Central Florida Psychological Consultants, Inc.

605 West Montrose Street
Clermont, FL 34711
PH: (352) 365-2245
FAX: (352) 394-9997

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 / Unspecified

Home #: (_____)_____-_____ **Cell #**: (_____)_____-_____

Home Address:

_____
Street Address

_____
City State Zip

Social Security Number; _____ - _____ - _____

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

Occupation: _____ **Employer**: _____

How did you hear about Central Florida Psychological Consultants, Inc.:_____

Reason For Seeking Services: _____

Emergency Contact_____(_____)_____
Full Name Phone Number

Fees and insurance reimbursement:
(IF YOU ARE A SELF-PAY CLIENT, PLEASE CONTINUE ON TO NEXT PAGE)

Assignment of Insurance Benefits and Patient Responsibility (FOR INSURANCE PATIENTS ONLY)
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 am responsible for all services not covered by my insurance and understand a statement will be sent to reflect unpaid charges.
I understand that a fee of $60.00 will be assessed to my account if I do not show for my appointment or give less than 24hr in advance notice for cancellation and this fee is 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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This form is optional and you are free to decline. However, in doing so, please note that no one else will have access to your care including confirming or cancelling appointments on your behalf. If there is anyone else you want to have access to your treatment, please list them below and identify how you would like your information shared.

Central Florida Psychological Consultants, Inc. strives to provide you with the highest standards of psychological care possible. For this reason, we are able (at your request) to send a letter to your primary care physician that states that you are a client at Central Florida Psychological Consultants, Inc., to inform them of your tentative treatment plan and diagnosis, and offer to collaborate in your care. Also, if you would like Central Florida Psychological Consultants, Inc., to communicate with others, such as family members, please list each person's name on this form.

PLEASE READ THE FOLLOWING PAGE CARFEULLY AND SIGN AND/OR INITIAL WHERE INDICATED

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 *INITIAL* the following options for what you would like released:

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

_____ ***INITIAL*** 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.

_____ ***INITIAL*** 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: O Self O Legal Representative O Parent/legal guardian O 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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NOTICE OF PRIVACY PRACTICES

(Health Insurance Portability and Accountability Act provisions)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

Protecting Your Privacy…

Psychologists have always managed psychological records with great concern for privacy and confidentiality. Although the security of psychological records has continuously been addressed by Psychology Codes of Ethics as well as State and Federal laws, the rules have been strengthened and made more transparent by the provisions of the Health Insurance Portability and Accountability Act (HIPAA) which went into effect on April 14, 2002. The following information provides details about the provisions of HIPAA and your rights concerning privacy and your psychological records.

Confidentiality is waived if: (according to Florida Statute 490 and 491, as well as chapters that cover medical personnel)

1. A patient makes a specific threat to cause serious bodily injury to an identified or readily available person and
2. The psychologist or therapist uses their clinical judgement to assess the intent and ability to immediately or imminently carry out the threat, and finds it credible.
3. The psychologist or therapist may communicate the threat to the victim (permissive).
4. The psychologist or therapist must communicate the threat to a law enforcement agency (mandated)
5. The psychologist or therapist has liability immunity when doing the above.

Who will observe these rules?

The following individuals are required by HIPAA to comply with the privacy rules:

- Your treating psychologist;
- Any secretary or receptionist who may have limited access to your identifying information (e.g., name, address, telephone number);
- Any billing agency or collection agency that handles information about you (e.g., name and address, diagnostic codes, treatment codes, consultation dates, but not actual clinical records).

YOUR RIGHTS REGARDING PSYCHOLOGICAL INFORMATION ABOUT YOU

As a patient or client of CFPC, you have the following rights:

THE RIGHT TO INSPECT AND OBTAIN A COPY OF YOUR PSYCHOLOGICAL RECORD

Professional records constitute an important part of the therapy process and help with the continuity of care over time. According to the rules of HIPAA, your treatment and consultations with CFPC are documented in two ways. The Clinical Record, which is a required record that includes the date of your therapy sessions, your reasons for seeking treatment, your diagnosis, therapeutic goals, treatment plan, progress, medical and social history, treatment history, functional status, as well as any reports to your insurance carrier. Psychotherapy Notes are optional notes that are kept by some providers to document specific content or analyses of therapy conversations, how they impact on the therapy, and notes of your therapist that may assist in treatment.

