Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Welcome to the office of Sheryl M. Hakala, M.D., P.A. Please take a moment to complete the following patient information for: ( ) Child ( ) Adult

Today's Date: ____/____/__ __ Referred By: _____

Patient Name: _____ Sex: ( ) Male ( ) Female

Home phone: (____)_____-_____ Cell phone: (____)_____-_____

Date of Birth: ____ - ____ - _____ Age: _____ S.S.#: _____ - _____ - _____

Marital Status: ( ) Single ( ) Married ( ) Other

Employment: ( ) Full-Time ( ) Part-Time ( ) Unemployed ( ) F-T Student

Company: _____ City: _____ Work Phone: (____)_____-_____

If student, school attends: _____

Home Address: _____ City:_____ Zip: _____

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____

Emergency Contact: _____ Phone: (____)_____-_____

Relationship: _____

Responsible Party (If different from above):

Name: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Home Phone: (____)____-_____ Work Phone: (____)____-_____ Cell: (____)____-_____

Printed Name: _____ Signature: _____

PLEASE NOTE: PAYMENT IS DUE AT BEGINNING OF EACH SESSION.

PATIENTS ARE RESPONDISBLE FOR THEIR OWN INSURANCE FILLING IF APPLICABLE

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Consent for Treatment And Financial Policy

Sheryl Hakala M.D., P.A.

This establishes the terms and conditions pursuant to which services are provided and are binding. I am committed to providing you the best possible care based on my expertise and education. My initial evaluations range from 60-90 minutes with a fee of $625. If the evaluation is longer than 90 minutes, an additional fee may be charged. My follow-up appointments for medication management are 15 minutes with a fee of $195, 30 minutes sessions with a fee of $245, and 50-60 minutes sessions with a fee of $325. Longer than 60 minute sessions may also be available for additional fees. The initial evaluation with the Advance Registered Nurse Practitioner or Physician Assistant range from 60-90 minutes with a fee of $250, and follow-ups are $100 for 15 minutes, $150 for 30 minutes, and $200 for 60 minutes.

Once I have decided on a diagnosis, I will expect the patient to become an active member of the treatment process. I will set follow up appointments depending on the diagnosis and availability of appointments. I expect you to follow through with the prescribed treatment, taking medications as prescribed, calling when side effects or emotional difficulties occur, in addition to homework, readings, and appointments with other health care professionals and attending your sessions. In the event that you do not follow through with your prescribed treatment, after 12 weeks of no contact from you, I will document in your chart that this was a treatment failure due to non-compliance. You have the right to discontinue treatment for any reason including that you feel better or changed psychiatrists at any point. All I need from you is a letter or a call telling me of this decision.

If you have health insurance, I will give you a receipt in order to allow you to submit it to the insurance company. If any further documentation is required, I may or may not be able to provide this. It is your responsibility to work with the insurance company. I need your help in understanding my payment policy. Payments for services are due at the time the services are rendered.

I accept cash or check. Returned checks will be subject to a $25.00 process fee. Balances over 90 days will be collected through a collection agency, thus releasing your name for collection of unpaid balances. Checks that are dishonored by the bank and not covered by the patient will also be sent to collections along with an attached collection charge of $35.00.

What I offer my patients is my time. Therefore, charges will also be made for No Shows or broken appointments. My No Show fee is the full charge of the appointment which must be paid by you before the next appointment is made. If you need to cancel or reschedule an appointment, please feel free to do so 24 hours before scheduled appointment. You may leave it on my confidential voice mail. All calls are dated and time stamped for your convenience.

I understand that my medical records are electronic, and all original copies of documents are shredded after they are saved electronically.

_____ ____/____/_____

Patient Signature Date

If patient is a minor, parent or legal guardian must sign.

Your signature constitutes a legal contract between you and Sheryl M. Hakala, M.D., P.A.

