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Jacksonville, FL 32223
904-432-3321 (Office)
904-432-3324 (Fax)
www.nautilusbehavioralhealth.com

New Patient Information Form

Please complete and submit this form by email to admin@nautilusbehavioralhealth.com or by fax to **904-432-3324**. You will be contacted within 48 hours to schedule an initial appointment. For questions, please contact us at **904-432-3321** or email us at info@nautilusbehavioralhealth.com.

Today's Date: _____________ Name of person requesting services: ______________________________

How did you find out about Nautilus Behavioral Health? (select all that apply)

☐ Insurance Company
☐ Search Engine (e.g., Google)
☐ Psychology Today Listing
☐ Other
☐ Nautilus Behavioral Health Website
☐ Personal Referral (Word of Mouth)
☐ Social Media (Facebook, LinkedIn, Google+)

Patient Background Information

Patient's Name: ______________________________

Patient's Date of Birth: _____________ Sex: ☐ Male ☐ Female ☐ Transgendered

Home Phone: _____________________ Cell Phone: _____________________

Email Address: _________________________________

Home Address: ____

Does the patient know about this request request for services? ☐ Yes ☐ No

Caregiver Background Information

Caregiver 1: Caregiver Name: ______________________________

Relationship to Patient: ☐ Mother ☐ Father ☐ Foster Parent ☐ Relative ☐ Other

If relative caregiver, specify your relationship to patient (e.g., Aunt, Grandparent): _______________

Caregiver Social Security Number (if required for insurance): _____________________

Caregiver's Date of Birth: _____________ Sex: ☐ Male ☐ Female ☐ Transgendered

Home Phone (if different from patient): _____________________ Cell Phone: _____________________

Work Phone: _____________________ Email Address: _________________________________

Home Address (if different from patient):

____

Employment: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Homemaker ☐ Unemployed

Employer (if applicable): ____

Caregiver 2: Caregiver Name: ______________________________

Relationship to Patient: ☐ Mother ☐ Father ☐ Foster Parent ☐ Relative ☐ Other

If relative caregiver, specify your relationship to patient (e.g., Aunt, Grandparent): _______________

Caregiver Social Security Number (if required for insurance): _____________________

Caregiver's Date of Birth: _____________ Sex: ☐ Male ☐ Female ☐ Transgendered

Home Phone (if different from patient): _____________________ Cell Phone: _____________________

Work Phone: _____________________ Email Address: _________________________________

Home Address (if different from patient):

____

Employment: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Homemaker ☐ Unemployed

Employer (if applicable): ____

Communication Preferences and Consents

I consent for Nautilus Behavioral Health, PLLC to do the following (select all that apply):

☐ Call and leave a voicemail on:

☐ Caregiver 1 Home Phone ☐ Caregiver 1 Cell Phone ☐ Caregiver 1 Work Phone

☐ Caregiver 2 Home Phone ☐ Caregiver 2 Cell Phone ☐ Caregiver 2 Work Phone

☐ Patient Home Phone ☐ Patient Cell Phone

☐ Send a text to:

☐ Caregiver 1 Cell Phone ☐ Caregiver 2 Cell Phone ☐ Patient Cell Phone

☐ Send an email to:

☐ Caregiver 1 ☐ Caregiver 2 ☐ Patient

Caregiver 1 Preferred Means of Communication:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Caregiver 2 Preferred Means of Communication:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Preferred Contact Person:

☐ Caregiver 1 ☐ Caregiver 2 ☐ Patient

Insurance Information

We are Certified Non-Network Tricare Providers and are In-Network Providers for Aetna. We are out-of-network providers for Blue Cross Blue Shield, United and Cigna. We will gladly directly bill your insurance for in- or out-of-network benefits for therapy. Please note that assessment and group are self-pay only and insurance will not be billed. For more information, please review the insurance, billing, fee and payment policies in the Informed Consent for Services.

What insurance benefits (if any) will you be using?

☐ In-Network Insurance ☐ Out-of-Network Insurance ☐ No Insurance (Self-Pay)

Primary Insurance Company: ___________________________________

Insurance Address: ____

Insurance Phone Number: ____________________

Name of Policy Holder: _____________________________

Member ID: ______________________________________ Group Number: ____________________

Plan Name: ______________________________________

☐ Please check this box if patient also has secondary insurance and provide the insurance company name, address and phone number, policy holder name, member ID, group number and plan name for secondary insurance: ____

____

____

Presenting Concerns

Please select all general areas of concern from the list below (select all that apply):

