full range of mental disorders and emotional problems. As a result, you may see several of us in the course of your treatment. One of the great advantages of a group practice is the ease with which care can be coordinated and the ready availability of on-the-spot consultation. Because we recognize the importance of families and know that one family members' problems have an effect on the entire family, we try to include the whole family in treatment, whenever possible.

### **HOURS**

Our office hours are: Monday through Thursday, 8:30 am to 6:00 pm and Friday, 9 am to 2 pm.

Telephone hours are: Monday through Thursday, 9 am to 6:00 pm and Friday, 9 am to 2 pm.

Requests for prescription refills should be made during those times. We require 4 days notice to process refills, so please request refills prior to running out of medications.

### **APPOINTMENTS**

Initial visits are one hour long and are \$325 to see a Physician or \$250 to see a Nurse Practitioner or Psychologist. Follow-up appointments may be scheduled for 15 minutes up to 45 minutes, depending on your needs, the service being provided, and the individual practitioner.

You have the option to receive a courtesy confirmation call one day prior to any existing appointments. These calls are a courtesy only. You are responsible for your scheduled appointments and will be responsible for any fees incurred from missed or late arrivals, regardless of whether or not your appointment was confirmed.

### **PAYMENTS**

For your convenience, we accept cash, checks, Visa, MasterCard, American Express and Discover.

Our fees are based on time and skill, as well as overhead factors. It is our goal to provide you with the best possible services for the fees we charge. In order to keep our overhead as low as possible, we require payment of all fees at the time of service. If for any reason this is not possible, financial arrangements must be made prior to your visit. **Please Initial here stating that you understand our policy \_\_\_\_\_**

### **FEES FOR MISSED APPOINTMENTS**

Missing an initial appointment = \$325 or \$250

Missing a follow-up appointment = \$75

Once an appointment is scheduled, this time is reserved for you only. In order for us to see all of our clients at the scheduled time, it is extremely important that you arrive on time for your appointment. If you miss an appointment, you'll need to reschedule. Note that refill requests may not be honored if follow-up appointments have not been kept. New patients who do not arrive on time or do not show for their initial appointment will be required to pay the full visit fee of \$325 or \$250 prior to rescheduling. This will be applied to the missed appointment, not to the rescheduled appointment.

An appointment will be considered "missed" in each of the following situations:

- You arrive more than 15 minutes late for your appointment
- You cancel an appointment without sufficient notice (48 hours for the initial appointment, 24 hours for a follow-up)
- You don't show for a scheduled appointment

**Please initial here stating that you understand our policy \_\_\_\_\_**

**OTHER FEES**

- Returned check = \$50
- Interest applied to balances over 60 days = 1.5% per month.
- Telephone conferences between you and your provider = based on the length of the conversation.
- Letters and forms completed on your behalf = based on the length of the letter or forms.

**Please initial here stating that you understand our policy \_\_\_\_\_**

If this account is assigned to an attorney for collection, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. **Please Initial here stating that you understand our policy \_\_\_\_\_**

**I have read, initialed and understand Sarkis Family Psychiatry's Office Policies explained in the *WHAT NEW PATIENTS SHOULD NOW ABOUT SARKIS FAMILY PSYCHIATRY.***

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

New Patient Information Sheet

Please complete all information on the enclosed forms and return this packet as soon as possible.

Patient's Name: *Last* \_\_\_\_\_ *First* \_\_\_\_\_ *MI* \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Patient's Information: Employed \_\_\_\_\_ Student \_\_\_\_\_

Employer/School: \_\_\_\_\_

Work #: \_\_\_\_\_ (Give only if we may call you at work)

Courtesy Confirmation call #: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Phone #: \_\_\_\_\_

Referring Doctor(s): \_\_\_\_\_

*If patient is a minor of divorced parents or has a legal guardian that is not a biological parent, please provide custody/guardianship agreement pertaining to medical and mental health treatment.*

Guardian's Name: \_\_\_\_\_ Guardian's Phone #: \_\_\_\_\_

Guardian's Address: \_\_\_\_\_

**INSURANCE ASSIGNMENTS & AUTHORIZATION**

If you do not have insurance or you do not wish to use insurance, please initial here and skip this page \_\_\_\_\_

We are **OUT-OF-NETWORK** with all insurance companies. As a courtesy we will file most insurances for you. You will need to pay for the full fee at the time of service. If your plan provides out-of-network benefits, your insurance company will usually send the reimbursement check to you, depending on your plan. If we receive the check, we will apply it as a credit to your account. **Please initial here stating that you understand our policy** \_\_\_\_\_

1. RELEASE OF INFORMATION: I, the below named patient or guardian, do hereby authorize any physician examining and/or treating me to release to third party payer (Blue Cross and Blue Shield) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.
2. PHYSICIAN INSURANCE ASSIGNMENT: I, the below named subscriber, hereby authorize payment directly of medical benefits to the physician examining or treating me herein specified and otherwise payable to me for their services as described, but not to exceed the reasonable and customary charges for these services.
3. I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENT TO BE USED IN PLACE OF THE ORIGINAL THAT IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge.

**Insurance Information**

If possible send us a copy of the front and back of your insurance card so that we may verify your coverage.