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

I understand that the first appointment with this psychiatrist is for the purpose of evaluating, diagnosing and treatment planning of my presenting complaint I understand that this initial evaluation my range from 60-90 minutes and may require future sessions or referral to another professional, depending on the diagnosis and specialty of the psychiatrist.

I understand that no medications are without risk for untoward events, and that there are rare and fatal side effects that can occur with any medication. I understand that it is my responsibility *to* notify my primary care provider then Dr. Hakala immediately if my child or I have any new physical ailments or side effects. I also understand that during my treatment, if I am prescribed more than one medication at a time, there may be possible drug interactions. I also understand that if I am prescribed a medication for my child, it will more than likely not have a black box warning for the use in children or not be FDA approved for the use in children. Most medications prescribed by psychiatrists also have a risk for suicidality. If my child or I am suicidal, it is my responsibility to notify Dr. Hakala personally. If I am unable to speak to Dr. Hakala immediately, it is my responsibility to obtain safe transportation to the nearest ER which may entail calling 911. Most medications prescribed by psychiatrists could cause possible harm to a fetus. It is my responsibility to ensure that my child or I do not become pregnant on psychotropic medications. I understand that any of the following methods: tubal libation, vasectomies, barrier methods, RID's, and oral contraceptives are not without risk of pregnancy.

I understand that Dr. Hakala makes every effort to be available twenty four hours a day, but my ability to reach her may be dependent upon and limited by the function or dysfunction of electronic devices, such as cell phones going out of range or satellites not working properly. I understand that if a disaster occurs that Dr. Hakala will make every attempt to be available by phone, but this may not be possible due to the nature of disasters. If I sin unable to reach her, I will find safe transportation to the *eeriest* ER. If Dr. Hakala has any medical procedures done, she will not be available, and I will go to the ER for treatment at those times.

In the process of my treatment/evaluation, I allow this psychiatrist to discuss ray case with my therapist, previous psychiatrist, family doctor and any other professional directly involved in my treatment. I understand that in the course of my evaluation/treatment Twill be given a diagnosis. I understand that I am fully liable for these appointments. That if I make an appointment and fail to call or show, I will be charged the frill fee fur the appointment time. I also understand that this fee will not be reimbursed by my insurance. This fee must be paid out of pocket by me, before *another* appointment can be made. I also understand that if legal action has to be taken against I for the collection of any unpaid fees, said balances will be sent to a collection agency after *90* days of attempted collections. I also understand that I will be held responsible for any legal fees incurred in this process.

I agree not to call Dr. Hakala as a witness in any litigation or legal proceeding, nor request or use any of her records or notes for the purpose of litigation. Should anyone seek to compel Dr. Hakala to provide information in a court proceeding or elsewhere, I agree in advance that I will compensate her in advance at her hourly court rate of $950 per hour including travel and preparation, and costs of all legal services which Dr. Hakala might choose to employ to defend the confidentiality/privilege of *these* sessions and of her notes.

I have read the above policies and fully understand them. In the case that I did not understand some of the information stated in this document, I have asked for an explanation. No guaranties or assurances have been made to me concerning the results of these services. This is a release of any liability to Sheryl Hakala or Sheryl M. Hakala, M.D., P.A., from any decisions or actions that may or may not take place as a result of the evaluation, therapy, counseling, psychiatric treatment, or referral I receive. I understand that under HIPAA all my clinical information will be kept confidential. That the State of Florida affords privilege to patient's mental health service provided under a licensed professional.

_____	_____	_____/_____/_____
Signature of Patient	Name of Patient	Date
_____	_____	_____/_____/_____
Signature of Witness	Name of Witness	Date

If patient is a minor, parent or legal guardian must sign

Your signature constitutes a legal contract between you and Sheryl M. Hakala, M.D., P.A.

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

ARBITRATION AGREEMENT AND INFORMED CONSENT

PATIENT NAME: _____

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary to unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties of this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before ajury, and instead are accepting the use of arbitration.

