**SUSAN POSADA, PhD, LMHC, LMFT, NBCCH**
110 Country Club Dr
Tampa, Florida 33612

# YOUTH AND FAMILY ASSESSMENT

(To be completed by parents)

CHILD NAME:_____DOB:_____GRADE: _____
ADDRESS:_____
CITY: _____STATE:_____ZIP CODE: _____

PARENT NAMES:_____
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 REFERRED YOU? _____FOR WHAT REASON? _____
PARENT EMPLOYER:_____YEARS:_____OCCUPATION:_____
HIGHEST GRADE/DEGREE COMPLETED: _____
RELATIONSHIP STATUS: _____YEARS:_____
FAMILY RELIGIOUS ORIENTATION (if any):_____
Policy holder name:_____ DOB:_____ SS# : _____
Address (if different than client)_____

How are you paying for services?

Name of Plan:_____Phone Number (s): _____

Policy Numbers: _____
Authorization Numbers: _____
Number of sessions authorized _____
Amount of co-pay and/or deductible? _____

I accept full responsibility for any and all fees incurred by myself or my family members including those fees that my insurance company or employee assistance program, for what ever reason, does not reimburse. Payments of my portion of fees, including co-payment, 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 a 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 POSADA, PhD, LMHC, LMFT, NBCCH**

# 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, including fees which my insurance company or Employee Assistance Program, for whatever reason, fails to reimburse. 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 including co-payments 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. I understand that a missed appointment without providing adequate notice **BY PHONE** 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 CONSENT 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 WARRANTY 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

**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:_____

**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, managed behavioral health care plan 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

_____ _____
Parent, Gaurdian or authorized representative Date

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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 $130.00-$150.00 for each therapy session.

_____ _____
Client Signature Date

**YOUTH AND FAMILY ASSESSMENT**
**(To be completed by parents)**

Presenting Problems:

_____
_____

What are your therapy goal(s) :

_____
_____

Current Description of Family / Marriage (marital status, ages of children, years married, deaths):

_____
_____
_____
_____

Family and child history of experiencing/witnessing physical, sexual, verbal abuse and mental abuse:

_____
_____
_____

Child use of alcohol or drugs (amount, frequency and impact on self and others):

_____
_____

Parent use of alcohol or drugs (indicate amount, frequency and impact on self and others):

_____
_____

Describe your child's temperament, interests, ability to get along with family:

_____
_____
_____

Does anyone contribute to your child's problems? _____ Who?_____

Describe your child's behavior and performance in school:

_____

Describe your child's ability to get along with others:

_____
_____

Family and Child Social / Community Support System:

_____

Family and Child Mental Health and Psychiatric History (problems, treatment, outcome):

_____
_____

Family and Child Medical / Health Problems (list medications):

_____
_____

Please list name and phone number of treating physician:

_____

Family and Child Legal Issues (arrests, convictions, DUI, restraining orders, child custody complications):

_____
_____

Family and Child Strengths:

_____
_____

Family and Child Interests/Hobbies:

_____
_____

Who do you think might be important to include in therapy sessions and why?

_____
_____

Emergency contact name, relationship and phone number:

_____

I will Allow Dr. Posada to contact _____in an emergency situation.
Signature: _____ Date:_____