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

(Please Print)
Name:____
First Middle Last
Address:____
Mailing Address(If Different):
____

Please indicate the best number to reach you **May we call you?**: **Leave a message?**
Home Phone: ( ) ____________________ O Yes O No O Yes O No
Work Phone: ( ) ____________________ O Yes O No O Yes O No
Cell Phone: ( ) ____________________ O Yes O No O Yes O No
May we text an appointment reminder? O Yes O No, I will manage my own appointment reminders.
May we contact you through email: O Yes O No Send appt reminder through email? O Yes O No
e-Mail: ____

Social Security # _______- _____ -_________ Date of Birth _____/_____/______ Age ___
Sex: 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

INSURANCE INFORMATION

Primary Insurance Carrier: ____________________________________Ins. Phone #:___________
Policy Holder Name: ____Date of Birth:___________
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: _______________________________ Sex: o Male o Female
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:______________________________

Help Begins Here ...

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

CONSENT FOR SERVICES

This form is to document that I, _________________________________ give my permission and consent
PRINT NAME
to 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.

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 Name: ____________________________________ Phone:__________________________
Physician Name: ____________________________________ Phone: __________________________

Is there someone else you would like us to share information with?

Name: _________________________________ Relationship:___________________ Phone:______________

Signature: ____ Date: ____________________

Help Begins Here ...

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

NOTICE OF PRIVACY PRACTICES

I have read a copy of HIPAA posted in the office (A copy is available upon request). This document outlines the method of communications that work within the privacy guidelines covered by law.

Electronic Communication: If I choose to utilize an electronic means of communication with my therapist or the staff of Central Florida Counseling & Psychological Services, Inc (the Office) I understand that not all formats are considered HIPAA compliant. Therefore, while we will make a best effort to protect your information, I cannot be guaranteed the same confidentiality as in-office, person to person communication. For instance, emails, SMS texts and phone calls are not HIPAA compliant. Your therapist can confirm if your desired method of communication is HIPAA compliant, and if not he/she may offer HIPAA compliant alternatives where applicable.

As a convenience to our patients, we may also offer Telehealth options where it is determined by your therapist that your sessions can be offered in a remote setting (e.g. at home). Your therapist will discuss the available options for these sessions as appropriate. I understand that my therapist, or the office, cannot be held liable for any disclosure of any information shared by me that is not via a confirmed HIPAA method. Additionally, I understand that even while using HIPAA compliant software, in very rare instances, security protocols could fail, causing a breach of privacy of personal information. I understand I may discuss any concerns about these policies with my therapist.

FINANCIAL AGREEMENT

As a courtesy, our billing service will file claims with the insurance company on your behalf based on the accuracy of the information you provided us. I understand that it is my responsibility to pay any deductibles, co-insurance or any other balance not paid by my insurance within a reasonable period, not to exceed 60 days. Insurance is a contract between you and your insurance company, and we have limited access to your insurance benefit information. We may verify your benefits, however, this is not a guarantee of benefits. Ultimately, it is the patient's responsibility to confirm coverage with your insurer as well as to determine if any additional authorization is required. We have the right to utilize a collection service for any outstanding balances.

Other Fees: 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 you permit us, we will send a courtesy SMS text and/or email reminder, however we are not responsible for lost or undelivered messages.

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.

By signing below, I am confirming that I have read and understand the above Notice of Privacy Practices and the Financial Agreement and agree to the terms outlined.

Signature(s): ____ Date: ____________

Help Begins Here ...

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

Name: ___________________________________ Date: ______________

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 else
___ 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 use of drugs and/or alcohol
___ Excessive use of prescription medication
___ Excessive behaviors (spending, gambling, sex)
___ 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

Previous outpatient therapy? ____ No ____ Yes, with ______________________
What was accomplished?____

____

Previous hospitalization? ____ No ____ Yes Number of hospitalizations _____
ECT/TSM? _______ If yes, when_______________________________________

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

History Form- Adult

Name____ Date ________________ Age _____

What has led you to seek counseling at this time? ____

____

____

Who referred you? ____

What is your relationship status?

