# Welcome to Lumos Psychiatric Services!

I appreciate that you have chosen my office to obtain your mental health and psychiatric needs. I always aspire to provide the most integrated services and the best treatment for my patients.

In the following pages, you will find everything that you need to assist me in getting to know you better and initiate your services. I will appreciate you bringing to our office all the enclosed forms completed. In addition, the following is a checklist of all the information you need to bring on your first visit for evaluation:

- A list of all your current medications and/or over the counter supplements with their dosage and frequency. (You may also bring all your pill bottles if it would be easier for you).
- A copy of your medical insurance cards including pharmacy benefits and a valid ID (driver's license or passport). If the patient is a minor (17 years or younger), bring ID from parent or guardian.
- In case of minors, if you are a parent with sole custody or a legal guardian or adoptive parent, you must present a copy of the legal documents awarding custody of the minor. In case of adults or elderly with a legal tutor, you must present a copy of the legal document awarding guardianship.
- Copy of the following documents (if available):
  - Psychological Evaluation / Psychoeducational Evaluation / Neuropsychological Evaluation
  - School Records or Grades / 504 Plans or IEP
  - Previous Mental Health or Psychiatry Records
- If you have been recently discharged from a psychiatric facility, please bring a copy of the discharge summary provided there.
- Information about your primary care physician and your primary pharmacy used.
- Read and sign the following documents: Patient rights and responsibilities and Office policies.
- Complete all the following forms:
  - New patient information form
  - Authorization to release or obtain confidential information
  - Screening Scales included for the age group of the patient: Children (5-12y/o), Adolescents (13-17y/o), Adults (18-64y/o), Geriatric (65y/o or older).

Thank you for choosing Lumos Psychiatric Services! I look forward to working with you and provide you with the highest quality of psychiatric services.

Cordially,

Luis J. Olivera-Rodríguez, MD
Board Certified Psychiatrist


6001 Vineland Road Suite 109 Orlando FL 32819 / P: (407) 930-6684 F: (949) 404-8433

**Lumos Psychiatric Services /Luis J. Olivera-Rodriguez, MD**
**New Patient Information Packet - Geriatric**

**Patient's Name:** _____ Date: ____/____/_____ MR: _____
**Legal Guardian/Tutor** (If applies):_____

**Date of Birth:** ____/_____ /_____ Age: _____ Sex: ___ Female ___ Male Gender: _____

Home Phone: (_____)_____ Cellphone: (_____)_____
Email Address: _____

**Postal Address:**

Street & Num: _____
City: _____ State: _____ Zip Code: _____

Primary Health Insurance: _____ Policy #: _____
Secondary Health Insurance: _____ Policy #:_____
(Please present a copy of all your medical insurance cards including for pharmacy benefits).
___ I do not have medical insurance and will cover the cost of treatment as self-pay.

**Primary Insured Person:** ___ I am the primary insured. ___ I am **NOT** the primary insured.

- Please provide the following information of the primary insured person of your health insurance.

Complete Name: _____ Date of Birth: _____/_____/_____
Postal Address: Relationship with Patient:_____
Street & Num: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (_____)_____ Cellphone: (_____)_____

**Emergency Contact:**

| Name | Relationship | Home Phone | Work Phone | Cellphone |
|---|---|---|---|---|
| | | | | |

Person who refers you: _____

**Primary Care Physician:**
Name: _____ Practice Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

**Pharmacy:**
Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

**Medications:** (Please list all your medications with name, dose and frequency taken/can also bring pill bottles)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____


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Patient Name: _____ Date of Birth: ___/___/_____ Date: ___/___/_____

## Consent for Treatment Form

I, _____, authorize Lumos Psychiatric Services (LPS) and/or Luis J. Olivera-Rodriguez, MD to provide psychiatric evaluation and medication and/or therapy treatment services for myself or for _____ (Patient's name if minor or if they have a legal tutor). I understand that although Dr. Olivera-Rodriguez strives in providing the best treatment possible for his patients, the treatment provided may not always yield the desired results and that there are not full guarantees. Every patient's treatment will be conducted in a confidential manner, as stated under the HIPAA Regulations. The disclosure of confidential information will not be done unless specifically authorized in writing by the patient or guardian or under a subpoena issued by a court.

