CENTRAL FLORIDA PSYCHOLOGICAL CONSULTANTS, INC
WWW.CENTRALFLORIDAPSYCHOLOGY.COM

Central Florida Psychological Consultants
P.O. Box 490134
Leesburg, FL 34749
(352) 365-2243
www.centralfloridapsychology.com

Personal Information & Insurance Form

Name: _____
Last Middle Initial First

Date of Birth: _____/_____/_____

If patient is a minor, parent's (insurance policy holder's) Date of Birth: _____/_____/_____

Sex (circle one): Male / Female

Home #: (_____)_____-_____

Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Best way to contact you: _____

E mail Address: _____

Home Address: _____
Street

_____
City State Zip code

Social Security Number; _____ - _____ - _____

If patient is a minor, parent's (insurance policy holder's) Social Security Number: _____ - _____ - _____

Occupation: _____Employer: _____

Reason For Seeking Services: _____

Emergency Contact: _____(_____)_____
Full Name Phone Number

Assignment of Insurance Benefits and Patient Responsibility

By Signing this form I am voluntarily authorizing the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes Central Florida Psychological Consultants, Inc., to submit claims for benefits for services rendered without having to obtain my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed each particular claim.

I _____, hereby authorize, _____
(Insured Name) (Name of Insurance Company)

to pay and herby assign directly to Central Florida Psychological Consultants, Inc., all benefits if any, otherwise payable to me for his/her services as described on this form. **I understand that I am financially responsible for ALL charges incurred, including services not covered by insurance.** I further acknowledge that any insurance benefits, when received by and paid to Central Florida Psychological Consultants, Inc., will be credited to my account in accordance with the above said statement.

I understand that a NO SHOW or less than 24hr in advance cancellation fee of $60.00 will be assessed and will be due before my next scheduled appointment. I also acknowledge, that if I am late for an appointment, I will still be charged for the session in full

_____ Date: _____/_____/_____
Client's Signature

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Fees and insurance reimbursement:

Your insurance company may reimburse you for part of your fee; however it is your responsibility to pay your fee upfront unless other arrangements are made. If you cannot pay the full fee, please ask for a sliding scale fee evaluation form and submit it to your therapist. Your fee will not be changed until the form is fully filled out and returned to your therapist for evaluation. Your fee reduction is based on the information you have provided. If you are having difficulty keeping up with the charges please notify your counselor or the office manager, and they will be glad to reevaluate at any time.
Fees for court appearances, phone sessions, copies of records etc. will be discussed with you by your therapist as the need arises.
Your fee will be collected at the beginning of each session. Checks and cash are accepted. If you are going to use a check please have it ready when you come in to save time. Make checks payable to **CFPC, INC**. For an additional fee you can use your credit or debit card.

Beginning a course of psychotherapy requires both client and therapist to commit to regular sessions. Your therapist reserves a weekly time for which you are responsible. If you are unable to keep a given appointment, the policy is to reschedule or cancel **no less** than 24 hours in advance. If you need to reschedule or cancel with *less* than 24 hours notice, our policy is to charge for the missed appointment. A no show/cancellation fee of $60.00 will be charged to your card. To avoid payment for missed appointments, cancellations need to be made *24 hours or more in advance.* This fee may be waived on a case-by-case basis for extraordinary circumstances.

Your therapist will make every effort to work with you to reschedule a missed session. There are therapeutic, as well as business reasons for this policy and your therapist would be happy to discuss any questions or concerns you may have.

At times it may be clinically beneficial or necessary for your therapist to provide services in addition to therapy. These services may include but are not limited to phone consultations with adjunct mental health professionals, schools, attorneys, or physicians, as well as create reports or letter writing, or time spent providing any other service authorized by you including travel time. It is our policy to charge a prorated amount for these services based on our standard session fee. There will be no charge for phone consultations less than 15 minutes as this is considered reasonable part of the clinical counseling relationship.

All accrued fees are to be **paid in full prior** to your next scheduled appointment unless prior arrangements have been made with your clinician. In the space below please provide a credit card or debit card number that you would like to keep on file for such fees. You may choose to use the same form of payment for all appointments; however, it is *not* required. For attended sessions, any form of payment is accepted.

