MARSH LANDING
BEHAVIORAL GROUP

1538 The Greens Way, Suite 101
Jacksonville Beach, Florida 32250
(904) 543-0161

PATIENT INTAKE AND CONSENT TO TREATMENT

PATIENT INFORMATION:

Name: _____ Address: _____

Date of Birth: ____/____/____ Age: _____ Sex:_____ City: _____

Social Security #: _____Phone #: _____ State: _____ Zip Code: _____

Which doctor or therapist will you see today? _____

How did you hear about us? _____

Child Patient

School: _____ Grade: _____ IEP (y/n): ____ 504 plan (y/n): ____

Other Special Program(s): _____

Adult Patient

Employer or College: _____ Type of work or major: _____

RESPONSIBLE PARTY (if other than patient)

Name: _____ Address: _____

Social Security #:_____Phone #: _____ City: _____

Relationship to patient: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Name of policy holder: _____ Insurance Co.: _____ Insurance type: _____

Insurance ID#: _____ Employer: _____ Insurance Phone #: _____

Date of Birth: ____/____/_____

CONSENT TO TREATMENT

I hereby consent to evaluation/examination and treatment. I hereby affirm that I am of legal age and otherwise competent to consent to medical treatment. If not, the person signing below represents that he or she is a parent, legal guardian or person otherwise allowed by law to consent to the examination and treatment of the patient, and by his or her signature hereto so consent. *Please read additional pages in this packet for general office policies.*

_____ _____

Patient's Signature Date Parent, Legal Guardian, Etc. (if necessary) Date

_____

Witness Date

1538 The Greens Way, Suite 101
Jacksonville Beach, FL 32250
Phone: (904) 543-0161
Fax: (904) 543-9172

RELEASE OF INFORMATION CONSENT FORM

Patient's name: _____ DOB: _____

I, _____ hereby authorize Marsh Landing Behavioral Group to Release _____ Obtain _____ Exchange ____ information with the following:
Person or Facility name: _____
Address of person or facility: _____
Phone number: _____ Fax number: _____

Authorization is given for the following items. (check all that apply)
__ Office notes __ Evaluation __ Lab results __ Testing reports
__ Other *(please specify)* _____

Authorization is given for the following reason(s): _____

Medical information as well as psychiatric, psychological, drug or alcohol records in compliance with ES 90.503, 394.459, 395.017, 396.112, 397.053 and Federal Regulation 42CFR, part 2. The information is necessary for evaluation and treatment. This authorization is to be valid until revoked in writing.

I have read the above and also have been advised of my rights to receive a copy of this authorization. Further, I understand the contents of this written authorization in it's entirety and have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

_____ _____
Signature of Patient Date

_____ _____
Parent or guardian if a minor Date

_____ _____
Witness Date