I understand that Dr. Olivera-Rodriguez is obligated by Florida Statutes 827.03 and 394.451-394.892 to report any suspiciousness of child abuse and/or neglect or if they demonstrate potential to cause harm to self or others requiring a Baker Act. In addition, I understand that Dr. Olivera-Rodriguez must report to the local Health Department any HIV status/infection or potential infection to a partner that the patient has identified pursuant to Florida Statute 456.061(1), F.S. and Rule 64D-2.00.(2)(I), F.A.C.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Olivera-Rodriguez if I or my minor, have a change in health.

_____ _____

Patient or Parent/Guardian Signature Parent/Guardian Name (Print – If applicable)



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Patient Name: _____ Date of Birth: ___/___/_____ Date: ___/___/_____

## Telehealth Agreement and Informed Consent

I _____ , hereby consent to engaging in Mental Telehealth Services and or Medication Management with LUMOS PSYCHIATRIC SERVICES, LLC. as part of my treatment. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that, with my signed consent, telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Florida.

I understand that I have the following rights with respect to Telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

(2) The laws that protect the confidentiality of my medical information also apply to Telehealth. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from Telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my treatment, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that Telehealth based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of psychiatric services (e.g. face-to-face services) I will be referred to a provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatric/psychotherapy and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from Telehealth, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Florida state law.

I have read and understood the information provided above. I have discussed it with my provider, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment.

_____ _____

Patient or Parent/Guardian Signature | Parent/Guardian Name (Print – If applicable)

_____ _____

Witness Signature | Witness Name (Print)



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Patient Name: _____ Date of Birth: ___/___/_____ Date: ___/___/_____

## Patient's Rights and Responsibilities

**Patient Rights:**

- The patient has the right to receive information from Dr. Olivera-Rodriguez and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest and to receive an independent professional opinion.
- The patient has the right to make decisions regarding the health care that is recommended, hence they are able to accept or refuse any recommended medical treatment.
- The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation or disability.
- The patient has the right to confidentiality. Dr. Olivera-Rodriguez will not reveal confidential communications or information without the consent of the patient, unless provided by law or by the need to protect the welfare of the individual or the public interest.
- The patient has the right to continuity of health care. Dr. Olivera-Rodriguez has an obligation to cooperate in the coordination of medically indicated care with other healthcare providers treating the patient. Dr. Olivera-Rodriguez may discontinue care, provided he gives the patient reasonable assistance, direction, and sufficient opportunity to make alternative arrangements.

**Patient Responsibilities:**

- Good communication is essential to a successful health physician-patient relationship. To the extent possible, patients have a responsibility to be honest and express their concerns clearly to have better outcomes in their treatment.
- Patients have a responsibility to provide a complete medical and psychiatric history, to the best of their knowledge, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to their present health.
- Patients have a responsibility to request information or clarification about their health status or treatment as many times as necessary when they do not fully understand what has been described or recommended.
- Once a treatment plan is agreed upon, patients have a responsibility to cooperate with said treatment plan. Compliance with the psychiatrist's instructions is often essential to ensure good outcomes of treatment and to ensure public and individual safety. Patients also have a responsibility to truthfully disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
- Patients should also have an active interest in the effects of their conduct or behavior on others and refrain from such behavior that places the health or safety of others at risk.

I hereby understand my rights and responsibilities as a patient of Lumos Psychiatric Services. I have read and understand the terms describes above.