You have the right to inspect and receive a copy of your Clinical Record. Viewing your record is best done during a professional consultation, rather than on your own, in order to clarify any questions that you may have at the time. You may be charged a nominal fee for accessing and photocopying the record. Psychotherapy Notes, may be disclosed to insurance companies. You have the right to deny your records be submitted; however, please note this may result in the insurance company denying your claims and the cost of the evaluation/session rolling to your responsibility. Psychotherapy notes are for the use of the treating psychologist in tracking the many details of consultations that are too specific to be included in the Clinical Record. If your case manager or insurance company requests to see the psychotherapy notes, you have a choice about consenting (authorizing release of this information) or denying access to them. However, as stated earlier, if you refuse the release of your treatment record it may and will likely result in denial of your claims. If you are a self-pay client, you do not have to release any records at your request. PLEASE NOTE: all signed court orders by a Judge will result in release of records. The client will be contacted prior to any release of records.

THE RIGHT TO REQUEST A CORRECTION OR ADD AN ADDENDUM TO YOUR PSYCHOLOGICAL RECORD

- **Correction:** If you believe that there is an inaccuracy in your clinical record you may request a correction. If the information is accurate, or if it has been provided by a third party (e.g., previous therapist, primary care physician, etc.), it may remain unchanged, and the request may be denied. In this case you will receive an explanation in writing, with a full description of the rationale.
- **Addendum:** You also have the right to make an addition to your record, if you think it is incomplete.

THE RIGHT TO AN ACCOUNTING OF DISCLOSURES OF YOUR PSYCHOLOGICAL INFORMATION TO THIRD PARTIES

You have the right to know if, when, and to whom your psychological information has been disclosed (exclusive of treatment, payment, and health care operations). However, you likely would already be aware of such disclosures, as you would have signed consent forms allowing for them (such as to other psychotherapists, primary care physicians, etc.). This accounting must extend back for a period of six years.

THE RIGHT TO REQUEST RESTRICTIONS ON HOW YOUR INFORMATION IS USED

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You have the right to request restrictions on certain uses or disclosures of your psychological information. These requests must be in writing, and most likely will be honored, although in some cases they may be denied. This office does not use or release your protected health information for any purpose other than treatment, payment, healthcare operations, and other exceptions specified in this notice.

THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS
You have the right to request that your therapist communicate with you about your treatment in a certain way, or at a certain location. For example, you may prefer to be contacted at work instead of at home, or on a cell phone, in order to schedule or cancel an appointment. Or, you may wish to receive billing statements at a Post Office Box, or at some other address.

THE RIGHT TO A COPY OF THIS NOTICE UPON REQUEST
You have the right to have a copy of this Notice of Privacy Practices.

HOW THIS OFFICE MAY USE AND DISCLOSE PSYCHOLOGICAL INFORMATION ABOUT YOU

FOR TREATMENT
CFPC will access your record and use psychological information about you to assist in the continuity of your treatment services. This information will not be shared with other health care professionals; unless you specifically request it or agree to it, and sign a consent form to that effect.

FOR PAYMENT
This office may use and disclose psychological information about you for billing purposes. This generally is restricted to your name and other personal identifiers (address, relevant identifying information, or other needed information), diagnostic and treatment codes, dates of services, and any similar information.

FOR HEALTH CARE OPERATIONS
CFPC may share basic identifying information with an administrative assistant or other office staff to assist in scheduling and treatment procedures. This would not normally include the contents of your psychological record.

AS REQUIRED BY LAW
It is possible (though unlikely) that the Department of Health and Human Services may review how this office complies with the regulations of HIPAA. In such a case, your personal health information could be revealed as part of providing evidence of compliance.