Article 2: All **Claims Must Be Arbitrated**: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement binds all parties as to all claims, including claims arising out of, relating to treatment or services provided by the health care provider including any heirs or past, present, or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence given rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working associated with or serving as a backup for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within, thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rate share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joiner in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joiner any existing court action against such additional person or entity shall be stayed pending arbitration.

_____	_____	____/____/_____
Signature of Patient	Name of Patient	Date

(Or patient's representative. Please indicate relationship if signing for patient.)

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

ARBITRATION AGREEMENT AND INFORMED CONSENT

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to *this* Arbitration Agreement.

Article 4: **General Provision**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article *5:* **Revocation**: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU *ARE* GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____	_____	_____/_____/_____
Signature of Patient	Name of Patient	Date

(Or patient's representative. Please indicate relationship if signing for patient.)

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

PATIENT TREATMENT CONTRACT

Patient Name _____ Date ____/_____/_____

As a participant in treatment, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
7. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
8. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
9. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
10. I understand that violations of the above may be grounds for termination of treatment.

_____	_____	____/____/_____
Signature of Patient	Name of Patient	Date

(Or patient's representative. Please indicate relationship if signing for patient.)

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

HIPAA NOTICE OF PRICACY PRACTICES (1/4)
Effective Date: July 5, 2006

This notice describes how medical Information about you may be used and disclosed and how you can get access to this Information, Please review It carefully. If you have any questions about this notice, please contact: Sheryl M. Hakala, M.D., P.A. at 813-503-7404 or 941-375-2812.

This notice describes the privacy practices at our office.

We are required by law to:

* Maintain the privacy of protected health Information
* Give you this notice of our legal duties and privacy practices regarding your health information
* Follow the terms of the notice currently in effect.

How we may use and disclose your health information. Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health Information only with your written permission. You may revoke such permission at any time by writing to Sheryl M. Hakala, M.D., P.A.

Treatment. We may use and disclose your health' information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, Including people outside our office, who are involved in your medical care and need the information to provide you' with medical care.

Payment. We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give Information to your health plan so that they will pay for your treatment.

Health Care Operations. We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share Information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose your health Information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your health information with a person Involved In, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

HIPAA NOTICE OF PRICACY PRACTICES (2/4)
Effective Date: July 5, 2006

Research. We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help Identify patients who may be included in their research, as long as they do not remove or copy any of your health Information.

As Required by Law. We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business *Associates.* We may disclose your health information to our business associates that perform functions on our behalf or provide us with services If necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not-allowed to use or disclose the information for any other purpose than appears In their contract with us.

Military and Veterans. If you are a member of the armed forces, we may release your health Information, as required by military command authorities. If you are a member of a foreign military we may release your health Information to the foreign military command authority.

Worker's Compensation. We may release your health Information for worker's compensation or similar programs that provide benefits for work-related injuries or Illness.

Public Health Risks. We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health Information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned-that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities. We may disclose your health Information to a health oversight agency for activities authorized by law. These may include audits, Investigations, inspections, and Ilcensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your health Information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only If efforts have been made to tell you about the request or to obtain an order protecting the information requested.

HIPAA NOTICE OF PRICACY PRACTICES (3/4)
Effective Date: July 5, 2006

Law Enforcement. We may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) If the request is limited to information needed to Identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even If, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed In an emergency to report a crime, the location of a crime or victims, or the Identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release your health Information to a coroner, medical examiner, or funeral director to Identify a deceased person or cause of death, or other5imiiar circumstance.

National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional Institution or in custody we may disclose your information 1) for the Institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the Institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and copy your medical and billing records by written request to Sheryl M. Hakala, M.D., P.A.

Right to Amend. You have the right to request an amendment to your records by written request to Sheryl M. Hakala, M.D.,P.A.

Right to an Accounting Of Disclosures. You have a right to an accounting of certain disclosures by written request to Sheryl M. Hakala, M.D.,P.A.

