COMPASS COUNSELING SERVICES

Helping You Towards A Better Direction

Confidential Patient Intake Form

PATIENT DEMOGRAPHICS

Patient's Full Name_____ Preferred Name:_____

Patient's D.O.B.: _____ Age: _____ Sex: ☐ Male ☐ Female

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address: _____ Apt/Suite #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ ☐ May we leave a message here: ☐ Yes ☐ No

Mobile Phone: _____ ☐ May we leave a message here: ☐ Yes ☐ No

Work Phone: _____ ☐ May we leave a message here: ☐ Yes ☐ No

Email Address: _____ ☐ May we send a message here: ☐ Yes ☐ No

Referred by: _____

PRIMARY CARE PROVIDER- must provide

Physician's Name: _____ Office phone #: _____

Street address: _____

City: _____ State: _____ Zip: _____

PSYCHIATRIST

Psychiatrist's Name: Office phone #: _____

Street address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

PRIMARY PARTY INFORMATION (Please complete all areas in this section regarding the primary insurance holder.)

Primary Policy Holder's Name: _____ D.O.B.: _____

Social Security #: _____ Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Other

Street Address: _____ Apt/Suite#: _____

Home Phone: _____ Cell Phone: _____

Employer: _____

ORLANDO OFFICE
1400 North Semoran Blvd. Suite E Orlando, Fl 32807
Phone: 407-823- 8421 Fax: 407-823-8195

KISSIMMEE OFFICE
201 Ruby Ave, Suite B Kissimmee, Fl. 4741
Phone: 407-933-1847 Fax: 407-933-1849

RESPONSIBLE PARTY AGREEMENT

Insurance Company Name: _____ Insurance phone # _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Policy/ID#: _____ Insurance Group #: _____

I certify that the above information is true and correct. I agree to take responsibility for the any amounts not covered by this insurance, including copayments and deductibles which are due for any and all services rendered by Compass Counseling Service, LLC.

Patient/Parent/Guardian/Guarantor Signature Date

Patient Name (Print) D.O.B.

NOTIFICATION OF POLICY CHANGES

LATE APPOINTMENT CANCELLATION & NO-SHOW PROCEDURES:

(Please Initial)

_____Patient, Parent, Or Guardian are expected to attend all scheduled appointment as agreed upon with their primary Psychotherapist and/or Psychiatrist.

_____A missed or cancelled appointment is costly to the practice and to the other individuals who are in need of available services.

_____Patient who fail to show for their appointments and/or who do not notify the practice *24 hours (or more) in advance* of a planned absence, will be charge **a TWENTY FIVE DOLLAR ($25) FEE.**

_____As insurance does not pay for these appointments; the patient/guarantor is responsible.

_____Three canceled and/or missed appointments could result in being discharged from care.

_____If patient is discharged he/she will receive a 30 day notification letter along with a list of possible referrals. Purpose of notification is to provide enough time for patient to access another service provider. Copies of all correspondence are to be placed in the patient's medical record.

_____If a patient arrives 15 minutes after the appointed hour, it will be necessary to reschedule the appointment.

PATIENT ACKNOWLEDGEMENT:
I have reviewed the above policy change and understand the procedures regarding late cancellations or no-show.

_____

Name (please print) Date

Signature (if not patient state relationship)

URINE DRUGSCREEN POLICY

Routine and urine drug screening (UDS) has become a standard of care in managing patients.

All new patients should have UDS with confirmation routinely.

UDS will be a requirement for treatment to every "established" adult patient (18 years old and older) if:

a) The patient tested positive for an illicit or undisclosed controlled substance on the day of the first visit;

b) The patient was started/continued on controlled substances on the first visit;

c) Active chemical dependency/dual diagnosis or illicit substances abuse/recreational use is endorsed or documented by the time of the Psychiatric Evaluation;

d) At any time according to clinical judgment of the Compass Counseling Psychiatric or Psychotherapist.

A negative UDS plus confirmation will be a requirement for a Psychiatric Evaluation and Psychotropic medication management in every minor (less than 18 years old) **WITH NO EXCEPTIONS.**

A negative UDS and confirmation is a requirement for prescriptions of **CONTROLLED SUBSTANCES** for 18 years or older with no exceptions.

PrintName:_ Date:

Signature (If not patient or patient state relationship)

Witness: Date: _____

RIGHTS AND RESPONSIBILITIES AS A PATIENT OF COMPASS COUNSELING SERVICES, LLC

Welcome to Compass Counseling Services, LLC. We hope that we can give you the kind of support and help that you are looking for.

When you receive services from CCS you have the right to:

- **Receive high-quality service**
- **Be treated with respect and courtesy**
- **Have your information kept private and confidential except as described in CCS *privacy statement*.**
- **Be listened to and have staff work with you to make a plan to address your concerns and needs.**
- **Receive service in offices that are safe, clean and accessible.**
- **Get information and support to help you make decisions to improve your situation.**
- **Be served without discrimination.**
- **Discuss your service with staff to identify if it is working for you and express any questions or complaints that you may have.**
- **Request a change of provider member if there is another provider available who can address your issues and your request is reasonable -- you should know that discriminatory requests will not be considered.**

This is what we ask from you:

- **Treat the staff and others at CCS with courtesy and respect.**
- **Let CCS know 24 hours before if you cannot come to an appointment. Please refer to CCS's policy on late cancellation/No shows.**

_____ _____

Patient Signature and/or Legal Guardian if minor **Date:**

_____

Witness: