Help Begins Here …

Central Florida Counseling & Psychological Services, Inc
1514 W. Main St., Leesburg, Fl 34748
(phone)352-365-6506 (fax)352-365-6596

CONFIDENTIAL PATIENT INFORMATION - UPDATE

(Please Print)
Name: _____
First Middle Last
Address: _____
Number Street City State Zip
Mailing Address (If Different):_____
Number Street City State Zip

Please indicate the best number to reach you		May we call you:	May we leave a message:
Home Phone:	( ) _____	Yes or No	Yes or No
Work Phone:	( ) _____	Yes or No	Yes or No
Cell Phone:	( ) _____	Yes or No	Yes or No

Social Security # _____- _____ -_____ Date of Birth _____/_____/_____ Age ____ o Male o Female
Marital Status: o Single o Married o Divorced o Separated o Partnered o Other
Employer: _____o F/T o P/T Student o F/T o P/T
e-Mail _____ May we contact you through email: o Yes o No

Has there been any changes to your insurance since your last visit? ___Yes ___No

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Ins. Phone #: _____
Policy Holder Name: _____ Date of Birth:_____ o Male o Female
Policy/ID Number: _____ Group Number: _____
Social Security # _____-_____-_____ Employer: _____
Relationship to patient: o Self o Other _____ Phone: _____

Secondary Insurance Carrier: _____ Ins. Phone #: _____
Policy Holder Name:_____ Date of Birth_____
Policy/ID Number: _____ Group Number: _____
Social Security Number: _____- _____-_____ Employer: _____
Relationship to patient: o Self o Other _____ Phone: _____

RESPONSIBLE PARTY INFORMATION (if other than patient)

Name: _____ Check if: o Custodial Parent o Legal Guardian
Address: _____
Home Phone: ( ) _____ Work Phone: ( ) _____Cell Phone: ( ) _____
Relationship to Patient: _____e-Mail: _____

_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process all claims. I authorize payment of medical benefits to: CM Reid & Associates, Inc./Central Florida Counseling & Psychological Services, Inc.

SIGNED: _____ DATE: _____

FOR OFFICE USE ONLY: Dx: _____
MANAGED CARE: # Sessions Auth'd _____Start _____ End_____ Auth. # _____

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CONSENT FOR SERVICES

This form is to document that I, _____ give my permission and consent
PRINT NAME
to the above, Central Florida Counseling & Psychological Services, Inc., to provide

psychotherapeutic treatment and/or assessments to me and/or _____,
PRINT NAME
who is/are my child/children or for whom I am legal guardian, custodian, or legal Power of

Attorney.

I understand the following:

- Although I expect benefits from this treatment and/or evaluation, such benefits or particular outcomes cannot be guaranteed.
- This therapist is not providing an emergency service. In case of an emergency, please call 911or go to your nearest emergency room.
- Regular attendance will produce maximum benefits, but I am free to discontinue treatment at any time.
- Your therapist may terminate treatment for non-compliance of treatment goals, no shows, last minute cancelations, inappropriate or criminal behavior or non-payment of fees.
- We may utilize a collection service for non-payment of fees.
- Conversations with the therapist are confidential. However, by law, there are certain exceptions to the limits of confidentiality. These limits include actual or suspected child abuse, elder abuse, and threats of harm toward oneself or others. The therapist will make reasonable efforts to discuss these issues before breaking confidentiality, however disclosure may become necessary when ordered by a court of law.

I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

Signature: _____ Date: _____

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FINANCIAL AGREEMENT

As a courtesy, this office will file claims with the insurance company for you. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor/therapist. I understand that it is my responsibility to pay any deductibles, co-insurance or any other balance not paid by my insurance or third party payer within a reasonable period of time, not to exceed 60 days. Unless this office has a direct contract with your insurer, we ask that you pay for each session in advance. We are contracted with Medicare and most other major carriers. However, it is the patient's responsibility to confirm coverage with your insurer and determine if preauthorization is required.

Treatment Summary Requests, Professional Letters, E-mails or Phone/Conference calls may be billed, if requested, in 15 minute increments at the individual therapeutic rate.

If you need to cancel or reschedule an appointment, please give us 24 business hours advance notice; otherwise, you will be billed at the hourly rate.

If I am asked to participate in any legal proceedings on your behalf, my rates are $240 per hour with a 3 hour minimum and includes preparation, travel and testimony.

Signature(s): _____ Date: _____

COORDINATION OF TREATMENT

It is important that all healthcare providers work together. As such, I would like your permission to communicate with your Primary Care Physician and/or Psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

_____ You may inform my Physician(s). _____You may NOT inform my Physician.

Physician/Psychiatrist Name: _____

Address: _____Phone: _____

Physician/Other Name: _____

Address: _____Phone:_____

Signature(s): _____Date: _____

NOTICE OF PRIVACY PRACTICES

I have read a copy of HIPPA posted in the office. (A copy is available upon request) I may discuss any concerns about these policies with the therapist.

Signature(s): _____Date:_____

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Name: _____ Date: _____ Age: _____

What would you like to see accomplished in therapy? _____

_____

CHIEF COMPLAINT (CHECK ALL THAT APPLY TO YOU):

___ Depression
___ Low energy
___ Low self-esteem
___ Poor concentration
___ Hopelessness
___ Worthlessness
___ Guilt
___ Sleep disturbance (more/less)
___ Appetite/weight change (more/less)
___ Thoughts of hurting yourself
___ Thoughts of hurting someone
___ Isolation/social withdrawal
___ Sadness/loss
___ Stress
___ Anxiety/Panic
___ Heart pounding/racing
___ Chest pain
___ Trembling/shaking
___ Sweating
___ Chills/hot flashes
___ Tingling/numbness
___ Fear of dying
___ Fear of going crazy
___ Nausea
___ Phobias
___ Obsessions/compulsive behaviors
___ Thoughts racing
___ Not thinking clearly/confusion
___ Easily agitated/frustrated/angered
___ Delusions/hallucinations

___ Feeling that you are not real
___ Feeling things around you are not real
___ Lose track of time
___ Unpleasant thoughts won't go away
___ Defies rules
___ Blames others
___ Argues
____Excessive behaviors (spending, gambling, sex)
___ Excessive use of drugs and/or alcohol
___ Excessive use of prescription medication
___ Change in Alcohol use (more/less)
___ Physical abuse issues
___ Sexual abuse issues
___ Spousal abuse issues
___ Other problems/symptoms:
_____
_____
_____

The degree to which these symptoms cause distress with day to day functioning:

At Work:
O Minimal **O** Moderate **O** Severe

At Home:
O Minimal **O** Moderate **O** Severe

Socially:
O Minimal **O** Moderate **O** Severe

Changes in symptoms or life events since your last visit that your Therapist needs to be aware of:

_____
_____

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Name_____ **Date** _____

Changes in Medications? __ Yes __ No Please list below

Drug	Dose Frequency	Reason given	Prescribing Doctor	Date started	Comments

Suicide Assessment:

Have you attempted suicide? **O** Yes **O** No Number of attempts _____

If yes, how long ago was the last attempt? _____

Do you have current thoughts of harming yourself? **O** Yes **O** No

If yes, do you have a plan? **O** Yes **O** No

If yes, please describe your plan: _____

_____

Support System:

Do you feel you have a support system? **O** Yes **O** No

If yes, who are they? _____

_____