Right to Request Restrictions. You have the right to request restriction or limitation on your health Information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Sheryl M. Hakala, M.D.,P.A. We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Sheryl M. Hakala, M.D., P.A. We will accommodate reasonable requests.

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

HIPAA NOTICE OF PRICACY PRACTICES (4/4)
Effective Date: July 5, 2006

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Sheryl M. Hakala, M.D.,P.A. Please, copy this page and keep for your records.

Sheryl M. Hakala, M.D., P.A.
815 S Rome Ave
Tampa, FL 33606
813-503-7404

_____	_____	_____/_____/_____
Sign Full Name	Print Full Name	Date
_____	_____	_____/_____/_____
Sign Name of Witness	Print Name of Witness	Date

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Personal Information

Date: ____/____/____

Full Name: _____

Address: _____

Home phone: (____)_____-_____ Work phone: (____)_____-_____

Cell phone: (____)_____-_____ Other phone : (____)_____-_____

Gender: ( ) Male ( ) Female Date of Birth: ____/____/____ Age: _____

Marital Status:

____ Single ____ Separated ____ Significant Other

____ Engaged ____ Divorced ____ Widowed

____ Married

Who lives with you?

____ Live alone ____ Parents ____ Spouse

____ Child(ren) ____ Grandparents ____ Roommate

____ Significant Other ____ Other

Family History

Where were you born? _____

Where did you grow up? _____

Who primarily raised you? _____

Father's name: _____ Age: _____

Occupation: _____

Is your father still living? ____ Yes ____ No If no, age of death: _____ Your age: _____

Mother's name: _____ Age: _____

Occupation: _____

Is your mother still living? ____ Yes ____ No If no, age of death: _____ Your age: _____

If your parents are still living, what is the status of their relationship?

____ Married ____ Never Married ____ Separated

____ Divorced ____ Widowed ____ Other, explain: _____

Describe your mother: _____

_____

_____

_____

Describe your father: _____

_____

_____

_____

Describe your parents' (or parent substitutes') relationship with each other:

_____

_____

_____

What was your relationship like with your parents as a child?

_____

_____

_____

What was your relationship like with your parents now?

_____

_____

_____

Rate the degree that you confided in your parents as a child.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Very Often	At all times

Often At all times Rate the degree that you confide in your parents now

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Very Often	At all times

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

How many siblings do you have? _____

What is your birth order? _____

What was your relationship like with your siblings when you were growing up?

_____

_____

How were things financially in your family when you were growing up?

_____

_____

Were there any difficulties while you were growing up in your family?

_____

_____

Describe your home environment as a child:

_____

_____

Describe yourself as a child (0 to 12 years of age):

_____

_____

_____

How would you characterize your childhood?

_____

_____

_____

Describe your parents discipline method:

_____

_____

_____

Describe childhood fears you may have had as a child:

_____

_____

As a child, were there any situations or events that made you sad or upset? Please describe.

_____

_____

_____

How much contact do you have with your immediate family (parents, siblings) now?

_____

_____

School History

Where did you go to school?

Elementary _____

Middle _____

High School _____

What grade did you finish? ___ When did you receive your high school diploma or GED? ____

If you left high school before graduating, what were the reasons for leaving?

_____

_____

_____

How did you do academically in school?

_____

Did you have any disciplinary or behavior problems when in school?

_____

_____

_____

Describe your relationship with your teachers:

_____

_____

_____

Describe extra-curricular activities that you were involved in, including jobs.

_____

_____

_____

Did you attend college? If so when and where?

_____

List your degrees and areas of professional study/specialty training:

_____

_____

_____

Work History

What is your current occupation? _____

How long have you worked in this field? _____

Are you satisfied with your present employment? If no, please explain.

_____

_____

Describe any difficulties you have had in your present employment?

_____

_____

Describe your boss.

_____

_____

How would your boss describe you?

_____

_____

What other fields have you worked in?

