UF UNIVERSITY of FLORIDA

College of Public Health and Health Professions
Department of Clinical and Health Psychology

1600 SW Archer Rd, Room G-901
PO Box 100165
Gainesville, FL 32610-0165
Phone: (352) 273-6617
Fax: (352) 273-6156

ASSESSMENT APPOINTMENT INFORMATION

Appointment Date _____ Appointment Time _____

Your child has been referred for an evaluation at Dr. Brenda Wiens' Child Psychology Clinic at the Shands Hospital Psychology Clinic. Since Shands is a teaching hospital, Dr. Wiens typically has doctoral and/or intern trainees assisting her in the assessments. The Child Psychology Clinic provides specialized testing to children who have had developmental, school, or medical problems. This testing typically involves one-on-one testing (thinking tasks, puzzles, academic tests) with your child to evaluate their intellectual, memory, attention, language, and academic abilities. **To ensure that your child can do their best on these tests, be sure your child is well-rested and fed, bring any necessary hearing aids/glasses/medication, *and* have your child take their regular medication as prescribed** *(including ADHD medications).* Evaluation results help in planning for your child's special needs at school or at home. This visit will include an interview and discussions about the difficulties that your child and family may be facing, including cognitive changes or academic problems, developmental history, and your own view of what has been helpful. As such, it is important to **have a caregiver (i.e., parent) present for the full evaluation day**. If you have any school records (recent report card & IEP), medical information (medications, etc), or reports from prior testing (OT, Speech/Language, psycho-educational, or neuropsychological evaluations), **please bring any such available records for us to review.**

In most cases, this appointment takes all morning and much of the afternoon. Although some evaluations take less time than others, please make arrangements for you and your child to be at our Clinic until 5:00pm in the event that the full day is required to complete the evaluation. In most cases, your child will complete the tests in a private room under Dr. Wiens' supervision while you complete questionnaires in our waiting room regarding their behaviors and development. Since most evaluations extend into the afternoon hours, you and your child will be provided with a short break for lunch (please bring necessary money to get lunch in the hospital or bagged lunch).

Enclosed are forms for you to complete *prior* to your child's appointment. Please complete all of these forms and bring them with you to your child's appointment – they will be collected when you arrive. The forms include: 1) clinic forms requiring parent signature and insurance information and 2) a questionnaire about your child's developmental history (BASC-3 Structured Developmental History). Included with your clinic forms is an Authorization to Use or Disclose Protected Health Information. Please put **your name and address in the "To" section**. This will allow us to mail you a copy of the evaluation report to you when it is completed. You may provide copies of the evaluation to your child's school and other health professionals. However, if you would like a copy of the evaluation sent directly to other providers by our clinic, please let us know so we can have you sign additional authorization forms.

Should you need to cancel/reschedule, please contact us no later than 3 days prior to your appointment. If you should have any questions, please contact the clinic at (352) 265-0294 or 1-800-749-7424 (extension 50294). The Psychology Clinic is located on the Ground Floor of Shands Hospital, Room G-901. Please see the enclosed map for directions. **If you are a new patient to Shands,** it will be necessary to register prior to your appointment. For further information, contact the Psychology Clinic at (352) 265-0294 or 1-800-749-7424 (extension 50294). Patients that have a Shands medical record number will need to update registration and insurance information when you arrive for the appointment.

We look forward to meeting your child at the upcoming appointment with us!

Department of Clinical and Health Psychology
P. O. Box 100165
Gainesville, FL 32610-0165
352-265-0294

University of Florida Psychology Clinic

INSURANCE INFORMATION REQUEST

****PLEASE COMPLETE THIS FORM CORRECTLY OR YOUR INSURANCE COMPANY WILL NOT BE BILLED APPROPRIATELY AND THE BALANCE WILL BECOME YOUR RESPONSIBILITY****

Date_____

Patient Name_____

Date of Birth _____

Primary Insurance	**Secondary Insurance**
1. Name of Insurance Company_____	1. Name of Insurance Company_____
Address _____	Address _____
Insurance Phone Number_____ (see back of card)	Insurance Phone Number_____ (see back of card)
2. Subscriber/Policy/Member/Contract ID #	2. Subscriber/Policy/Member/Contract ID #
3. Name of Policy Holder _____	3. Name of Policy Holder _____
4. Policy Holder's Date of Birth _____	4. Policy Holder's Date of Birth _____
5. Relationship of Policy Holder to Patient _____	5. Relationship of Policy Holder to Patient _____
6. Is this group or individual insurance? Group____ Individual___	6. Is this group or individual insurance? Group____ Individual ___
IF GROUP, PLEASE COMPLETE:	**IF GROUP, PLEASE COMPLETE:**
Group Number _____	Group Number _____
Employer Name _____	Employer Name _____
Address _____	Address _____
Phone_____	Phone_____

7. AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND PAY INSURANCE BENEFITS:

I hereby authorize Clinical and Health Psychology to release information related to all psychological care, attention and treatment to the above listed carrier. I also hereby authorize and request payment directly to Florida Health Professions Association, Inc. for bills covering this period of treatment, by all Insurance carriers with whom I have coverage. I further agree to pay all charges connected with this treatment not covered by any insurance I may have, and understand insurance coverage does not release me of obligation to begin payment upon initial visit. (Copies of this agreement shall be valid as the original)

_____ _____

Signature - Patient or Guardian Date

_____ _____

Signature - Policy Holder or Guarantor (if other than patient/guardian) Date

UF UNIVERSITY of FLORIDA

The Foundation for The Gator Nation

Patient Information Form

Thank you for choosing the University of Florida Psychology Clinic for your healthcare needs. Please complete this form to ensure we have the most accurate and current information. We may ask you to review this information from time to time to make sure it stays up-to-date.

Patient **First** Name: _____
Patient **Last** Name: _____

Address: _____
_____
City: _____
State: _____ Zip Code: _____

Home Phone: (___) _____
Work Phone: (___) _____
Cell Phone: (____) _____
Parent/ Guardian's Name: (if applicable)
_____

May we contact you at home? Yes/ No
May we contact you at work? Yes/ No
If yes, what time(s) would be good for contacting you? _____
Can a message be left at home? Yes/ No

Social Security #:_____

Date of Birth: _____
Age: _____

Marital Status: **(circle one)** Single Married Divorced Widow(er) Other

Religion: _____

Ethnic/Racial Background: **(circle one)**
African-American Asian
Caucasian Hispanic/Latino
Native American Multiracial
Other: (explain)

Employer: _____

Emergency contact person: _____ Relationship: _____
Emergency Contact Phone #: (____) _____
Who referred you to us? _____

************DO NOT WRITE BELOW THIS LINE************

OFFICE USE ONLY

Primary Insurance: _____ Phone: _____ Other Notes:
Address_____ Fax: _____
_____
Policy Holder: _____ Policy #:_____
Group #:_____

Secondary Insurance: _____ Phone: _____
Address: _____ Fax: _____
Policy Holder: _____ Policy #:_____
Group #:_____
Provisions: Authorization Needed? Yes/ No Date Obtained: _____
Authorization #:_____
Deductible Amount: _____ Amount Satisfied: _____
Co-pay Amount: _____
Co-Insurance Amount: _____ Self-pay Amount: _____
Visits Authorized: _____ Terms:_____
Testing Authorization: _____ _____

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Psychology Clinic

1600 SW Archer Rd, Room G-901
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Phone: (352) 265-0294
Fax: (352) 265-0096

Informational Handout

The Psychology Clinic in Shands Hospital at the University of Florida provides assessment and treatment services for children, adolescents, adults, older adults, couples, and families. Our clinic provides services for emotional problems and those with a range of medical illnesses. Licensed and board certified faculty psychologists are responsible for all services in our clinic. Like Shands Hospital and the University of Florida Clinics, the psychology clinic is a training site. Therefore, trainees are likely to be involved in your care. In all cases, these trainees work under the direction of a faculty member. This may involve the faculty member watching the trainee through a one-way mirror or taped recording. Our trainees are bound by the same ethical and legal standards as our licensed psychologists. Please discuss with your provider any questions or concerns you might have about this or any issue related to our clinic.

Hours of Operation

The Psychology Clinic schedules patient appointments between 8AM-5PM Monday, Wednesday, Thursday, and Friday. Appointments are scheduled between the hours of 8AM -7PM on Tuesday's.

What to Expect

The Licensed Psychologist and trainee assigned to you work as a team. Your team will likely start with an assessment. This assessment gathers information to answer questions about your particular case. This information is also helpful in planning effective treatment if needed. Your team conducts this assessment through an interview with you and/or family and friends. In addition, testing may be appropriate. This may include paper and pencil testing of your thinking and learning abilities, memory, emotions and/or behaviors.
You should be sure and understand the purpose {purposes} of this testing by talking with either the licensed psychologist or trainee. In all cases, all procedures will be explained to you. This evaluation may take from 2-8 hours.

Following your assessment, it may be suggested to you that you begin treatment in our clinic. We attempt to provide the most helpful treatment possible for your situation based on our own research and the research of others. Previous research studies indicate that many patients are helped by therapy. However, treatment benefits cannot be guaranteed. Your therapist will be happy to discuss any questions you may have. These therapy sessions can last as little as 30 minutes or as long 80 minutes. Your therapist will discuss the length of your sessions before you begin treatment.

