NORTHSIDE BEHAVIORAL HEALTH CENTER

MR# (Office Use Only):	Date:	Social Security#	
Last Name:	First Name:		Middle Initial:
Address 1 (Mailing):			
Address 2 (Physical):			
City:	State:	Zip:	County:
Gender: ___Male ___Female		Date of Birth:	Age:
Home Phone: ( )	Work Phone: ( )	Other Phone: ( )	
Who referred you to Northside?			
Employment Status (circle one):			
If Working: Full Time Active Military Part Time Unpaid (Family Business)			
If Not Working: Homemaker Student Disabled/Unable to Work Criminal Inmate Inmate-Other Not Authorized to Work Retired On Leave of Absence Unemployed (in Labor Force)			
Marital Status (circle one): Single Married Divorced Separated Widow Cohabitate Child Reg Domestic Partner			
Primary Language:	Language(s) Spoken:		
Race (circle one): White Black Native American Alaska Native Asian Hawaiian/Pacific Islander Multi Racial Other			
Ethnicity (circle one): Puerto Rican Mexican Cuban Mexican -American Haitian Other Latino Non-Hispanic Other Hispanic None of the Above			
Religion:			
Education Level: No Years of Schooling; Kindergarten; Nursery School/Preschool/Head Start; School Grade:_____; High School Graduate (Diploma/GED); Associate Degree; Bachelor Degree; Master Degree; Professional Degree; Doctorate Degree; Special School; Vocational School; College Undergraduate Year 1 2 3 4			
Living Arrangements (circle one):			
Assisted Living Facility (ALF); Dependent Living - with Non-Relative; Dependent Living - with Relatives; Foster Care/Home; Homeless; Hospital; Independent Living – Alone; Independent Living - with Non-Relatives; Independent Living - with Relatives; Jail or Correctional Facility; Mental Health Assisted Living Facility (ALF); Nursing Home; Other:_____; Group Home (Residential, Rehab, etc.); Supported Housing			
Current Living Situation (circle one): Stable Homeless Shelter Streets			
Veteran Status:			
Military Service Yes No	Military Related Disability Yes No		

Military Status:	Active	Reserve	National Guard	Inactive	Veteran	Retired
Last Branch of Service:	Air Force	Army	Coast Guard	Marines	Navy	Public Health
Discharge Type:	Honorable	General	Medical	Dishonorable		
Discharge Year:						

NORTHSIDE BEHAVIORAL HEALTH CENTER

Insurance/Guarantor Information:

Circle One Insurance Type: No Insurance Medicaid Private Insurance Medicare Other: _____

Private Insurance Name: | Policy #:

Address:

Phone #:

Name of Person Financially Responsible: | Relationship:

Address of Person Financially Responsible:

Phone # of Person Financially Responsible:

SSN #_____ | Gender: Male Female | DOB: ____/____/_____

Employment Status:

Employer Name:

Employer Address:

Emergency Contact:

Name: | Relationship: | Living with you? Yes No

Address:

City: | State: | Zip: | County:

Home Phone: ( ) | Work Phone: ( ) | Other Phone: ( )

Individual Income: $ **Circle One:** Weekly Bi Weekly Monthly Yearly

Total Family Income: $ **Circle One:** Weekly Bi Weekly Monthly Yearly

Additional Source of Income (circle): SSI SSDI AFDC Food Stamps Cash (SSI)

Child Support Other: _____

Number of Children in Household: | Number of Adults in Household:

Disability Status - please circle Yes or No:

Hearing Disability	Yes	No
Physical Disability	Yes	No
Visual Disability	Yes	No
Speech Disability	Yes	No
Learning Disability	Yes	No
Limited English	Yes	No

Next Of Kin:

Name: | Relationship:

Address:

City: | State: | Zip: | Phone: ( )

Does the individual seeking services have a Legal Guardian: Yes No

If YES, Legal Guardian's Name:

Medical Problems:

Please check if you have had any of the following:

☐ Breathing Problems	☐ Diabetes	☐ Glaucoma	☐ Sleep Problems	☐ Venereal Disease
☐ Asthma	☐ Thyroid Disease	☐ Heart Disease	☐ Headaches	☐ HIV/AIDS
☐ Kidney Problems	☐ Epilepsy/Seizures	☐ Hypertension	☐ Head Injury	☐ Other: _____
☐ Bladder Problems	☐ Liver Disease	☐ Intestinal Problems	☐ Hepatitis	☐ Other: _____

My signature is to certify that the above information is true and accurate.