_____ _____

Patient or Parent/Guardian Signature Parent/Guardian Name (Print – If applicable)



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Patient Name: _____ Date of Birth: ___/___/_____ Date: ___/___/_____

## Office Policies

I am here to serve the mental health needs of every patient and I request your cooperation in complying with the following office policies in order to better help you and others.

**Patient Responsibilities:**
It is the patient's and/or guardian's responsibility to inform Lumos Psychiatric Services, of any telephone, address, and medical insurance information changes in order to properly ensure continuation of your appointments.

**Confidentiality:**
Lumos Psychiatric Services & Luis J. Olivera-Rodriguez, MD adhere to strict confidentiality in accord with federal laws, state laws, and HIPAA regulations. No information will be disclosed unless specifically authorized in writing by the patient or his/her guardian or under subpoena issued by a court. There are some exceptions to confidentiality for example, if a patient should express or report a specific and serious intent to inflict harm to themselves or others, Dr. Olivera-Rodriguez may break this agreement, but only when necessary in order to ensure the patient's safety, as well as the safety of others. By law, I also have a duty to report cases of abuse when the victim is a minor, elderly or disabled. By law I also have a duty to report to the local Department of Health any HIV status/infection or potential infection to a romantic partner that the patient has identified.

**Payments:**
Every patient is responsible for paying fees and any balance that is not covered by his/her insurance at the time of the appointment. If you need to make a special payment agreement, please discuss this with my office staff before the visit. All debit or credit card transactions will have a $2.00 processing fee. Will also accept cash and check payments. A $30 fee will be charged for all returned checks. If a patient fails to make a proper restitution of any pending balance within a reasonable time, the patient may not be able to continue receiving services in this office and may have to search for services elsewhere.

**Check-In Time:**
Appointment times are reserved for you and should start promptly to prevent delays in schedule and affecting other patients. I advise you to arrive at the office 10-15 minutes prior to your scheduled appointment in order to properly ensure your appointment. This time is needed for the completion of triage, screening scales and payment collection. If you arrive over 5 minutes late to a 15-, 20- or 30-minute appointment, or if you arrive over 10 minutes late to a 40- or 60-minute appointment you may have to re-schedule for another day.

**No Show/Late Cancellations:**
Missed appointments or appointments that are not cancelled before the scheduled appointment time will be charged a $25.00 fee. If you present evidence for the missed appointment this fee may be waved on a case by case basis. Insurance will not reimburse the patient for this charge, nor will Lumos Psychiatric Services bill the insurance for it. The reminder service at this office sends confirmations and reminders via calls, emails or texts as a courtesy only to our patients, but it is the patient's responsibility to keep tract and comply with scheduled appointments.

**Prescription Refills / Lost or Stolen Prescriptions:**
In the case of missed appointments and/or loss of a prescription an administrative fee of $10.00 will be charged to the patient's account for refill requests due to this reason. If you present evidence for the missed appointment this fee may be waved on a case by case basis. Insurance will not reimburse the patient for this charge, nor will Lumos Psychiatric Services bill the insurance for it. If a prescription for a controlled medication is stolen or lost, the patient or guardian must make a report to the police and submit that report or its reference number to our office staff to be documented in the patient's chart in order to receive a replacement for the prescription. The replacement of a controlled medication prescription is limited to one time per year per patient.

**Other Service Charges:**
There will be a charge for the preparation of forms, reports ($50.00 per document) and letters ($25.00 per letter) related to the services provided at this office. With few exceptions, the fees for the completion of these documents will be the responsibility of the patient. Please ask the front desk staff if you have any questions regarding any fees for specific documentation. All photocopies and requests of the patient's medical records will be charged $1.00 for the first 20 pages and 0.35¢ per each additional page up to a total of no more than $25.00. Any changes made to the service fees will be informed to patients in advance.


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## Office Policies (Cont.)

