BLUEWATER BEHAVIORAL HEALTH

4400 East Highway 20, Suite #313, Niceville, FL 32578* Receptionist (850) 797-2598 * Nurse (850) 797-1344 * Fax (850) 807-5127

Name (Last, First, MI)	SSN	Date of Birth	Marital Status
Address	City, State, Zip	Currently Employed? YES NO	Place of employment?
Cell Phone #	Email Address	Emergency Contact Name	Emergency Contact Phone #
Are you applying for any type of disability or workers compensation? YES NO If Yes, explain:			
If any, please describe your military background: Branch: Years of service: Active duty or Retired:			Highest Level of Education Completed:
If patient is under 18 or not the insured party, please fill out the responsible party's information below:			
Name (Last, First, MI)		Relationship to Patient	Date of Birth
Address (If different than above)	City, State, Zip	Phone Number	
Payment Information			
Primary Insurance Or Cash?	ID Number	Secondary Insurance Carrier	ID Number
Sponsor Name (Last, First, MI)	Date of Birth	Sponsor Name (Last, First, MI)	Date of Birth
Current Medications: List ALL psychiatric and medical medications currently prescribed to you.			
Medication	Dosage	Times Taken Per Day	

Past Psychiatric Medications: Please list all past psychiatric medications taken and why you stopped taking it.	
Medication	Why you stopped taking it
Medication Allergies: Please list below any allergies to medications and the reaction.	
Medication	Reaction

Substance Use: Please list substances you are using or have used in the past below.			
Nicotine Intake: Do you smoke/vape? YES NO	If so, approximately how much per day?	How many years?	
Caffeine Intake: Do you drink caffeinated beverages? YES NO	If so, approximately how many per day?	Type of beverages typically consumed: Coffee Tea Soda Energy Drinks Other: _____	
Alcohol Intake: Do you consume alcoholic beverages? YES NO	If so, approximately how many per week?	Type of beverage typically consumed:	
Do you, or have you, ever taken unprescribed drugs, legal or illegal? YES NO	If so, what type?	Are you still using any of these drugs? YES NO Which One(s)?	
MENTAL HEALTH HISTORY			
Past and Recent Psychiatric Providers: Please list all current, recent and past mental health providers you have seen.			
Name	Location	Name	Location
Psychiatric Inpatient Hospitalizations:			
Name	Location	Date	
Known Psychiatric/Mental Health Diagnoses: Please check below any previously diagnosed mental health disorders.			
Depression	Anxiety	OCD	Panic Disorder
Bipolar	Substance Use Disorders	Eating Disorder	PTSD
Schizophrenia Spectrum Disorders	Dissociative Disorder	Anorexia	Bulimia
Pica	Erectile Disorder	Sexual Disorder	Tic Disorder
Insomnia	Narcolepsy	ADHD	Histrionic Personality Disorder
Autism Spectrum Disorder	Conduct Disorder	Tourette's Disorder	Agoraphobia
Borderline Personality Disorder	Dependent Personality Disorder	Multiple Personality Disorder	Adjustment Disorder
Alzheimer's Disease	Dementia	Brief Psychosis	Delusional Disorder
Gender Dysphoria	Hoarding	Gambling Disorder	Pseudobulbar Affect
Cyclothymia	Schizoaffective Disorder	Dysthymia	Bereavement
Trichotillomania	Other:		
Family Mental Health History: Please list diagnoses and family members with any known mental health disorders.			
Family Member	Diagnosis	Family Member	Diagnosis

MEDICAL HISTORY			
Current Primary Care Provider	Location (City)	Are you currently sexually active? YES NO	If yes, are you trying to get pregnant? YES NO N/A
Personal Medical History Please check any condition below that applies to your personal medical history.			
Diabetes	Hypertension	High Cholesterol	Stroke
Chronic Pain	GERD/Acid Reflux	Allergic Rhinitis	Cancer
Asthma	COPD/Emphysema	Hypo/Hyperthyroidism	Fibromyalgia
Vision Problems	Arthritis	Irritable Bowel Disease	Sleep Apnea
Congestive Heart Failure	Heart Disease	Parkinson's Disease	Seizures
Stroke	Seizures/Epilepsy	Kidney Disease/Failure	Other:
Please list any past surgeries:			
Family Medical History Please circle and list any family member diagnosed with any of the below medical conditions.			
Diabetes Family member:	Hypertension Family member:	High Cholesterol Family member:	Asthma Family member:
Allergic Rhinitis Family member:	GERD/Acid Reflux Family member:	Sleep Apnea Family member:	COPD/Emphysema Family member:
Hypo/Hyperthyroidism Family member:	Vision Problems Family member:	Arthritis Family member:	Fibromyalgia Family member:
Vision Problems Family member:	Arthritis Family member:	Fibromyalgia Family member:	Kidney Disease/Failure Family member:
Stroke Family member:	Heart Disease Family member:	Seizures/Epilepsy Family member:	Cancer Family member:
Parkinson's Disease Family member:	Other: Family member:	Other: Family member:	Other: Family member:

INFORMED CONSENT FOR MENTAL HEALTH EVALUATION/TREATMENT

Initials_____	I hereby voluntarily consent to mental health treatment. I understand that this may include psychiatric evaluation, medication management and/or psychotherapy either individually or with my family. I understand that my health information will be held private unless as described/outlined in the Privacy of Health Information Practices document I reviewed/received.
Initials_____	I have been requested to participate in a court-ordered psychological evaluation/treatment program. The results of the evaluation or treatment progress will be reported to: _____.