_____ _____

Signature of Individual Completing Form **Date**

Patient Financial Affidavit

Patient

Name_____ **Date of Birth:** _____

Number in Household: _____ **Annual Household Income:** _____

0% will be assessed a minimum fee of $3.00 per Outpatient chargeable service or $2.00 a day for Residential service.

Eligible Family Annual Income

150% Minimum Income	150% Maximum Income	NUMBER IN HOUSEHOLD							
		1	2	3	4	5	6	7	8
$0.00	$21,870.00	0%	0%	0%	0%	0%	0%	0%	0%
$21,870.01	$29,580.00	5%	0%	0%	0%	0%	0%	0%	0%
$29,580.01	$37,290.00	10%	5%	0%	0%	0%	0%	0%	0%
$37,290.01	$45,000.00	15%	10%	5%	0%	0%	0%	0%	0%
$45,000.01	$52,710.00	25%	15%	10%	5%	0%	0%	0%	0%
$52,710.01	$60,420.00	35%	25%	15%	10%	5%	0%	0%	0%
$60,420.01	$68,130.00	45%	35%	25%	15%	10%	5%	0%	0%
$68,130.01	$75,840.00		45%	35%	25%	15%	10%	5%	0%
$75,840.01	$83,550.00			45%	35%	25%	15%	10%	5%
$83,550.01	$91,260.00				45%	35%	25%	15%	10%
$91,260.01	$98,970.00					45%	35%	25%	15%
$98,970.01	$106,680.00						45%	35%	25%
$106,680.01	$114,390.00							45%	35%
$114,390.01	$122,100.00								45%
$122,100.01	$129,810.00								
$129,810.01	$137,520.00								

I hereby attest that my Annual Household income reported is correct.

_____ _____ _____ _____

Patient/Guarantor Signature **Date** **Witness Signature** **Date**

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BAYCARE BEHAVIORAL HEALTH SERVICES
FINANCIAL APPLICATION FOR FUNDING
BC BH 5328 **Rev. 01/23**

PATIENT

FIN# _____

CPI# _____

Northside Behavioral Health
Orientation to Services

Name: _____ Case # _____

Date of Admit: _____

General Orientation: ☐ **Northside Orientation Guide Provided**
☐ **Northside Orientation Guide Previously Provided**

My Rights and my responsibilities	Corporate responsibility
Ways I can provide input	Standards of professional conduct
Confidentiality and Notice of Privacy Practices	Consent to treatment
Grievance and appeal process	Infection control practices
Health and safety practices	Advanced Directives
Response to potential risk	Psychiatric Advanced Directives
Financial obligations	Voter Registration
Important phone numbers including Abuse Registry number	

I received information on the above items and understand I can ask questions at any time.

_____ _____
Client Date / Time

_____ _____
Legal Guardian Signature (if applicable) Date / Time

NORTHSIDE BEHAVIORAL HEALTH SERVICES

Client Agreement and Consent

Last Name:	First Name:	MI
MR#	RU#:	Date:

As a condition of my admission to Northside Behavioral Health, I hereby agree to the following:

CONSENT TO TREATMENT: I hereby authorize the physician/clinician in charge of my care and Northside Behavioral Health to oversee my treatment plan and monitor my behavioral health medication as required by my behavioral health symptoms. I understand that, under the direct supervision of my treating physician, an Advanced Registered Nurse Practitioner may be utilized in my care and treatment.
I voluntarily consent to treatment.

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION: I hereby authorize Northside Behavioral Health and or/any treating physician/clinician to obtain, use and/or release information (current and historical) for the purpose of treatment, payment and/or operations as outlined in the Notice of Privacy Practices. This may include collection agencies and credit bureaus and will be limited to the minimum amount necessary (including psychiatric, drug abuse, alcohol or HIV status). I hereby authorize Northside Behavioral Health and/or the treating physician/clinician to release information from my medical records to other healthcare facilities/providers to which I may be transferred for emergency services.