_____

_____

Describe any difficulties you had with past employers.

_____

_____

Social History

Where do you live now and how long have you lived there?

_____

_____

Describe the neighborhood that you live in.

_____

Describe your home and home environment, including facilities for kids (ie. Playground, pool).

_____

_____

Medical History

How would you rate your physical health?

____ Poor ____ Not well ____ Fair ____ Somewhat Good ____ Moderately Good

____Good ____ Very Good ____ Extremely Good ____ Excellent

Do you eat a well-balanced diet? Yes No Do you exercise on a regular basis? Yes No

Do you smoke? If yes, how much? _____

Do you drink alcoholic beverages? If yes, how often and how much do you drink?

_____

Please identify any major medical problems or disability(ies) that you have.

_____

_____

Who is your primary medical provider (name, address, phone, etc)?

_____

_____

Are you presently under the care of any other medical practitioner(s)(name, address, phone, etc)?

_____

_____

Are you presently seeing a psychiatrist? If yes, who?

_____

Please list all prescription medications you are on presently and prescribing doctor.

_____

_____

Are you taking any over the counter vitamins or herbs? If yes, please list.

_____

_____

What concerns do you have about your physical health?

_____

_____

Please identify major surgery(ies) that are relevant to your emotional and physical well-being.

_____

_____

Psychological Background

Have you ever participated in therapy or counseling of any sort? ___ Yes ____ No

What type(s)? _____

_____

_____

If you have been in therapy, who is your therapist or counselor? _____

When did you start therapy and how often did you attend?

_____

_____

_____

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

In general, what kinds of issues did you talk about in therapy?

Have you ever been hospitalized for psychological or psychiatric reasons? If yes, when/where?

Does any member of your family have mental or emotional health problems? ___ yes ____ no

Have you ever attempted to commit suicide? ___ yes ____ no

Has any member in your family ever attempted to commit suicide? ___ yes ____ no

Have you ever been sexually abused? If so, please describe the physical abuse as it began first.

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Substance Use History and Treatment

Please identify by checking whether you have never used, ever used or currently use any of the following substances?

Substance	Never Used	Ever Used	Currently Use
Beer			
Wine			
Hard Liquor			
Marijuana			
Heroin			
Cocaine			
Amphetamines (uppers)			
Benzodiazepines (downers)			
Prescription drugs (w/out prescription)			

When did you use these substance(s), please list for each substance identified.

_____

_____

Has the use of any of the substance cause problems for you? If so, please describe.

_____

_____

_____

_____

Have you ever neglected your family, children, or friends because of your use of substances, including alcohol? If yes, please describe.

_____

_____

_____

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Have you ever been in a treatment program for substance use or abuse? If yes, please describe when, where and for how long.

_____

_____

Are you currently involved in a treatment program including outpatient therapy or 12-step support groups (ie. AA, NA)? If so, please describe how often you attend meetings and your level of activity in the group.

_____

_____

Criminal History

Have you ever been arrested for a crime? ___ yes ___ no

If yes, when was the arrest, was it a misdemeanor or felony charge, and what was the outcome for each charge?

_____

_____

_____

If you were convicted of a crime, what was the outcome and how long did you serve? (ie. Prison time, probation)

_____

_____

_____

Relationships

Is it easy for you to make friends? ___ yes ___ no

Do you keep friends that you make? ___ yes ___ no

Do you have one or more friends that you share most personal thoughts and/or experiences with? ___ yes ____ no

Did you have a lot of dates in high school? ___ yes ____ no

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Did you have a lot of dates in college? ___ yes ____ no

Describe a relationship of yours that is positive.

_____

_____

_____

Describe a relationship of yours that is negative.

_____

_____

_____

In social situations, describe how you generally feel.

_____

_____

_____

How many times have you been married? _____

Please list the dates of the marriages, name of partner and how the marriage ended, if applicable.

_____

_____

_____

If you are not married, are you presently involved in a serious relationship? If so, please describe the relationship.

