**SUSAN M. POSADA, PhD, LMHC, LMFT** 110 Country Club Dr

Phone: (813) 215-5558 Tampa, Florida 33612

**CLIENT INFORMATION**

CLIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_AGE:\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_\_ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I contact you at this number? \_\_\_\_\_\_\_

CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I contact you at this number? \_\_\_\_\_\_\_

WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I contact you at this number? \_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May I Email you at this address? \_\_\_\_\_\_\_\_

WHO REFFERED YOU? \_\_\_\_\_\_\_\_\_\_\_\_FOR WHAT REASON? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_YEARS:\_\_\_\_\_\_OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIGHEST GRADE/DEGREE COMPLETED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YEARS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELIGIOUS ORIENTATION (if any):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ACTIVE? \_\_\_\_\_\_\_

Primary Insured’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance or EAP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I accept full responsibility for any and all fees incurred by myself or my family. Payments of my fee’s will be made at the beginning of each visit. I agree to pay a 20.00 service fee on all returned checks. **If I must cancel an appointment, I will notify Susan Posada, Ph.D. at least 24 business day hours in advance** **BY PHONE(*initial*)**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that I must make payment of $75.00 on any missed appointments, which are not cancelled with-in 24 hour business day notice, prior to scheduling my next appointment.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **SUSAN M. POSADA, PH.D., L.M.H.C., L.M.F.T., P.A.**

# CLIENT CONTRACT

**CONFIDENTIALITY:** Please be aware that under the provisions of confidentiality between Mental Health Providers and their clients, Susan Posada will not be able to speak to anyone regarding your case without written consent from you. There are, however, specific limitations to client confidentiality. In the event of a suspected case of abuse/neglect of children or the elderly, or the commission of a felony, I am required by law to make a report to the authorities. Furthermore, as required by law, when a client voices suicidal ideations or homicidal ideations, I am required to take the necessary steps towards protecting the client or the target of the homicidal ideations. I am also required by law to honor subpoenas.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**CLINICAL RECORDS:** As a client you have the right to review your clinical record.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**FINANCIAL RESPONSIBILITY:** I accept financial responsibility for any and all fees incurred by myself or my family members for services provided by Susan Posada. I agree to have a credit card on file which will be charged for unpaid balances. Should I desire to have phone consultations or require that a third party communicate with Susan Posada, or request written documentation, I agree to pay for all additional fees are incurred. Payment of my portion of fees will be made at the beginning of each visit. If I default on payment, I agree to pay collection costs, and reasonable attorney fees associated with collection of outstanding balance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**CANCELLATION POLICY:** If I must cancel an appointment, I will notify the office at least **24** **business day** hours in advance (**BY PHONE).** I understand that a missed appointment without providing adequate notice will result in a **$75.00** fee, which will be due prior to my next session and may be charged to my credit card on file.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**CLIENT CONCENT TO TREATMENT:** I HEREBY AUTHORIZE SUSAN POSADA, Ph.D. TO ADMINISTER TREATMENT. SUSAN POSADA WILL PROVIDE ME WITH THE BEST POSSIBLE CARE. THIS, IN NO WAY CONSTITUTES A WARRENTY THAT MY PRESENT CONDITION WILL BE CURED. I SIGN THIS WILLING AND VOLUNTARILY IN FULL UNDERSTANDING OF THE ABOVE, AND IN DOING SO RELEASE SUSAN POSADA FROM ANY AND ALL LIABILITY WHICH MAY ARISE FROM THIS ACTION, WHETHER OR NOT FORESEEN AT PRESENT.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**SUSAN M. POSADA, PhD, LMHC, LMFT, NBCCH**

110 Country Club Dr

Tampa, Florida 33612

Phone: (813) 215-5558

# CLAIMS RELEASE AUTHORIZATION

Confidentiality and privacy are protected unless you give permission to discuss your case with others. As a participant in your insurance, managed behavioral health care plan or Employee Assistance Program, your therapist will need to communicate the release of psychological information to the necessary parties.

I authorize the release of any psychological or psychiatric information necessary to process my claims regarding my treatment under the care of Susan Posada. I request payment of benefits to be paid to said provider. I also request that the below signature be placed on file to process future claims regarding my treatment with Susan Posada.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

 Client Signature Date

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby AUTHORIZE my therapist, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 110 Country Club Dr

 Tampa, Florida 33612

To disclose information to my insurance company or Employee Assistance Program:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Company Name

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City, State, Zip

I authorize the release of any psychological or psychiatric information from Susan Posada for case management and /or utilization review at my insurance, managed care company or Employee Assistance Program. This information may be used for the purposes of establishing medical necessity, assuring quality of treatment, treatment planning reviews and case management of my care.