MEDICARE / MEDIGAP / MEDICAID / CLIENT CERTIFICATION / RELEASEOF INFORMATION & PAYMENT REQUEST:
I certify that the information given to apply for payment under title XVIII and/or XVIII and/or Title XIX, of the Social Security Act is correct. I authorize and holder of behavioral health information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare, Medigap or Medicaid for payment to me. I understand that I am responsible for any health insurance deductibles and co-payments. An itemized statement is available upon request.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, grant and transfer to Northside Behavioral Health, now and in the further, all my right and interest in the following: (a) Any and all benefits now or in the future owed or receivable by me or on my behalf from any insurer, health maintenance organization, PPO, employer health benefit plan or other third-party payor for those costs I incur in receiving services from Northside Behavioral Health. and (b) Any and all monies or other benefits paid or payable to me and/or my attorneys from any settlement, judgment or verdict which is obtained as a result of the injury or medical condition for which my debt to Northside Behavioral Health was or is to be incurred. I agree that should the amount received by Northside Behavioral Health be insufficient to cover the entire expense of service, including the co-payment and the deductible, I will be personally responsible for payment of the difference. I also understand and agree that if the nature of the services rendered by Northside Behavioral Health is not covered by said insurance policy, I am responsible to Northside Behavioral Health for payment of the entire bill.

GUARANTEE OF PAYMENT: For value received, the undersigned does agree to guarantee and promise to pay Northside Behavioral Health and/or any treating physician all charges and expenses incurred in the treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. If any action at law or inequity is brought to enforce this agreement, Northside Behavioral Health understanding that all bills are payable and become due upon presentation. I understand and agree that if Northside Behavioral Health is required to bring claim or file an action to enforce this agreement, Northside Behavioral Health shall be entitled to recover from me its reasonable attorney's fees, court costs, and any other costs of collections, in addition to the amount owed Northside Behavioral Health for its services.

DENIAL OF PAYMENT AUTHORIZATION: Northside Behavioral Health will make every effort to obtain payment authorization/preauthorization for all managed care contractual agreements. If, however, a denial is received, the Client/guarantor will be responsible for all incurred charges and penalties, payable and become due upon presentation.

CLIENT

NORTHSIDE BEHAVIORAL HEALTH SERVICES

Client Agreement and Consent

RELEASE OF RESPONSIBILTY AND LIABILITY FOR PERSONAL VALUABLES: I understand and agree that Northside Behavioral Health is not responsible for personal valuables or belongings brought into, or claimed to have been brought into the facility, by named Client/client or his/her agent. Personal valuables or belongings include, but are not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devises (such as hearing aides, artificial limbs, or assist devices such as: canes, walkers, or wheelchairs), credit cards, jewelry and money. I understand that a locked safe is available for securing my personal valuables small enough to fit in a security envelope.

DISCLOSURE OF ADMISSION FOR TREATMENT

Northside Behavioral Health will neither confirm nor deny your admission status without your consent /authorization, except when required by the Florida's Mental Health Act (Baker Act), S.394.4597 AND S. 394.4599, F.S.

AUTOMATED COMMUNICATION: I hereby expressly consent to allow the Facility and/or Provider (and/or business associates/third party collection agencies of the Facility and/or Provider) to contact me (including, but not limited to, through the use of contact information and/or telephone numbers that I have provided to the Facility and/or Provider) via telephone, text message, cellular phone, electronic mail and/or any other form electronic communication using pre-recorded messages, auto-dialers, and/or other forms of automated/electronic communication. Electronic communication can be intercepted in transmission or misdirected. Your use of electronic communication to us indicates that you acknowledge and accept the possible risks associated with such communication.

RECEIPT OF CLIENTS RIGHTS & RESPONSIBILITIES, NOTICE OF PRIVACY PRACTICES, AND ORIENTATION GUIDE: By my signature on this document, I acknowledge receipt of a Client's rights and responsibilities pursuant to Florida statute 381.026, a Notice of Privacy, and a copy of the Orientation Guide, prior to or at the time of admission.