_____

_____

_____

If you are involved in a relationship or remarried and the person has children, how well do your families blend together? Please describe.

_____

_____

_____

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Parenting History

How many children do you have? _____

What are their names, genders and birthdays?

_____

_____

_____

Please identify any additional information that you believe is important.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Authorization for Release of Information

I hereby request and authorize:

Sheryl M. Hakala, M.D., P.A.
815 South Rome Avenue, Tampa, Fl 33606, (813) 503-7404

To release written or verbal information specified below:

Verbal communication regarding treatment, labs, brief notes

To: _____
Name of Person(s) or Agency Requesting the Information

_____
Address

For the purpose of: Clinical Treatment

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR. There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information:

_____ Expiration Date	_____ Name and Social Security Number of Person		
_____ Signature of Competent Adult	_____ Printed Name of Competent Adult	___/___/____ Date	_____ am pm Time
_____ When applicable, Signature of:	_____ Printed Name of Substitute Decision Maker	___/___/____ Date	_____ am pm Time
☐ Guardian, ☐ Guardian Advocate, ☐ Health Care Surrogate/Proxy or ☐ Personal Representative/Equivalent (if deceased)			
_____ Signature of Witness	_____ Printed Name of Witness	___/___/____ Date	_____ am pm Time

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to s.394.4615 or other Florida statute is not subject to civil or criminal liability for such release. Such release must be in compliance with the federal HIPAA low.

See s.394.4615(1), Florida Statutes
CF-MH 3044, Feb 05 (obsoletes previous editions) (Recommended Form)

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Authorization for Release of Information

I hereby request and authorize:

Sheryl M. Hakala, M.D., P.A.
815 South Rome Avenue, Tampa, Fl 33606, (813) 503-7404

To release written or verbal information specified below:

Verbal communication regarding treatment, labs, brief notes

To: _____
Name of Person(s) or Agency Requesting the Information

_____
Address

For the purpose of: Clinical Treatment

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR. There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information:

_____ Expiration Date

_____ Name and Social Security Number of Person

_____ Signature of Competent Adult

_____ Printed Name of Competent Adult

___/___/_____ Date

_____ am pm Time

_____ When applicable, Signature of:

_____ Printed Name of Substitute Decision Maker

___/___/_____ Date

_____ am pm Time

☐ Guardian, ☐ Guardian Advocate, ☐ Health Care Surrogate/Proxy
or ☐ Personal Representative/Equivalent (if deceased)

_____ Signature of Witness

_____ Printed Name of Witness

___/___/_____ Date

_____ am pm Time

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to s.394.4615 or other Florida statute is not subject to civil or criminal liability for such release. Such release must be in compliance with the federal HIPAA low.

See s.394.4615(1), Florida Statutes
CF-MH 3044, Feb 05 (obsoletes previous editions) (Recommended Form)

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Authorization for Release of Information

I hereby request and authorize:

Sheryl M. Hakala, M.D., P.A.
815 South Rome Avenue, Tampa, Fl 33606, (813) 503-7404

To release written or verbal information specified below:

Verbal communication regarding treatment, labs, brief notes

To: _____
Name of Person(s) or Agency Requesting the Information

_____
Address

For the purpose of: Clinical Treatment

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR. There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information:

_____ Expiration Date	_____ Name and Social Security Number of Person		
_____ Signature of Competent Adult	_____ Printed Name of Competent Adult	___/___/____ Date	_____ am pm Time
_____ When applicable, Signature of:	_____ Printed Name of Substitute Decision Maker	___/___/____ Date	_____ am pm Time
☐ Guardian, ☐ Guardian Advocate, ☐ Health Care Surrogate/Proxy or ☐ Personal Representative/Equivalent (if deceased)			
_____ Signature of Witness	_____ Printed Name of Witness	___/___/____ Date	_____ am pm Time

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to s.394.4615 or other Florida statute is not subject to civil or criminal liability for such release. Such release must be in compliance with the federal HIPAA low.