O Single **O** Engaged **O** Married **O** Partnered **O** Divorced **O** Widowed

O Separated **O** Cohabitating and unmarried Spouse/Partner's Name: _______________________

How would you describe your current relationship? **O** Excellent **O** Good **O** Fair **O** Poor

How many times have you been married? **O** None **O** Once **O** Twice **O** Three or more

How would you describe your past relationship(s)? **O** Excellent **O** Good **O** Fair **O** Poor

Please describe your current living situation: ____

____

____

Please list your strengths: ____

____

Religious / Spiritual / Social Issues:

Are religious or spiritual issues important to you? O Yes O No

Do you wish to discuss them in counseling, when relevant? O Yes O No

Do you feel that you can socialize with others easily? O Yes O No

List clubs and organizations, you belong to: ____

____

What do you do for pleasure and relaxation? ____

____

____

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

Please tell us about your children: **O** I do not have children

Age of First Pregnancy _______________ **or** Age of First Fatherhood _______________

1. Name ___________________________________ Age _______ Sex: o Male o Female

O Biological **O** Adopted **O** Step **O** Foster **O** Relative **O** Other ___________________

Does this child live with you? **O** Yes **O** No

Does this child have a physical, emotional or learning disability? **O** Yes **O** No

How you describe your relationship with this child? **O** Excellent **O** Good **O** Fair **O** Poor

2. Name ___________________________________ Age _______ Sex: o Male o Female

O Biological **O** Adopted **O** Step **O** Foster **O** Relative **O** Other ___________________

Does this child live with you? **O** Yes **O** No

Does this child have a physical, emotional or learning disability? **O** Yes **O** No

How you describe your relationship with this child? **O** Excellent **O** Good **O** Fair **O** Poor

3. Name ___________________________________ Age _______ Sex: o Male o Female

O Biological **O** Adopted **O** Step **O** Foster **O** Relative **O** Other ___________________

Does this child live with you? **O** Yes **O** No

Does this child have a physical, emotional, or learning disability? **O** Yes **O** No

How you describe your relationship with this child? **O** Excellent **O** Good **O** Fair **O** Poor

* Please include additional children in the space below.

____

____

____

Family History:

Please describe any family history that may be relevant in our sessions, such as divorce, death, illnesses, issues with siblings, etc. ____

____

____

____

Education: What is the highest grade you have completed? _____________________________________

Occupation: Are you currently employed? **O** Yes, full-time **O** Yes, part- time **O** No

If yes, how long have you been employed? _____________________________________

Employer: ____

Job Title/ Occupation: ____(If retired, previous occupation)

Help Begins Here ...

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

Legal History/ Social Agency Involvement:

Have you ever been charged with a crime, other than a minor traffic offense? **O** Yes **O** No

If yes, please describe____

____

Medical History:

Have you ever had the following (if yes, please describe):

O Major Illness____________________________________ Date: _________________

O Serious Physical Injury____________________________ Date: _________________

O Accident _______________________________________ Date: _________________

How would you describe your current health? **O** Excellent **O** Good **O** Fair **O** Poor

Please describe any current medical problems: ____

____

____

____

Are you currently receiving disability? O Yes O No

Have you recently applied for disability? O Yes O No

Medications: Include prescription and non-prescription drugs and/or supplements.
(If you need to add more - please put on the back of this sheet or attach a list)

Drug	Dose Frequency	Reason given	Prescribing Doctor	Date started	Comments

Has a physician ever recommended any anti-anxiety, anti-depressant, ADHD, or anti-psychotic medication for you? **O** Yes **O** No If yes, please describe: ______________________________

____

Tobacco Use:

Do you use tobacco of any form? **O** Yes **O** No

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

Substance usage:

Do you use drugs? **O** Yes **O** No

If you use drugs, what kind you use and frequency: ____

____

Do you consume alcohol? **O** Yes **O** No

If you consume alcohol, how much do you consume? (Please list type and frequency) ______________

____

Have you ever felt like you should cut down on your alcohol or other drugs use (including prescription drugs)? **O** Yes **O** No

Has a friend or relative discussed concerns about your drug or alcohol use? **O** Yes **O** No

Have you ever had to take a drink or use a drug the next day to steady your nerves? **O** Yes **O** No

Are you a recovering alcoholic or recovering drug addict? **O** Yes **O** No

Is there a history of problems with alcohol or drug use in your family? **O** Yes **O** No

Suicide Assessment:

Have you attempted suicide? **O** Yes **O** No

If yes, how long ago was the last attempt? ______________How many total attempts? _____________

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: ____

____

Do you have the means to carry out this plan? **O** Yes **O** No

Your intention on initiating the plan: **O** None **O** Minimal **O** Moderate **O** Severe

Do you feel you have a support system (Family, Friend, Agencies, Church)? **O** Yes **O** No

If yes, who are they? ____

____

____

Additional comments: ____

____

____

____

____