I HEREBY AGREE THAT THE TERMS OF THIS AGREEMENT HAVE BEEN COMPLETELY READ, FULLY UNDERSTOOD AND ARE VOLUNTARILY ACCEPTED; THAT I HAVE VOLUNTARILY AND WITH FULL UNDERSTANDING EXECUTED THIS AGREEMENT; THAT I HAVE ACCEPTED ITS TERMS AND CONDITIONS; THAT I WILL RECEIVE A COPY OF THIS AGREEMENT UPON REQUEST; AND THAT I AGREE THAT A COPY OF THIS AGREEMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

Client Signature	Parent/Guardian Signature	Date	Time
Signature of Client's Authorized Representative		Date	Time
Witness Signature		Date	Time

CLIENT

Authorization to Use or Disclose Protected Health Information

- ☐ BayCare Alliant Hospital
- ☐ BayCare Behavioral Health
- ☐ BayCare Hospital Wesley Chapel
- ☐ Bartow Regional Medical Center
- ☐ Mease Countryside Hospital
- ☐ Mease Dunedin Hospital
- ☐ Morton Plant Hospital
- ☐ Morton Plant North Bay Hospital
- ☑ Northside Behavioral Health
- ☐ St. Anthony's Hospital
- ☐ St. Joseph's Hospital
- ☐ St. Joseph's Children's Hospital
- ☐ St. Joseph's Women's Hospital
- ☐ St. Joseph's Hospital – North
- ☐ St. Joseph's Hospital – South
- ☐ South Florida Baptist Hospital
- ☐ Winter Haven Hospitals
- ☐ _____

I authorize the above facility to release medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY)		Phone:	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):
This information for which I'm authorizing disclosure will be used for the following purpose:
Description: PCP Notification, Coordination of Services
Date(s) of Service: ____/____/____ through ____/____/____

- ☐ Discharge Summary
- ☐ Emergency Room Record
- ☐ Operative/Procedure Report
- ☐ Visit Summary
- ☐ Billing Records
- ☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____
- ☐ Psychotherapy Notes
- ☑ Other (Immunization Records, Medication Lists) Please specify: medication list,Verbal/ Written Communication
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan

How would you like your records delivered? (Choose one)

☐ Paper ☐ CD ☐ Mail or ☐ In-Person Pickup	☐ Electronic (Must have BayCare Patient Portal Account) ☐ Patient Portal

Where do you want the information sent? (Fill in boxes below):

Name:	Phone:
Mailing Address:	Fax:

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for 1 year from the date signed below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signed: _____ Date: _____ Time: _____
Patient or Authorized Person, ☐ Parent ☐ Legal Guardian ☐ Executor ☐ Power of Attorney
☐ Photo ID checked
Witness: _____ Date: _____ Time: _____
Copied by: _____ Date: _____ Time: _____ Pages copied: _____

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
BC 4761 Rev. 02/23

PATIENT

Authorization to Use or Disclose Protected Health Information

- ☐ BayCare Alliant Hospital
- ☐ BayCare Behavioral Health
- ☐ BayCare Hospital Wesley Chapel
- ☐ Bartow Regional Medical Center
- ☐ Mease Countryside Hospital
- ☐ Mease Dunedin Hospital
- ☐ Morton Plant Hospital
- ☐ Morton Plant North Bay Hospital
- ☑ Northside Behavioral Health
- ☐ St. Anthony's Hospital
- ☐ St. Joseph's Hospital
- ☐ St. Joseph's Children's Hospital
- ☐ St. Joseph's Women's Hospital
- ☐ St. Joseph's Hospital – North
- ☐ St. Joseph's Hospital – South
- ☐ South Florida Baptist Hospital
- ☐ Winter Haven Hospitals
- ☐ _____

I authorize the above facility to release medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY)		Phone:	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):
This information for which I'm authorizing disclosure will be used for the following purpose:

Description: Pharmacy Prescriptions

Date(s) of Service: ____/____/____ through ____/____/____

☐ Discharge Summary ☐ Emergency Room Record ☐ Operative/Procedure Report ☐ Visit Summary ☐ Billing Records

☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____ ☐ Psychotherapy Notes

☑ Other (Immunization Records, Medication Lists) Please specify: medications, allergies ☐ Psychiatric Evaluation ☐ Treatment Plan

How would you like your records delivered? (Choose one)

☐ Paper ☐ CD ☐ Mail or ☐ In-Person Pickup	☐ Electronic (Must have BayCare Patient Portal Account) ☐ Patient Portal

Where do you want the information sent? (Fill in boxes below):

Name:	Phone:
Mailing Address:	Fax:

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for 1 year from the date signed below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signed: _____ Date: _____ Time: _____

Patient or Authorized Person, ☐ Parent ☐ Legal Guardian ☐ Executor ☐ Power of Attorney

☐ Photo ID checked

Witness: _____ Date: _____ Time: _____

Copied by: _____ Date: _____ Time: _____ Pages copied: _____

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

BC 4761 Rev. 02/23

PATIENT