If you have any concerns about your assessment or treatment, you should discuss them with the supervising licensed psychologist or trainee. As we mentioned earlier, this is a training clinic and you may be observed during your assessment or treatment. If your psychologist or trainee wishes to tape record your assessment or treatment for use in supervision of your care, they will ask you to sign a separate form. This form grants them permission for taping before it occurs. You also may be offered the opportunity to participate in a research study. Participation in our research is voluntary. If you agree to participate, you will be informed about the particular study and will be asked to sign a separate permission form.

About Privacy

The information you provide at these sessions will be treated with great care and kept private according to state law and the rule of our profession. In a few rare circumstances, your privacy cannot be protected. Here are the most common examples:

1} if a court has ordered you to seek evaluation and treatment here, then the court has a right to this information
2} if a court orders release of your records for a legal proceeding
3} if you make a serious threat to harm yourself or another person
4} if your provider believes that either a child or an elderly person is being abused or neglected

There are other times when your information may be released. If you have concerns, please discuss these concerns with your provider.

My signature below indicates that I have read the above statements.

Please read, sign, and bring with you to your visit.

_____ _____

Signature of patient, parent or guardian Date

Consent and Authorization

Section A: Notice of Limited Liability

I, on behalf of myself, my child, and/or my ward, hereby acknowledge I have been informed that: Care and treatment that I/we receive at this and other Florida Health Professional Association clinics/facilities, associated with the Department of Clinical and Health Psychology, will be provided by University of Florida employees and/or agents. I understand that these health-care providers are under the exclusive supervision and control of the University of Florida Board of Trustees and liability for their acts or omissions is limited to $100,000 per claim or judgment by any one person and to $200,000 for all claims or judgments arising out of the same incident or occurrence (see Florida statutes 726.28). Effective October 1, 2011 the amounts will be adjusted to $200,000 per claim or judgment by any one person and to $300,000 for all claims or judgments arising out of the same incident or occurrence.

Section B: Treatment Authorization, Assignments of Proceeds, Authorization to Release Information and Guarantor Agreement

1. Authorization for Routine Diagnostic Procedure and Psychological Treatment-I hereby consent to such diagnostic procedures which in the judgment of my healthcare provider may be considered necessary or advisable while a client at a Florida Health Professionals Association (FHPA) clinics/facility. I recognize that the FHPA providers are employees of a healthcare teaching and research institution and that my treatment and care will be observed and in some instances aided by students under appropriate supervision.

2. Assignment of Benefits-I hereby assign to the FHPA payment from all third-party payers* and with whom I have coverage or from whom benefits are or may become payable to me, for the charges of health care services I receive for, related to, my treatment (past, present, or future). I agree to be personally responsible for payment of any healthcare services that are not covered by my third-party payers*, including, but not limited to, not covered or out-of-network services, deductibles, co-insurance, and/or co-payments.

3. Release of Medical Information by the Florida Health Professionals Association-By signing in the space below as Patient/Guardian, I hereby authorize the FHPA providing services during my outpatient clinical care, to release information from and/or copies of my psychological records and other information as may be required for my psychological care and to secure payment for charges incurred by me or on my behalf, to any other FHPA clinic/facility, my physician, to my referring physician, the guarantor on my accounts, insurance companies for which I have assigned benefits for my treatment and care, or to any sponsors that the

FHPA may later obtain to contribute payments for my treatment and care. I also authorize release of any information to any and all regulatory and/or accrediting organizations as necessary to the outpatient clinics to maintain its licensure and accredited status.

4. Guarantor Agreement- By signing in the space below as Patient/Guardian or guarantor, or as patient's/guardian's spouse or guarantor's spouse, I hereby agree that all charges connected with the treatment, not covered by any insurance, program, sponsorship or other third-party coverage I may have are due and payable by me at the time of the visit or discontinuation of treatment or in a pre-arranged payment plan agreeable to FHPA. If the insurance information I have provided is not active at the time of service or if the services provided are not covered by my insurance company, I will be responsible for any balance due. The charges I agree to pay are those listed in the master billing charge manual, which are available for inspection upon request and incorporated herein by reference. I hereby acknowledge that, unless the FHPA and my insurance company or third-party carrier have agreed that I will not be billed, if the FHPA has agreed to bill my insurance or other third-party carrier it has agreed to do so as a courtesy and that the FHPA has the right to demand payment in full from me at any time prior to full payment from any insurance carrier. If an overdue account is referred by collections, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the outpatient clinic charges I have agreed to pay.