BUSINESS ASSOCIATES
This office may contract with a billing agency or attorneys to attend to business issues on an as-needed basis. In this case, there will be a written contract in place with the agency requiring that it maintain the security of your information in compliance with the rules of HIPAA.

RESEARCH
This office is currently not participating in any research studies.

CHANGES TO THIS NOTICE

Please note that this privacy notice may be revised from time to time. You will be notified of changes in the laws concerning privacy or your rights as we become aware of them. In the meanwhile, please do not hesitate to raise any questions or concerns about confidentiality with this office.

Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms.

_____ _____
Printed Name of Client Date

_____
Signature of Client

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Consent to Treatment and Recipient's Rights

I, _____ the undersigned, hereby attest that I have voluntarily entered into
(your 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. 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. CFPC 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 Information Sheet 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.

Non-voluntarily Discharge from Treatment: A client may be terminated from CFPC if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at CFPC, 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 non-voluntary discharge by letter. The client may appeal this decision with their psychotherapist.

Client Notice of Confidentiality: The confidentiality of patient records maintained by CFPC is protected by federal and/or state law and regulations. Generally, CFPC may not say to a person outside CFPC 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, 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 '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 non-emancipated 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

CONSENT TO TREATMENT

I consent to treatment and agree to abide by the above-stated policies and agreements with Central Florida Psychological Consultants, Inc. Your signature below indicates that you have read the office policies, understand the Notice of Privacy Practices, and that you are completely responsible for full payment of fees - you are responsible to understand exactly what services your insurance policy covers. Insurance Claims: I authorize the release of any medical or other information necessary to process insurance claims. I also consent to payment of insurance benefits to the provider accepting assignment of said benefits.

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

_____ _____/_____/_____
Printed Name (First, Middle Initial, Last) Date

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BILLING PRACTICES

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.

Your fee will be collected at the beginning of each session. Our office accepts all major credit cards, checks and cash. If you are using a check please have it ready when you come in to save time. There is a $20.00 fee assessed for bounced checks. Make checks payable to **Central Florida Psychological Consultants, Inc**. **OR CFPC.** *Please do not make checks payable directly to the therapist.*

Beginning a course of psychotherapy requires both client and therapist to commit to regular sessions. Your therapist may reserve a weekly, bi-weekly, or monthly 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 cancel a Monday appointment, then it will need to be canceled by the previous Friday Morning. **If you reschedule or cancel with *less* than 24 hours' notice, a $60.00 fee will be assessed onto your account for which you will be responsible to pay prior to your next scheduled session.** To avoid a cancellation/no-show fee assessed for missed appointments, cancellations need to be made 24 hours or more in advance. 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. Missing of scheduled appointments and/or recurrent rescheduling of appointments may result in discontinuation of services. Making scheduled appointments is both a business and a therapeutic necessity.

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 to create reports or letter writing, or time spent providing any other service authorized by you including travel time, research and/or any other services involving your care. It is our policy to charge a prorated amount for these services based on your standard session fee, with the exception of legal proceedings detailed below and coping of records. The additional services requested and the fee assessed with be discussed with the client.

An administration fee (not to exceed $30.00) will be assessed if a records request is initiated by the client, which requires copying of your mental health records. If you are or become involved in legal proceedings that require therapist/providers participation the client is responsible for payment in full prior to the hearing/deposition date. **Court fees are set at an hourly rate for preparation, travel, and participation in all forms is $300 per hour with a three-hour minimum to be paid five (5) business days in advance.**

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.