☐ Abuse ☐ Academic/learning issues ☐ Adjustment to stressors

☐ Anxiety ☐ Aggression ☐ Anger problems

☐ Attention, distractibility ☐ Behavior problems ☐ Communication skills

☐ Coping skills ☐ Death of a loved one ☐ Depression

☐ Eating (e.g., restriction) ☐ Domestic violence exposure ☐ Family conflict

☐ Hallucinations ☐ Hyperactivity ☐ Impulsivity

☐ Mood (e.g., bipolar) ☐ Oppositional behavior ☐ Parent separation, divorce

☐ Parenting skills ☐ Peer relationships ☐ Physical health issues

☐ Risk taking ☐ Running away ☐ Safety (suicidal, homicidal)

☐ School (not academics) ☐ Self-injury ☐ Sleep

☐ Social skills ☐ Substance abuse ☐ Toileting accidents

☐ Trauma ☐ Other: ____

Please briefly describe what prompted you to seek services: ________________________________
____
____
____

Please select which services you are interested in (select all that apply):

☐ Individual Therapy

☐ Family Therapy

☐ Parent Behavior Management Training

☐ Educational Groups/Workshops

☐ Psychological, Psychoeducational, Learning or Gifted Assessment

Please describe the reason you would like an assessment: ___________________________
____
____
____

Living Situation

Relationship Status of Patient's Parents:

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married, Living Together

☐ Never Married, Living Apart ☐ Other

Who does patient primarily live with? (select all that apply)

☐ Biological Mother ☐ Biological Father ☐ Stepmother ☐ Stepfather

☐ Adoptive Mother ☐ Adoptive Father ☐ Relatives ☐ Foster parent(s) ☐ Other

If other, specify who the patient primarily lives with: _____________________________________

If patient's parents are not together and patient is under 18 years of age, are both parents aware of and consenting for services? ☐ Yes ☐ No- if not, please explain: ___________________________
____
____

If patient's parents are not together and patient is under 18 years of age, bring legal documents about custody, right to medical information and to make decisions to the initial appointment.

Please list individuals other than caregiver(s) that live in the patient's primary residence:

Name	**Age**	**Relationship**

Please list immediate family members (e.g., siblings) that do not live in the primary residence:

Name	Age	Relationship	Residence

School History

Name of Current School (if enrolled): ____

Current Grade (if enrolled): ______________

Has the patient been retained/held back? ☐ Yes ☐ No

If yes, select the reason for retention: ☐ Academic ☐ Behavioral ☐ Other (please specify):

____

Does the patient have an IEP, 504 plan or other school-based services or supports?

☐ Yes ☐ No

If yes, please describe: ____

____

____

If patient has an IEP or 504 plan, please bring a copy and any corresponding assessment reports.

Medical and Mental Health History

Patient's chronic and/or acute health conditions (if any): ______________________________

____

____

Patient's significant medical history (e.g., surgeries, hospitalizations, serious accidents or injuries):

____

____

Patient's existing mental health diagnoses (if any): __________________________________

____

____

Patient's current medications: ____

____

____

Patient's history of mental health treatment (if any): ___________________________________

____

____

Scheduling Considerations

Preferred Time(s) of Day: ☐ Morning ☐ Midday ☐ Afternoon ☐ Early Evening ☐ No Preference

Preferred Day(s) of the Week: ___________________

Release of Information

Please let us know if there are individuals and/or agencies you would like to communicate with Nautilus Behavioral Health, PLLC (select all that apply):

☐ Family- caregiver (for older adolescent/young adult patients), extended family member, etc.

☐ School- teacher, leadership, support services providers, etc.

☐ Medical- clinic, doctor, nurse practitioner, etc.

☐ Mental Health- psychiatrist, school counselor, previous therapist, etc.

☐ Other- please specify role/relationship: ______________

For patients 18 years of age or older, patients must sign a release of information if they want their caregiver(s) to be able to communicate with Nautilus Behavioral Health, PLLC.

Please note that the caregiver (for patients under 18 years of age) or the patient (for patients 18 years or older) will need to sign a separate release for each individual they would like to be authorized to communicate with Nautilus Behavioral Health, PLLC.

Verification of Information and General Authorization to Contact

Patient Name: ___________________________

Name of Person Completing this Form: ___________________________

I hereby acknowledge that in completing this form, I have provided Nautilus Behavioral Health, PLLC with accurate information about demographics, background, history and presenting concerns.

I authorize Nautilus Behavioral Health, PLLC to contact the individual(s) designated in the Communication Preferences and Consents section of this form in the way(s) I have designated.

If applicable, I will bring the necessary legal documentation regarding custody, right to medical information and right to make decisions to the initial appointment.

________________________________	______________________________	____________
Caregiver or Patient Signature	Caregiver or Patient Printed Name	Date

________________________________	____________
Provider Signature	Date