*Third-party payers include, but are not limited to, coverage available from: Medicare, Tri-care, or governmental programs; health, accident, automobile, or other insurance; workers compensation; HMO (commercial, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

Patient/ Guardian Signature: _____

Patient's/ Guardian's Spouse Signature: _____

Guarantor Signature (if other than patient/ guardian): _____

Guarantor's Spouse Signature: _____

Name of Insured (if other than patient): _____

Witness (Adult 18yrs and over): _____ Date: _____

Record Request: Authorization to Use and Disclose Protected Health Information ("PHI") Maintained by UF Health*

**For purposes of this agreement, UF Health describes a collaboration of the University of Florida Board of Trustees for the benefit of the University of Florida College of Medicine, Shands Jacksonville Medical Center, Inc., Shands Teaching Hospital and Clinics, Inc., and Shands Recovery, LLC. Collectively, these entities are referred to as UF Health in this form.*

Patient's Name	Date of Birth	Medical Record #	Verification of Identity ☐ Driver License/State ID ☐ Personally known ☐ Other:
Patient's Address / City / State / Zip			
Phone #	Last 4 digits of SSN (Optional)		☐ Check if patient is an employee of UF Health Shands

Complete the section below *only* if the person requesting records is not the patient:

Name of Representative	Relationship to Patient: Parent/Guardian	Legal Authority
Representative's Address & Phone Number	Verification of Identity: Drivers License	Verification of Authority

By signing this form, I authorize the release of PHI (i.e., medical records) as follows:

From the doctor, office, facility of other health care provider checked or written below:

☒ University of Florida person, class of persons, or organization:
UF Psychology Clinic
Clinic, person, class of persons, or organization
PO Box 100165, Gainesville, FL 32610
Address
352-265-0294
Phone Attn

- ☐ UF Health Shands Hospital ▪ PO Box 100345, Gainesville, FL 32610-0345 Phone: 352.265.0131 ▪ Fax: 352.265.1098
- ☐ UF Health Shands Rehab Hospital ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606 Phone: 352.265.5491 ▪ Fax: 352.627.4425
- ☐ UF Health Shands Psychiatric Hospital ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606 Phone: 352.265.5497 ▪ Fax: 352.627.4425
- ☐ UF Health Florida Recovery Center ▪ 4001 SW 13th Street, Gainesville, FL 32608 Phone: 352.265.5500 ▪ Fax: 352.265.5504
- ☐ UF Health Shands HomeCare ▪ 3515 NW 98th Street, Gainesville, FL 32606 Phone: 352.265.0789 ▪ Fax: 352.265.9276

To the facility / person below:

Parent/Guardian Name + Address

Clinic, person, class of persons, or organization — Address and Fax Number — ☐ Check here if same as patient ☐ Check here for records pick-up only

Attn:

The following PHI may be released *(describe in detail or use the check boxes below):*			**I further authorize the release of the following information which may be included in the PHI:**
☐ History and Physical	☐ Operative Reports(s)	☐ Discharge Summary	☑ Mental Health/Psychiatric Treatment
☐ Problem List	☐ Medication List	☐ Treatment Notes	☐ Alcohol or Substance Abuse Treatment
☐ Emergency Room Record	☐ Radiology Reports/Films	☐ Lab/Pathology Reports	☐ STD/HIV/AIDS Treatment(s) or Test(s)
Intake/Assessment results and reports; letters			☐ Genetic Testing
Is this needed for a doctor's appointment?	Write date below:	**Are there specific dates needed?**	Write dates below:

Purpose of this request?	☐ Treatment/Continued Care ☐ Payment/Billing ☑ Personal Use ☐ Other:
Format of Records?	☐ Through a web portal, with notice provided to my e-mail account at: _____ To request records in electronic PDF form, please check the box above and provide a valid and clear e-mail address. You will receive an e-mail from HealthPort and that e-mail will tell you how to get the records. ☑ Paper

This authorization allows UF Health to use and disclose (release) certain PHI, which includes medical records, as I have directed.

I understand that:

- The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and STDs.
- This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.
- This authorization will remain in effect for one (1) year or until I revoke it in writing (i.e., tell UF Health to cancel it).
- I have the right to revoke this authorization at any time, if I do so in writing to the Health Information Management Department at the organization named above and that the revocation will not apply to action already taken as a result of this authorization.
- I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- I understand that PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.
- I am aware that I may be charged a fee for this request as allowed by law, which may include up to $1.00 per page (plus applicable tax and handling) for Paper Records and fees associated with labor, supplies (i.e. cost of a computer disk), and postage for Electronic Records. Fees are waived when PHI is released to a health care provider for treatment purposes.

Signature of patient / patient representative _____ **Date** _____

UFHealth UNIVERSITY OF FLORIDA HEALTH — UF UNIVERSITY of FLORIDA

Authorization for Use or Disclosure of Protected Health Information

Distribution: Original – Patient Record; Copy – Requestor