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Mental Health Survey

Patient Name: _____ Date Completed: _____

Therapist Name: _____ Date Received: _____

	Mood and Behaviors Over the Past 2 Weeks	Never	Rarely	Sometimes	Mostly	Always	Comments
1	I feel sad, unhappy or depressed	1	2	3	4	5	
2	I feel lethargic, apathetic, or as though I have no energy	1	2	3	4	5	
3	I feel hopeless about the future	1	2	3	4	5	
4	I feel lonely, isolated or alone	1	2	3	4	5	
5	I have trouble sleeping	1	2	3	4	5	
6	I sleep too much	1	2	3	4	5	
7	I have no appetite	1	2	3	4	5	
8	I overeat	1	2	3	4	5	
9	I feel unproductive or get distracted easily at work	1	2	3	4	5	
10	I have trouble focusing on projects, work or activities	1	2	3	4	5	
11	Activities and work no longer interest me	1	2	3	4	5	
12	I have trouble getting along with family/friends/coworkers	1	2	3	4	5	
13	I feel tense or nervous	1	2	3	4	5	
14	I feel agitated, angry or irritable	1	2	3	4	5	
15	I think about hurting myself	1	2	3	4	5	
16	I consider suicide	1	2	3	4	5	
17	I drink or do drugs to escape or dull the pain	1	2	3	4	5	
18	I binge drink (more than 5 drinks in one hour)	1	2	3	4	5	
19	People express concern about my drinking or drug use	1	2	3	4	5	
20	I have had trouble at work or school due to alcohol/drugs	1	2	3	4	5	

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Mental Health Intake Form

Personal Information

Name: _____ Date: _____
Address: _____
Phone: _____ Email: _____
DOB: _____ Sex: _____
Primary Physician: _____ Phone: _____
Current Therapist: _____ Phone: _____

Complaint

What is your major complaint? _____
Start Date: _____ Have you previously suffered from this complaint? _____
Previous therapist(s) seen for complaint: _____
Previous treatment for complaint: _____
Aggravating Factors: _____
Relieving Factors: _____

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido Changes
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Changes	☐ Suspiciousness	☐	☐

Medical History

Exercise Frequency: _____ Exercise Type(s): _____
Allergies: _____
What medications are you currently using? _____
Previous diagnoses/mental health treatment: _____
Previously treated by: _____
Previous medications: _____
Dates treated: _____
Previous medical conditions: _____
Previous surgeries: _____

Family History

Were you adopted? _____ If yes, at what age? _____
How is your relationship with your mother? _____
How is your relationship with your father? _____
Siblings and their ages: _____
Are your parents married? _____
Did your parents divorce? _____ If yes, how old were you? _____
Did your parents remarry? _____ If yes, how old were you? _____
Who raised you? _____ Where did you grown up? _____
Family member medical conditions: _____
Family member mental conditions: _____
Treated with medication? _____
Medications: _____

Early Development

Where did you grow up? _____
How often did you move and where? _____
How old were you when you left home? _____

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Have any immediate family members died? _____ Who? _____
Have any committed suicide? _____ Who? _____
Describe any neglect you suffered, and by whom: _____
Trauma suffered and by whom: _____
Abuse suffered and by whom: _____
Highest education level completed: _____
Date completed and location: _____
Have you ever served in the military? _____ If yes, where? _____
Dates of service: _____ Highest rank achieved: _____

Present Situation

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
Are you married? _____ If yes, date of marriage: _____
Are you divorced? _____ If yes, date of divorce: _____
Prior marriages? _____ If yes, how many? _____
What is your sexual orientation? _____ Are you sexually active? _____
How is your relationship with your partner? _____
Do you have children? _____ Dates of Birth: _____
How is your relationship with your child(ren)? _____
List anyone else who lives with you: _____
Are you a member of a religion/spiritual group? _____
What is your level of involvement? _____
Have you ever been arrested? _____ When and why? _____

Have You Ever Tried the Following (Check All That Apply)

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (Pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain Killers

If yes to any, list frequency/dates of use: _____

Have you ever been treated for drug/alcohol abuse? _____ If yes, when? _____
For which substances? _____
Do you smoke cigarettes? _____ If yes, how many per day? _____
Do you drink caffeinated beverages? _____ If yes, how many per day? _____
Have you ever abused prescription drugs? If yes, which ones?

Anything Else You Want the Doctor to Know

_____ _____
Signature Date