I have read and understand the above policies and agree to comply with them and if necessary make any arrangements for those that may apply to me. By your signature below you are indicating that you have read and understood this Information and Consent Form and/or that any questions you have had about this statement have been answered to your satisfaction. Your signature also indicates that you are over 18 years of age and legally competent.

Card Type: _____ Expiration Date: _____/_____/_____

Card #: _____ CSC #: _____

_____
Print Name

_____ Date: _____/_____/_____
Client's Signature

_____ Date: _____/_____/_____
Parent/Guardian's Signature

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RELEASE OF INFORMATION CONSENT

Patient's Name: _____ Date of Birth: _____/_____/_____
Last Middle initial First

I, _____, authorize Central Florida Psychological Consultants, Inc., to
(Patient name)

to send and/or receive information to _____ .
(To whom you want information released to)

Receiving Parties address: _____
Fax #: _____
Phone #: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

Please check the following options for what you would like released:

_____ Academic testing results
_____ Behavior programs
_____ Progress reports
_____ Intelligence testing results
_____ Medical reports
_____ Personality profiles
_____ Psychological reports
_____ Psychological testing results
_____ Service Plans
_____ Summary reports
_____ Vocational testing results
_____ Psychotherapy notes
_____ **Entire record, except progress notes**
_____ Other, please specify:
_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year, this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right

Your relationship to the client: ❑ Self ❑ Legal Representative ❑ Parent/legal guardian
❑ Other: _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: _____ /_____ /_____

Parent/guardians/personal representative (if applicable):

Signature: _____ Date: _____ /_____ /_____

Witness (if client is unable to sign)

Signature: _____ Date: _____ /_____ /_____

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Consent to Treatment and Recipient's Rights

I, _____ the undersigned, hereby attest that I have voluntarily entered into

(client's printed name)

treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Central Florida Psychological Consultants, Inc. , hereby referred to as CFPC, Inc.. Further, I consent to have treatment provided by a psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. Central Florida Psychological Consultants, Inc. encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from my psychotherapist.

Nonvoluntarily Discharge from Treatment: A client may be terminated from CFPC, Inc. nonvoluntarily. if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at CFPC, Inc., and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the nonvoluntary discharge by letter. The client may appeal this decision with their psychotherapist.

Client Notice of Confidentiality: The confidentiality of patient records maintained by CFPC, Inc. is protected by federal and/or state law and regulations. Generally, CFPC, Inc. may not say to a person outside CFPC, Inc. that a patient attends sessions or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at CFPC, Inc., against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is CFPC, Inc.'s duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of nonemancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program

I consent to treatment and agree to abide by the above-stated policies and agreements with Central Florida Psychological Consultants, Inc.

_____ _____/_____/_____
Signature of Client/Legal Guardian Date

_____ _____/_____/_____
Witness Date

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What to expect;

No guarantee is made that the counseling you receive will affect the desired results. Individual success largely depends on the intentional application of the insights, skill and knowledge the client gains through the counseling process and their willingness to be active, open, honest and as consistent as possible with their therapist.

What your therapist expects from you:

Express concerns, ask questions
Complete assignments
Come to counseling free from the influence of any substances
Pay your fees upon arriving to your session (have checks made out in advance)
Be on time for your appointments
Cancel 24 hours in advance (by phone or email)
(No shows and cancellations made less than 24 hours in advance are billed at $25.00)

What is counseling like?

A safe place where you will be accepted no matter what your struggle or difficulty An opportunity to grow personally and spiritually
Personally challenging Teaches responsibility for the things you have control over
Most sessions are approximately 1 hour in length

What to expect from your therapist:

Return your calls within 24 hours in most cases
Continue to update their skills and obtain ongoing training
Treat you with kindness and respect
Develop a plan with you to help you achieve your goals and objectives
Discuss discharge planning with you as soon as clinically appropriate
Seek confidential consultation with other professionals when appropriate
Help you to find an appropriate referral if necessary
Counseling may be terminated for consistent failure to complete assignments, failure to pay fees, and failure to consistently show for scheduled appointments.

Couples Therapy

Successful marriages are based on trust. Therefore openness and honesty is the best policy. For successful therapy there can be no secrets within couples counseling. However, sometimes there are issues that are disclosed during individual sessions that may be difficult for one spouse to disclose to the other. When that is the situation, you and your counselor will work together on the best way to share that information with your spouse.