This authorization may be withdrawn at any time in writing except to the extent that the person that is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. At such time I will accept responsibility for all incurred fees. File copy is considered equivalent to the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

I **do not** want my insurance or managed\care company to be billed and will accept full responsibility for all fees accrued. Rather, I agree to pay for each therapy session.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client Signature Date

**CREDIT CARD CHARGE AGREEMENT**

I authorize Susan Posada, PhD, to keep my signature on file and to charge my credit card for unpaid balances on my account, which may include the following:

* Written documentation, forensic services, and phone consultations.
* $75.00 fee for missing my appointment or for not canceling my appointment 24 business day hours in advance.
* Book, DVD or CD borrowing fee equal to the purchase price of the item (You will be reimbursed you when item is returned) $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* Any returned check amount plus an additional 20.00 bank fee.
* Charge back fee’s

*I understand that as a courtesy, Dr. Posada will attempt to contact me if a charge needs to be made. However, she may place a charge whether or not she is able to contact me\_\_\_\_\_\_\_\_\_\_(initial) when I have an outstanding balance.*

Clients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder billing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

Type of card: Visa \_\_\_\_\_ Master Card \_\_\_\_\_ Discover \_\_\_\_\_\_ Am Ex \_\_\_\_\_\_\_

Charge card number: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Expiration date: \_\_\_\_\_\_\_\_\_ Security Code (3 digit # on back of card) \_\_\_\_\_\_\_\_

Cardholder’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

**PERSONAL INFORMATION**

Briefly describe your reason(s) for seeking counseling at this time:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List names of significant others who may be involved in your counseling sessions:

 NAME AGE RELATIONSHIP

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What would you like your partner to change?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you believe your partner would like you to change?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you believe your sex life has been impacted by couple issues and if so, in what way? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other issues impacting your sexual relationship?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How will you know when it’s time to terminate couples counseling (what will you see happening in your relationship that is different)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptom List**

***Please rate 0-10 only the following that pertain to you (10 being the highest):***

Difficulty with daily routine \_\_\_\_ Hyperactivity \_\_\_\_

Letting others take advantage of you \_\_\_\_ Nervous/Anxious \_\_\_\_

Persistent unwanted thoughts \_\_\_\_ Anger \_\_\_\_

Unable to stop certain behavior \_\_\_\_ Lying \_\_\_\_

Physically Abusing Others \_\_\_\_ Depression \_\_\_\_

Sexually hurting others \_\_\_\_ Stealing \_\_\_\_

Verbally hurting others \_\_\_\_ Euphoria (feeling high) \_\_\_\_

Being physically abused \_\_\_\_ Stress \_\_\_\_

Being sexually abused \_\_\_\_ Irritability \_\_\_\_

Being verbally abused \_\_\_ Self-esteem \_\_\_\_

Seeing or hearing things without cause \_\_\_\_ Sexual concerns \_\_\_\_

Thoughts of hurting your self \_\_\_\_ Self control \_\_\_\_

Thoughts of hurting others \_\_\_\_ Parenting issues \_\_\_\_

Worry about your health \_\_\_\_ Relationship issues \_\_\_\_

Worry about someone else’s health \_\_\_\_ Employment issues \_\_\_\_

Overly dependant on others \_\_\_\_ Grief or loss \_\_\_\_\_\_\_

Letting others overly depend on you \_\_\_ Financial Issues \_\_\_\_

Others complaining about your behavior \_\_\_ Sudden mood changes\_\_\_\_

Acting before thinking \_\_\_\_ Guilt\_\_\_\_\_

***Please rate 0-10 any of the following behaviors you use to cope:***

Shopping \_\_\_\_

Eating \_\_\_\_

Gambling \_\_\_\_

Sexual activity \_\_\_\_

Cleaning \_\_\_\_

Alcohol \_\_\_\_ How much do you drink a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drugs \_\_\_\_ What drugs do you use and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarettes \_\_\_\_ How much do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine \_\_\_\_ Source of caffeine and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please rate 0-10 your physical concerns:***

Sleep patters \_\_\_\_

Eating patterns \_\_\_\_

Bladder control \_\_\_\_

Bowel control\_\_\_\_

Seizures \_\_\_\_

Weight problem \_\_\_\_

Sexual functioning \_\_\_\_

Please list medical conditions or health issues you have had and indicate which ones affect your life now: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list medications you are taking and for what purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact name, relationship and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I will Allow Dr. Posada to contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_in an emergency situation.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_