**After Hours and Emergencies:**
In the event of an emergency situation (including those in which a person is feeling out of control, unable to care for him/herself, or having serious thoughts about harming themselves or others), call 911 immediately or go to the nearest Emergency Room as our office is not equipped to manage such emergencies. If you have an urgent concern that you need to discuss with Dr. Olivera-Rodriguez, please call the office to re-schedule your appointment to an earlier date. All phone messages including those left after office hours in the voice mail service will be returned and answered within the next 48 business hours by the office staff in the order in which they were received.

**Mental Health Assessments:**
I agree upon a request made by Lumos Psychiatric Services, to complete a free of charge screening scales for mental health assessment provided at my office visit, administered prior to my appointment by the medical assistant staff, and interpreted by Dr. Olivera-Rodriguez, with the purpose of measuring, summarizing and determining symptoms of depression, anxiety, mania and/or other psychiatric symptoms as part of the evaluation.

**Pharmacogenetic Testing:**
Dr. Olivera-Rodriguez offers his patients the opportunity to perform pharmacogenetic testing with the product Genesight from the company Assurex. It involves a simple swab in the mouth to collect patient's DNA to identify patterns of metabolism of medications and possible disadvantages to the use of certain medications. The results of this test usually help guide the medication treatment of each patient in a more individualized way with obtaining better results in the majority of cases.

**Screening Drug Testing:**
I hereby agree, upon the drug/alcohol testing policy by Lumos Psychiatric Services, to summit to a drug or alcohol test and to furnish a sample of my urine for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, that Dr. Olivera-Rodriguez can determine to not provide me with prescription of my medications in particular any controlled medications. I further authorize and give full permission to have Lumos Psychiatric Services' medical assistant to send the specimen collected to a laboratory for screening tests to determine the presence of any prohibited substances under the policy and for the laboratory or other testing facility to release any and all documentation relating to the results of such test to Lumos Psychiatric Services for the purpose of monitoring my treatment.

**Video Security Surveillance:**
Lumos Psychiatric Services has put in place video surveillance cameras in the common areas of the office for security purposes. These are located in the waiting room and the main hallway of the office. They are only video recording and have **NO** audio recording. There won't be any cameras in any of the offices of the practice. I hereby agree and understand the purpose of video surveillance in the office.

**Changes to this Notice:**
Lumos Psychiatric Services and/or Dr. Olivera-Rodriguez reserve the right to amend this notice at any time in the future and will make the new provisions available to all patients for all information that it maintains. Upon request, you have the right to a paper copy of this notice at any time.

I hereby understand and agree to follow the Office Policies of Lumos Psychiatric Services. Any violations or non-compliance to these Office Policies, may lead to m y dismissal as a patient from this practice. I have read and agree to comply with the terms described above.

_____ _____

Patient or Parent/Guardian Signature | Parent/Guardian Name (Print – If applicable)



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Patient Name: _____ Date of Birth: ___/___/_____ Date: ___/___/_____

## Authorization for Release of Information to Nonmedical Individuals and/or Decision Making

- Many of my patients request to allow family members or others to call, pick up documents, and request medical or billing information on their behalf. Under HIPAA requirements, I am not allowed to give this information to anyone unless I have the patient's informed consent. If you wish to have any of this information released to the individuals of your choice, this form needs to be completed. If you do not wish to provide this authorization, please draw a line across the form and sign at the bottom.

I, _____, hereby authorize Lumos Psychiatric Services staff and/or Dr. Olivera-Rodriguez to release the following information:

- ☐ Prescriptions/Medications
- ☐ Medical Records
- ☐ Appointment Dates/Time and/or Changes/Cancel
- ☐ Pick up Forms or Letters
- ☐ Billing Information
- ☐ Other: _____

To the following individual(s):

Name:_____ DOB: ___/___/_____ Relationship: _____
Name:_____ DOB: ___/___/_____ Relationship: _____
Name:_____ DOB: ___/___/_____ Relationship: _____

This authorization shall remain in effect until: ___/___/_____.