See s.394.4615(1), Florida Statutes
CF-MH 3044, Feb 05 (obsoletes previous editions) (Recommended Form)

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Authorization for Release of Information

I hereby request and authorize:

_____
Name of Person(s) or Agency Requesting the Information

_____
Address

To release written or verbal information specified below:

Verbal communication regarding treatment, labs, evaluations, progress notes

To: ***Sheryl M. Hakala, M.D., P.A***.
815 South Rome Avenue, Tampa, Fl 33606, (813) 503-7404

For the purpose of: Clinical Treatment

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR. There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information:

_____ Expiration Date	_____ Name and Social Security Number of Person		
_____ Signature of Competent Adult	_____ Printed Name of Competent Adult	___/___/____ Date	_____ Time am pm
_____ When applicable, Signature of:	_____ Printed Name of Substitute Decision Maker	___/___/____ Date	_____ Time am pm
☐ Guardian, ☐ Guardian Advocate, ☐ Health Care Surrogate/Proxy or ☐ Personal Representative/Equivalent (if deceased)			
_____ Signature of Witness	_____ Printed Name of Witness	___/___/____ Date	_____ Time am pm

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to s.394.4615 or other Florida statute is not subject to civil or criminal liability for such release. Such release must be in compliance with the federal HIPAA low.

CF-MH 3044, Feb 05 (obsoletes previous editions) (Recommended Form)

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Authorization for Release of Information

I hereby request and authorize:

_____
Name of Person(s) or Agency Requesting the Information

_____
Address

To release written or verbal information specified below:

Verbal communication regarding treatment, labs, evaluations, progress notes

To: ***Sheryl M. Hakala, M.D., P.A***.
815 South Rome Avenue, Tampa, Fl 33606, (813) 503-7404

For the purpose of: Clinical Treatment

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR. There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information:

Expiration Date	Name and Social Security Number of Person		
Signature of Competent Adult	Printed Name of Competent Adult	___/___/____ Date	_____ am pm Time
When applicable, Signature of:	Printed Name of Substitute Decision Maker	___/___/____ Date	_____ am pm Time
☐ Guardian, ☐ Guardian Advocate, ☐ Health Care Surrogate/Proxy or ☐ Personal Representative/Equivalent (if deceased)			
Signature of Witness	Printed Name of Witness	___/___/____ Date	_____ am pm Time

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to s.394.4615 or other Florida statute is not subject to civil or criminal liability for such release. Such release must be in compliance with the federal HIPAA low.

CF-MH 3044, Feb 05 (obsoletes previous editions) (Recommended Form)

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, Suite 9,
Sarasota, FL 34239
Phone: (941) 375-2812

Authorization for Release of Information

I hereby request and authorize:

_____
Name of Person(s) or Agency Requesting the Information

_____
Address

To release written or verbal information specified below:

Verbal communication regarding treatment, labs, evaluations, progress notes

To: ***Sheryl M. Hakala, M.D., P.A***.
815 South Rome Avenue, Tampa, Fl 33606, (813) 503-7404

For the purpose of: Clinical Treatment

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR. There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information:

Expiration Date	Name and Social Security Number of Person		
Signature of Competent Adult	Printed Name of Competent Adult	___/___/____ Date	_____ am pm Time
When applicable, Signature of:	Printed Name of Substitute Decision Maker	___/___/____ Date	_____ am pm Time
☐ Guardian, ☐ Guardian Advocate, ☐ Health Care Surrogate/Proxy or ☐ Personal Representative/Equivalent (if deceased)			
Signature of Witness	Printed Name of Witness	___/___/____ Date	_____ am pm Time

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to s.394.4615 or other Florida statute is not subject to civil or criminal liability for such release. Such release must be in compliance with the federal HIPAA low.

CF-MH 3044, Feb 05 (obsoletes previous editions) (Recommended Form)