Records and Confidentiality

The code of ethics for counselors and the state laws regulating most kinds of counseling consider personal information you discuss to be confidential. Except in a small number of situations, the helping professional may not reveal any information about you to another person without your explicit permission. Records of your treatment will be kept for seven years after your final session.

One exceptions to this rule includes if your fees are paid by a third party such as an insurance company, certain details of your treatment (e.g. dates of treatment, diagnosis, symptoms, progress) may be required to be revealed in order to obtain reimbursement. Most insurance companies allow you to file claims directly with them so that your employer will not see the information.

In cases where a court order has been issued and records have been subpoenaed the counselor has a legal responsibility to comply. INFORMATION AND CONSENT FORM Central Florida Psychological Consultants, Inc. PO Box 490134 Leesburg, Florida 34749 352-365-2243 www.centralfloridapsychology.com

Suicidality and Abuse

Another exception where counselors are legally required to disregard confidentiality involves situations where there is a potential for suicide or homicide. For example, if you reveal information that indicates a clear danger of injury to yourself or others the counselor will need to contact the appropriate authorities or family members. Another exception to confidentiality is that all helping professionals are required by law to report any knowledge of abuse or neglect of a child or incompetent person or disabled person including suspected abuse.

Your counselor will be happy to discuss any concerns you have about the protection of the information you provide.

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Witness Date

INTAKE

Client Name: _____ D.O.B: ____/____/____
Reason for seeking counseling: _____
_____

Please check any symptoms/behaviors which may apply to you and indicate if it is present or in the past:

Symptom/Behavior	Past	Present	Explanation
Change of Appetite			
Binging/Purging Food			
Weight Loss/Gain			
Mood Swings			
Withdrawn Behavior			
Depression			
Mood Swings			
Anxiety			
Obsessive Thoughts			
Compulsive Behaviors			
Anger Management			
Cruelty to Animals			
Poor Memory			
Processing Difficulty			
Fire Setting			
Enuresis			
Encopresis			
Aggression			
Lying			
Stealing			
Sexual Acting Out			
Sexual Dysfunction			
Nightmares/Night Terrors			
Vivid Dreams			
Fears			
Somatic Complaints			
Abuse/Neglect			
Grief/Loss			
Stress			
Flash Backs			
Financial Issues			
Addictive Behavior			
Impulsivity			
Hyperactivity			
Lethargic			
Poor Concentration			
Short Attention Span			
Poor Family Relations			
Poor Relations in the Workplace			
Hallucinations/delusions			
Difficulty with Authority			
Spiritual Issues			
Feeling Inadequate/Other			

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Mental Health History: (Past outpatient services and hospitalizations, include dates)
_____
_____
Was it effective/how so? _____
What was your diagnosis (es)? _____
Have you ever experienced suicidal/homicidal ideations? (circle one) Yes/No
Intentions? (circle one) Yes/No
If yes, please explain: _____
_____

Legal Issues: (List any past and/or present legal issues: i.e., arrests, convictions, bankruptcy, divorce etc. include dates) _____
_____
_____

Abuse History (has client been victim of any type of abuse?)**: (Please circle Yes or No)**
Physical abuse: Yes No Emotional Abuse Yes No Sexual Abuse Yes No
Domestic Violence Yes No Abandonment Yes No Neglect Yes No
Age(s) at time of abuse: _____ Treatment received: _____
Who was perpetrator? _____
Reported to Authorities? _____ Finding/disposition: _____

Did client witness any types of abuse listed above: Yes No
If yes, which type of abuse? _____
Who was the victim? _____ Who was the perpetrator? _____
Has client been the perpetrator of any abuse? Yes No Who was the victim? _____
If yes, which type of abuse? _____

Addiction/Substance Use History (If you need more space for explanation, please use back of this page)**:**
Please circle Yes or No
Alcohol Yes / No Pain Pills Yes / No Marijuana Yes / No
Tranquilizers Yes / No Stimulants Inhalants Yes / No
Sleeping Pills Yes / No Narcotics Yes / No
Hallucinogens Yes / No Heroin/Meth Yes / No
Sex Yes / No Gambling Yes / No Pornography Yes / No
Other: _____
Drug of preference: _____ How long used? _____ Last used? _____
Treatment program: _____ When? _____ How long? _____ How long clean/sober? _____