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Policy Dates: From: \_\_\_\_\_ To: \_\_\_\_\_

Member (Contract) ID: \_\_\_\_\_ Group #: \_\_\_\_\_

**Policy Holder's Information**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

**I have read and understand Sarkis Family Psychiatry's Policies about insurance explained in the *WHAT NEW PATIENTS NEED TO KNOW ABOUT SARKIS FAMILY PSYCHIATRY.***

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# **SARKIS FAMILY PSYCHIATRY**

## Child, Adolescent, and Adult Psychiatry

### **HIPAA Notice of Privacy Practices**

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

#### **UNDERSTANDING YOUR HEALTH RECORD**

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination and test results, diagnosis, treatment, and a plan for future care are recorded. This information is most often referred to as your "health record" or "medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used, will help you to ensure its accuracy and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

#### **UNDERSTANDING YOUR HEALTH INFORMATION RIGHTS**

Your health record is the physical property of the health care practitioner or facility that compiled it, but the content is about you, and therefore, belongs to you. You have the right to request restrictions on certain uses and disclosures of your information and to request amendments to your health record. Your rights include being able to review or obtain a paper copy of your health information and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

#### **OUR RESPONSIBILITIES**

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. If applicable, this office will post changes on our web site that provides information about our customer service and/or benefits. Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

#### **TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM**

For further explanation of this notice, you may want to contact the Privacy Officer, Jorge Franceschi, at 333-0094. If you believe your privacy rights have been violated, you have the right to file a complaint with this office by contacting the individual above, or by contacting the Secretary of Health and Human Services, with no fear of retaliation by this office.

#### **YOUR HEALTH INFORMATION WILL BE USED FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

**Treatment** – Information obtained by your health care practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those of others involved in providing your care, such as specialty physicians, nurse practitioners, or therapists.

**Payment** – Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed, and supplies used.

**Health Care Operations** – The medical staff in this office will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for

risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

### **UNDERSTANDING OUR OFFICE POLICY FOR SPECIFIC DISCLOSURES**

**Business Associates** – Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. For example, it may be necessary to obtain specialized assistance to process certain laboratory tests or radiology images. To provide your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

**Notification** – Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or your whereabouts.

**Communications with Family** – Using best judgment, a family member or close personal friend identified by you may be given information relevant to your care and/or recovery.

**Marketing** – This office reserves the right to contact you with appointment reminders or information about treatment alternatives and other health-related benefits that may be appropriate to you.

**Research** – Your information will be disclosed to researchers, upon assurance that established protocol to ensure the privacy of your health information has been obtained. Staff may review records to determine eligibility for current studies at our site.

**Food and Drug Administration (FDA)** – This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, or product defects for surveillance to enable product recalls, repairs, or replacements.

**Worker's Compensation** – This office will release information to the extent authorized by law in matters of worker's compensation.

**Public Health** – This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.

**Correctional Facilities** – This office will release information on incarcerated individuals to correctional agents or institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.

**Law Enforcement** – (1) Your health information will be disclosed for law enforcement purpose as required under state law or in response to a valid subpoena. (2) Provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more patients, workers, or the general public.

### **RESPECT OTHER PATIENT'S PRIVACY**

If you are found accessing another patient's medical record or any other documents with personal health information without the consent of the patient and permission from the facility, you will be asked to leave the clinic and not return.

### **NOTICE OF PRIVACY PRACTICES AVAILABILITY**

The terms described in this notice will be posted in the waiting area. A hard copy will be provided at your request.

**SARKIS FAMILY PSYCHIATRY**  
Child, Adolescent, and Adult Psychiatry

**Notice of Review and Agreement**

I acknowledge that I have reviewed and agree to the HIPAA Notice of Privacy Practices as presented by Sarkis Family Psychiatry. I understand if I wish to make any changes to this agreement that it must be done so in writing.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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

**In the event of an addendum:**

Signature: \_\_\_\_\_

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

**In the event of an addendum:**

Signature: \_\_\_\_\_

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

**Sarkis Family Psychiatry Intake Questionnaire-Child/Adolescent**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Place a check next to any of the following that have been a significant problem for your child during the past month.

- Difficulty with getting things organized
- Frequent procrastination of important tasks
- Forgetfulness
- Being easily distracted by noise or activity around them
- Being overly restless or fidgety
- Getting easily bored
- Irritability or impatience
- Meltdowns and/or temper tantrums
- Aggressive behavior
- Worrying too much
- Fear of being separated from you
- Other fears
- Refusing to go to school
- Complaining about stomach pain
- Appearing sad or down
- Not enjoying their usual activities
- Fatigue and/or low energy
- Difficulty falling asleep
- Difficulty staying asleep
- Wanting to sleep too much
- Low self-worth
- Anxiety attacks and/or panic attacks
- Talking too fast
- Acting impulsively
- Poor grades in school
- Behavioral Problems at school
- Other problems (describe): \_\_\_\_\_

We also have clinical trials for treatment of many common conditions such as Attention Deficit Disorder, Depression, Bipolar disorder and Anxiety Disorders. These research programs help with the advancement of treatment options and you may be eligible for compensation for your time and participation.

***Would you be interested in being contacted about clinical trials for which you might be eligible?***

- Yes
- No

Describe the problem(s) you most want us to help your child with:

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List any medications your child is currently being prescribed:

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List any recent surgeries, illnesses, or hospitalizations:

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Are you interested in seeing a specific clinician? If so, please list the clinician's name. \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

If another clinician referred you or recommended you to us, please tell us their name. \_\_\_\_\_

Is your child being treated by another mental health clinician? \_\_\_\_\_