Counseling & Development Center

PATIENT INFORMATION

(Patients 18 and Older)

PATIENT NAME (LAST, FIRST, MIDDLE) DATE OF BIRTH SEX

ADDRESS: STREET, CITY, ST, ZIP

PATIENT SOCIAL SECURITY NUMBER MARITAL STATUS

PATIENT HOME PHONE CELL PHONE

EMERGENCY or ALTERNATE CONTACT NAME RELATIONSHIP TO PATIENT PHONE

PATIENT'S EMPLOYER WORK PHONE AND EXT

FAMILY PHYSICIAN PHONE

INSURANCE POLICYHOLDER NAME POLICYHOLDER DATE OF BIRTH

E-MAIL ADDRESS (*Please indicate first name of e-mail contact*)

PLEASE CHECK YOUR PREFERENCE OF CONTACT FOR CONFIRMATIONS AND/OR OTHER CONTACT:

□ CELLULAR PHONE □ HOME PHONE □ WORK PHONE □ EMAIL

WHO REFERRED YOU TO OUR OFFICE?

I CONSENT TO THE TREATMENT AND PROCEDURES PROVIDED TO ME, AND I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ANY FINANCIAL OBLIGATION NOT COVERED BY OR PAID BY INSURANCE.

PATIENT SIGNATURE **DATE**

Counseling & Development Center

SIGNATURE ON FILE REQUIRED BY STATE

I authorize use of this form on all my insurance submissions and authorize release of information to all of my insurance companies.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies and I authorize payment direct to my doctor.

I permit a copy of this authorization to be used in place of the original.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Counseling and Development Center abides by the Health Insurance Portability and Accountability Act Privacy Practices. *The Notice of Privacy Practices can be found on the table in the lobby.* Please take a few moments to review the privacy practices and sign below as acknowledgement that you have been offered the opportunity to read a copy, as required by HIPAA.

FINANCIAL POLICY

Our agreement is with you, not your insurance company. Although we will submit a claim to your insurance company, you are ultimately responsible for payment for the service you receive. Payment to our office is not contingent or dependent upon your carrier.

I understand I am financially responsible to Counseling and Development Center for charges of deductibles, co-pays, co-insurance and non-covered services not paid by my insurance company within 90 days of initial billing date. I also understand that for any balance owed by myself over 90 days from the initial date, an interest rate of 1.5% will apply. If your account should be sent to collections due to failure to pay, or if we cannot contact you, you will be charged all collection fees which can be up to 33% over your billing amount. **Please initial here _____**

MEDICARE: We are participating providers and accept Medicare; however, a referral is required for services to be deemed authorized and medically necessary for payment. You are responsible to obtain this referral from your primary care doctor in order for services to be paid by Medicare.

HMO, PPO, and Employee Assistance Program (EAP) MEMBERS: If you are a member of an HMO, PPO, or EAP in which we participate, your deductible and/or coinsurance is required at the time services are rendered. **You are responsible to see that we have a current referral and authorization on file, if your insurance requires one. If we do not have this referral or authorization at the time of your visit, you will be held responsible for all charges**. You may also be sent back to your Primary Care Physician prior to being treated to obtain a current referral.

BROKEN APPOINTMENT: Established appointment times require a minimum of 24-hours notice of cancellation. There will be a $25.00 fee for failure to do so. Failure to provide stated notice of cancellation for two or more appointments may result in discharge from services, providing you with a referral to seek mental health benefits elsewhere. Please initial here_____

PATIENT SIGNATURE DATE

Counseling & Development Center

AUTHORIZATION TO RELEASE RECORDS

This form when completed and signed by you, authorizes **Counseling and Development Center** to release and/or request protected information from your clinical record.

I, _____ hereby authorize the administration and clinical staff of Counseling and Development Center to release/request records, test results and/or other.

This information should only be released to / requested from: _____

_____

You have the right to revoke this authorization, in writing at any time by sending such written notification to:

Counseling and Development Center
101 East Maud St.
Tavares, FL 32778

However, your revocation will not be effective to the extent that we have taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA privacy Rule.

_____
PRINT NAME OF PATIENT OR LEGAL GUARDIAN

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

Counseling & Development Center

BRIEF MEDICAL HISTORY

Please check if any of the issues below apply:

- ☐ Accidents
- ☐ Alcohol Abuse
- ☐ Aneurysms
- ☐ Asthma
- ☐ Birth Defects
- ☐ Bleeding
- ☐ Blood Pressure – High
- ☐ Blood Pressure – Low
- ☐ Brain Tumor
- ☐ Cancer
- ☐ Colitis
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Gout
- ☐ Head Injury
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Macular Degeneration
- ☐ Meningitis
- ☐ Seizures
- ☐ Smoking
- ☐ Speech Problems
- ☐ Stroke
- ☐ Surgeries
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Have you previously worked with a mental health professional? Yes____ No____

Please describe your reason for seeking counseling:

_____

_____

_____

_____

Please list the medications (both over the counter and prescription) you are currently taking:

Name	Dose/Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____

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Counseling & Development Center

Counseling and Development Center offers a variety of counseling and evaluation services; however, we are cognizant of the limitations of our services. As an outpatient counseling center, we are not prepared, structured, or staffed for crisis intervention services. Individuals experiencing life threatening crisis situations need to immediately call 911 or seek care from medical providers who can arrange hospitalization, initiation of medication, and follow up in a more controlled setting.

We do not handle emergency situations, such as the cases of individuals with active suicidal tendencies or issues related to debilitating anxiety and panic because our level of care is not sufficient to provide the needed services to these individuals. If such services are requested of our therapists, we will immediately refer the individual to more intense treatment settings that can coordinate medications and possible hospitalizations, as well as follow up.

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