BRANCH PSYCHIATRY & ASSOCIATES.
GENERAL & CHILD/ADOLESCENT PSYCHIATRY
1806 TOWN PLAZA CT WINTER SPRINGS, FL 32708
PH: 407-542-4946 FAX: 407-695-3674

GENERAL INFORMATION Date**:** _____

Patient Name: _____ Date of Birth: _____
Sex: _____ Email: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Cell: _____ Secondary Number: _____

PARENT/GUARDIAN NAME (IF PATIENT IS A MINOR)

Name: _____ Relationship to Patient: _____
Address: _____ City: _____ State: ____ Zip: _____
Cell # _____ Work: _____

Name of nearest relative not living at home: _____
Cell**:** _____ Relationship**:** _____

Pharmacy Information: _____ Ph: _____

Address: _____ City: _____ State: ____ Zip: _____

AUTHORIZATION FOR TREATMENT

I hereby authorize Myrtho Mompoint-Branch, M.D. to administer treatment.
I understand that information of the nature and purpose of treatment common side effects and alternative treatment modalities Will be provided to me, and that consent can be revoked orally or in writing prior to or during the treatment period.
Appointment cancellations require 24-hour advance notice. I understand that I will be charged the total copayment (up to $150.00) for a missed appointment without prior cancellation.

Signature of Patient/ Representative: _____ Date: _____

Relationship to patient: _____

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Patient Name: _____ DOB: _____ Date: _____

PRIMARY INSURANCE INFORMATION

Name of Policyholder**:** _____ DOB: _____ Sex: ____

Relationship to Patient: _____ Insurance Policy # _____

Insurance Company: _____ Phone # _____

Group # _____ Is this through employer? _____ Employer: _____

ASSIGNMENT OF INSURANCE BENEFITS:
I authorize payment of benefits to Myrtho Mompoint-Branch M.D., otherwise payable to the patient or guarantor. I also assign all rights to insurance coverage relative to this treatment, interpretation and/or examination.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION:
I give permission for Myrtho Mompoint-Branch, M.D. to disclose any medical, psychiatric, alcohol and/or drug abuse information contained in my record to my insurance company for the purpose of review and authorization.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Print name and Relationship to Patient Date

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CONSENT FOR TREATMENT WITH PSYCHOTROPIC MEDICATIONS

Patient name: _____ Date of birth: _____

During my initial evaluation, my provider will explain to me the nature of my mental health disorder, and will decide the best course of treatment with one or more of the following medications:

Note: AD=antidepressant; AP-antipsychotic; AX=anti-anxiety; CB=cognitive enhancer; MS=mood stabilizer; SH=sedative hypnotic; PS=psychostimulants; NPS=non psychostimulant for ADHD

The risks and benefits of taking medication will be discussed as well as other possible alternative treatments.

The most common side effects associated with the medication(s) will be explained and I understand that other possible side effects from my medication(s) may occur. If any untoward side effects / adverse effects should occur, I will promptly notify my provider.

My signature below represents that I am consenting to treatment with medication.

_____ _____
Signature of patient or representative Date

_____ _____
Print name of representative and relationship. Date

Authorization to communicate:

☐ I give consent for the office to reach me in the form of a secure email or phone call**.**

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Date: _____

FINANCIAL POLICY

(Please **initial** to acknowledge understanding of the following)

____ Co-Pays, deductibles, and coinsurances are collected at the time of visit.

____ Appointment cancellations require 24 HR advance notice. A fee of $150.00 will be charged for No-Show confirmed appointments as well as for cancellation calls received the same day of the appointment.

____There is a charge of $1.00 per page for copying medical records, including lab results.

____There is a charge for requested letters:

- FMLA: $35
- Short Letters: $25
- Long Letters: $45
- Summaries of treatment: $50
- 504 plan (short) for school children: $10

____There is a $2.00 fee for payments not paid at the time of the visit.

Notice: We do not accept checks. Form of payment is accepted by cash or card.