Medical History (If you need more space use back of page)**:**
List any major accidents, illnesses, operations with date of occurrence: _____
_____
_____
List date and type of any head injuries or seizures: _____
_____
List current medications and reason prescribed: _____
_____
List any allergies to medications: _____

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Physician:
Are you currently under a physician's care? _____
Names of Physicians/Specialists who are treating you: _____
_____
_____
_____

Education:
Highest grade completed: _____ Graduated/degree: _____
Any difficulty learning to Read: _____ Write: _____ Math: _____
Did you ever repeat a grade? Yes/No For what reason: _____
Favorite subject: _____ Most accomplished subject: _____
Circle One:
I learn best by: seeing it done reading about it hearing about it

Occupation:
Current occupation/vocation: _____ How long: _____
On a scale of 1-10, 10 being very satisfied how satisfied are you with your current occupation? _____
Please describe any difficulties you are having concerning your occupation: _____
_____
_____

Social Relationships:
How frequently do you socialize with friends? _____
How frequently do you socialize with extended family? _____
What kinds of activities do you do when you get together? _____
_____
On a scale of 1-10, 10 being very satisfied:
Rate your satisfaction with peer relationships: _____
Rate your satisfaction with extended family relationships: _____
Who do you feel is "on your side" in life? _____
Are there any people in your life you can talk to about your problems? _____
Please describe any difficulties you are having socially: _____
_____

Family History (Please list those family members with a history of mental illness, learning disabilities, mental retardation or addictions) (If you need more space use back of page)
Children: _____
_____
Parents: _____
_____
Siblings: _____
_____
_____
Maternal Grandparents: _____
_____
Paternal Grandparents: _____
_____
Maternal Aunts and Uncles: _____
_____
Paternal Aunts and Uncles: _____
_____

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Developmental History:
Prenatal health issues: _____
_____
Birth Trauma (C-section, birth injuries, complications): _____
_____
Developmental Milestones: Describe any problems with the following:
Attachment/bonding: _____
Motor skills: _____
Toileting: _____
Speech/language: _____
Social Skills: _____
Temperament: _____

Sexual History:
Age at first sexual experience? _____
On a scale of 1-10, 10 being very satisfied, how would you rate your sexual experiences: _____
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your sexual self-image: _____
On a scale of 1-10, 10 being very satisfied, how satisfied are you with the frequency of sex: _____
Please describe any sexual difficulties you are having: _____
_____
_____

Nutrition:
Do you eat a balanced diet by the food pyramid standard? _____
How much caffeine do you consume daily (8 oz cups of coffee/tea, 12 oz sodas etc.)_____
How much tobacco do you smoke/chew daily? _____
How many Alcoholic drinks do you consume: 1-3 Daily 1-3 Weekly 1-3 Monthly None
How much fast food do you eat: 1-3 Daily 1-3 Weekly 1-3 Monthly None
Energy level: lethargic low average high hyperactive
How would you rate your current health: poor fair good excellent
List any food allergies you have: _____
How would you rate your weight/height/body fat ratio: poor fair good excellent
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your body image
Please describe any difficulties you are having with health, nutrition, body image: _____
_____
_____

Spiritual History:
Do you have a religious affiliation with which you are active? Yes No
How does your faith help you to cope with life's problems? _____
_____
_____
What spiritual disciplines do you practice and how much time do you spend (i.e. prayer, reading, study, worship etc.)?_____
_____
Please describe any difficulties you are having concerning your faith _____
_____
_____

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Goals for Counseling:

What three things would you like to change by participating in counseling?
1. _____
2. _____
3. _____

How long do you think it will take to make these changes? _____
_____
_____

What do you think it will require on your part to make these changes? _____
_____
_____
_____
_____
_____

_____

How will you know when you have accomplished your goals for counseling? _____
_____
_____
_____
_____
_____

_____

What else do you think is important for your counselor to know about you? _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Emergency Contact:
Who do you want contacted in case of an emergency? (Include name, phone number and relationship.)
_____
_____

Client Signature: _____ Date: _____

Primary Caregiver's signature: _____ Date _____