APPOINTMENT POLICY

Thank you for choosing Bluewater Behavioral Health, Inc. We are committed to your successful treatment. The following is our appointment policy which we request you read, understand, and sign prior to treatment.

It is your responsibility to schedule follow-up appointments to ensure you do not run out of medication. Appointment availability could be as long as 8 weeks out. Failure to schedule appointment before medication refill is due or missing the appointment will result in a $25 administrative fee for medication refill. Refills without an appointment are limited to 1 time, additional occurances may result in termination of treatment.

If you are unable to make your scheduled appointment, we must be notified **AT LEAST 24 HOURS/1 BUSINESS DAY IN ADVANCE**. If staff does not receive proper notification, the time scheduled with your clinician becomes a missed opportunity and delay for another patient to be seen. If two or more sessions are missed without proper notification, you may not be able to continue services with Bluewater Behavioral Health. I also Acknowledge that I may be charged a no-show fee for missed appointments or those appointments without propper notification.

Please note: appointment confirmations are a courtesy ONLY. You are responsible for your appointment date and time.

My signature acknowledges that I have read, fully understand and agree to all parts of this appointment policy.

MEDICAID INSURANCE

Bluewater Behavioral Health is not a Medicaid participating provider. Thereby, it is illegal for Bluewater Behavioral Health to see patients who have Medicaid insurance benefits.

_____ I hearby attest that I do not qualify for any Medicaid benefits or have Medicaid insurance coverage.

FINANCIAL POLICY

All payments (i.e. co-pays, co-insurance, deductibles) ARE DUE AT TIME OF SERVICE. Payments are accepted in the form of cash, check, money order, and credit card (Visa, Mastercard, Discover, American Express Accounts must remain in good standing to continue receiving treatment at Bluewater Behavioral Health. In the event that your insurance denies your claim, you will be charged the cash pay rate for the appointment. Additional charges due once remittance is received will be charged to the card on file. All unpaid balances must be paid before making additional appointments. Cash fee rates for 2022 are as follows. Intake or 1 Hour follow-up = $250, Follow-up 30 minute appointment $175, 15 Minute Consult $85, Med refills without appointment $25. Fee changes are at the discretion of the provider.

A $30.00 service fee will be added to your account for each returned check from your bank. Only cash payment will be accepted if two NSF

Refunds or overpayment reimbursements are only made after full insurance reimbursement and patient responsibility is paid in full for all services rendered on your account.

_____ I understand that I may not be rescheduled or provided refills if my account balance exceeds $50.

_____ I understand if I do not attend my scheduled follow-up appointment and fail to notify the office at least 24 hours/1 Business day in advance, I may be charged a $65 no-show/late cancellation fee per first follow-up visit missed. Additional no-show/late cancellations will be charged $85. The first missed intake appointments will be charged $100, and may result in denial of future treatment/appointments. A second missed intake appointment will be charged $200. Two or more no-shows/late cancellations may result in termination of treatment. Fee is not applicable to VA patients.

_____ I have read, fully understand and agree to all parts of this financial policy. I understand that my account may be turned over to a collection agency if it becomes delinquent.

Credit Card #	Exp Date	CVV	Billing Zip Code

PATIENT BEHAVIOR POLICY

_____ I understand effective clinical relationships are founded on mutual respect. In the event that a patient or family member violates this principal, they will be given a warning which will be documented in the patients chart. Further violations will result in the immediate discharge for cause from the clinic.

PRIVACY OF HEALTH INFORMATION PRACTICES CONSENT

Bluewater Behavioral Health and staff can communicate via e-mail on matters related to your health and/or your treatment. At your discression, texting to and from patients are available but be advised that they are not HIPAA compliant

I want to receive text messages and auto phone reminders. Yes _____ No _____	I want to receive and communicate through email. Yes _____ No _____

I understand that any confidential health information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via email or text.

I also understand if I utilize an email provider that does not use encryption technology the information included may not be secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

My signature acknowledges that I have read, fully understand and agree to all parts of this document and the policies stated within.

Patient is a minor ____ or is unable to provide consent because _____.
My relationship to the patient is _____and I have signed this consent on his/her behalf.

Signature	Date