SUSAN M. POSADA, PhD, LMHC, LMFT
Phone: (813) 215-5558

110 Country Club Dr
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 REFERRED 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 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

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

Symptom List

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

Difficulty with daily routine ____
Letting others take advantage of you ____
Persistent unwanted thoughts ____
Unable to stop certain behavior ____
Physically Abusing Others ____
Sexually hurting others ____
Verbally hurting others ____
Being physically abused ____
Being sexually abused ____
Being verbally abused ___
Seeing or hearing things without cause ____
Thoughts of hurting your self ____
Thoughts of hurting others ____
Worry about your health ____
Worry about someone else's health ____
Overly dependent on others ____
Letting others overly depend on you ___
Others complaining about your behavior ___
Acting before thinking ____

Hyperactivity ____
Nervous/Anxious ____
Anger ____
Lying ____
Depression ____
Stealing ____
Euphoria (feeling high) ____
Stress ____
Irritability ____
Self-esteem ____
Sexual concerns ____
Self control ____
Parenting issues ____
Relationship issues ____
Employment issues ____
Grief or loss _______
Financial Issues ____
Sudden mood changes____
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:_____________