The office of:
Dr. Myrtho Mompoint Branch - MD
1806 Town Plaza Court
Winter Springs, FL 32708
PH: 407-542-4946 FAX: 407-695-3674

CREDIT CARD AUTHORIZATION FORM/ FINANCIAL POLICY
RECURRING PAYMENTS FOR SERVICES RENDERED

Per our office policy, we require to retain credit card information on file to collect for all services rendered including missed appointments, known as a "No Show". The Credit Card on file will pay for Patients copay payments, front end deductibles requirement based on their insurance verification of benefits, known as "VOB, coinsurance payments and/or self pay payments not covered by the patient's insurance provider.

I, _____, authorize the office
(PRINT NAME)
Dr. Myrtho Mompoint Branch - MD, "Branch Psychiatry & Associates", to deduct for any and/or all services as stated above and/or within this Credit Card Authorization Form/ Financial Policy.

Patient services , *OTHER THAN MYSELF*, Which I am in agreement for the credit card on file to be processed for their completed services:

_____
(PRINT PATIENT'S NAME, RECIPIENT OF PAYMENT RENDERED BY CARD HOLDER)

CREDIT CARD SELECTED: CHECK ONE

VISA ☐ MASTERCARD ☐ DISCOVER ☐

AMERICAN EXPRESS CARDS ARE NOT ACCEPTED

Credit Card #_____

Card Holder Name:_____

CVV_____ Exp. Date_____ Zip Code_____

Mailing Address:_____

A credit card authorization may be rescinded as long as all services are paid in full and no other recurring appointments will be scheduled.

I authorize the use to my credit card and agree to the guidelines contained within this form:

_____ _____
Card Holder Signature Date

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TELEHEALTH CONSENT FORM

By signing this form, you agree to the following points:

1. I authorize Branch Psychiatry & Associates to use appropriate telecommunication technologies for the purposes of evaluating and diagnosing my medical condition and any health complaints.

2. I understand that technical issues may arise before or during telehealth sessions and, on occasion, my appointments may not start or end at agreed-upon times.

3. I accept that medical professionals will attempt to contact me using video conferencing software. However, I also understand that other communication channels, such as telephone calls, may be used in case of internet connectivity or other issues.

4. I understand that my insurance plan may not encompass telehealth services. In cases where my insurance plan does not cover any expenses which have been incurred, I will be personally liable to cover these expenses.

5. I understand that I can't be driving during telehealth sessions for my own safety and will park in a safe location if I'm in a vehicle.

I AGREE TO THE TERMS AND CONDITIONS LISTED ABOVE.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Print name and Relationship to Patient Date

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of this Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____

Authorization for Release Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____ Phone # _____
Street Address: _____ City/state/zip: _____

I Authorize the Release Use and Disclosure of Protected Health Information about the Above Individual as Described Below

Myrtho Mompoint Branch, M.D. Child, Adolescent & Adult Psychiatry
1806 Town Plaza Court, Winter Springs, FL 32708
Phone: 407-542-4946
Fax: 407-695-3674

This information may be ☐ Released to or ☐ obtained from:

Name of Facility/Individual: _____

Street Address: _____ City/State/ Zip: _____

Phone #_____ Fax# _____

The Purpose of this disclosure

☐ Changing Physician	☐ Legal Investigation	☐ Other (please specify)
☐ Mental Health Treatment	☐ Inspection/copying of records	
☐ Academic Performance	☐ Personal	

The Type of Information to be disclosed is as Follows

☐ Complete Record	☐ Abstract Of Medical record	☐ Educational Evaluation/records	☐ **Other (explain below)**
☐ Intake/Discharge summaries	☐ Medical History & Physical	☐ Letter/ summary of treatment	
☐ Mental Health Evaluations	☐ Test Results	☐ Verbal Communication	
☐ Progress notes	☐ X-ray and Imaging Reports	☐ **Laboratory Results (RECENT)**	

I Understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency Virus (HIV). It may also include information about behavioral or mental Health services and treatment for alcohol and/or substance abuse. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under terms of this authorization.

I understand that I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires within six (6) months, unless otherwise specified. Other specified expiration date:

Signature of patient or patient's representative: _____ **Date:** _____

Print Name of patient/ representative: _____ **Relationship:** _____

•**Minor** _____ •**Dependent** _____ •**Other** _____