- Many parents from my pediatric patients (ages 5-17y/o) often need to send their children to their appointments with other family members (stepparent, grandparents, aunts or uncles) when their schedules prevent them from bringing them on their own. These family members unfortunately do not have decisional power to make medical decisions for the patient's parent unless it is specifically given in writing. If you wish to give this permission to a family member or other to assist you in the care of your children, please complete this part of the form but the persons assigned must be adults over the age of 18. If you do not wish to provide this authorization, please draw a line across the form and sign at the bottom.

I, _____, hereby authorize Dr. Luis J. Olivera-Rodriguez to make treatment decisions for my child with the following individuals:

Name:_____ DOB: ___/___/_____ Relationship: _____
Name:_____ DOB: ___/___/_____ Relationship: _____
Name:_____ DOB: ___/___/_____ Relationship: _____

This authorization shall remain in effect until: ___/___/_____.

I understand I have the right to revoke this authorization in writing at any given time. I understand that by giving this consent, I will be allowing the individual(s) identified above to inspect or copy the protected health information to be disclosed. As a result, the information disclosed to any above recipient will no longer be protected by federal or state law and that it may be subject to re-disclosure by its recipient.

_____ _____
Patient or Parent/Guardian Signature | Parent/Guardian Name (Print – If applicable)

_____ _____
Witness Signature | Witness Name (Print)



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Patient Name: _____ Date of Birth: ___/___/_____ Date: ___/___/_____

## Authorization to Release or Obtain Confidential Medical Information

I, _____, hereby authorize Lumos Psychiatric Services and/or Luis J. Olivera-Rodriguez, MD to ☐ Release or ☐ Obtain confidential medical information by mail or facsimile (fax) to/from:

Physician Name: _____ Practice Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

The following information is to be disclosed:

☐ Medical Records Dates from: ___/___/_____ to: ___/___/_____
☐ Psychiatric Evaluation ☐ Psychological Assessment ☐ Substance Abuse Treatment
☐ Medication Management Notes ☐ Other: _____

For the purpose of: ☐ Continuity of Care ☐ Personal ☐ Psychiatric Clearance ☐ Other: _____

I understand that this information may be used to release information related to mental health treatment. I further understand that the information disclosed may include psychiatric, drug/alcohol abuse and/or HIV/AIDS data. I understand that I have the right to refuse to sign this authorization or to take back my consent at any time prior to the release of information. If I do not revoke this authorization, it will automatically expire one year from the date of signature unless otherwise noted below.

| _____ | _____ | ___/___/_____ |
|---|---|---|
| Patient Signature | Patient Name (Print) | Date |
| _____ | _____ | ___/___/_____ |
| When applicable, Signature:<br>☐ Parent ☐ Guardian ☐ Healthcare Proxy ☐ Power of Attorney | When Applicable, Name (Print):<br>☐ Parent ☐ Guardian ☐ Healthcare Proxy ☐ Power of Attorney | Date |
| _____ | _____ | ___/___/_____ |
| Witness Signature | Witness Name (Print) | Date |

This information has been disclosed to you from records protected by Federal confidentiality rules Florida Statutes 394-459, 397.501 and/or 90.503 and 42 Code of Federal Regulations. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for privacy of individual identifiable health information (Privacy Standards) 45 CFR, 160 & 164, and all federal regulations and interpretative guidelines promulgated there under. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Florida Statutes 394-459, 397.501 and/or 90.503. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I have been informed that this authorization is subject to revocation by me at any time except to the extent that Lumos Psychiatric Services has already taken action in reliance on it. Once the requested protected information is disclosed, the Privacy Regulation may no longer protect it if the PHI's recipient re-discloses it. Further, I understand that despite all care taken, information is occasionally received by a party not intended to be the recipient. I hereby release Lumos Psychiatric Services and Dr. Luis J. Olivera-Rodriguez from all liability should this information be received by someone other than the above-intended recipient.



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