Counseling Associates of Lake Mary

Individual, Family, & Couples Counseling

CLIENT INFORMATION RECORD

PROVIDER: Jodi Miller, LMHC

BLACK INK ONLY - Please complete form in its entirety

PATIENT NAME: _____ DOB: _____/_____/_____

SSN: _____-_____-_____ BIRTH SEX: Male / Female RACE: _____

GENDER IDENTITY: _____ SEXUAL ORIENTATION: _____

MOBILE PHONE #: (_____)_____-_____ HOME #: (_____)_____-_____

LANGUAGES: _____

ADDRESS: _____ APT / STE / UNIT: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL: _____

MARITAL STATUS: ***(Please Circle One)*** – Married / Single / Divorced / Widowed / Separated

EMPLOYMENT: Employed / Full-Time Student / Part-Time Student / Unemployed

PREFERRED APPT REMINDERS? ***(Please Circle One)***–None/Voicemail/Text/Voice & Text/Email

WHO REFERRED YOU TO OUR OFFICE?: _____

PRESENTING PROBLEM: _____

CURRENT PSYCH. MEDICATIONS? _____

WHO MANAGES THEM (M.D.)? _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ PHONE #: (_____)_____-_____

**PLEASE LIST WHOM YOU AUTHORIZE US TO RELEASE ONLY YOUR APPT INFORMATION TO:*

1. _____ RELATION: _____ PHONE #: (___)_____-_____

2. _____ RELATION: _____ PHONE #: (___)_____-_____

****I VERIFY THAT THE INFORMATION ON THIS PAGE IS CURRENT & ACCURATE.**

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

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INSURANCE NFORMATION

***Primary Insurance:** _____

ID #: _____ Group #: _____

Phone #: (_____)_____-_____ Effective Date: _____/_____/_____

***Secondary Insurance:** _____

ID #: _____ Group #: _____

Phone #: (_____)_____-_____ Effective Date: _____/_____/_____

*Subscriber Name: _____ *DOB: _____/_____/_____

Subscriber's SSN: _____-_____-_____

***IF PATIENT IS A MINOR, NAME OF PARENT/GUARDIAN SIGNING PAPERWORK AND SOCIAL SECURITY #**

Name: _____ DOB: _____/_____/_____

Social Security #: _____-_____-_____ Phone #: (_____)_____-_____

Employer: _____ Position: _____

Office Use Only:

Yearly Max Visits:	Authorization Needed?	If yes, Auth Info:
Deductible:	Amount Met:	Amount Left:
Co-Insurance:		
1st Co-Pay:	2nd Co-Pay:	3rd Co-pay:
Claims Address:		

****I VERIFY THAT THE INFORMATION ON THIS PAGE IS CURRENT & ACCURATE.**

_____ _____

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PRIVACY OF PROTECTED HEALTH INFORMATION

I consent to the use of disclosure of my protected health information by Counseling Associates of Lake Mary (hereinafter referred to as "CALM") for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my healthcare bills, or to conduct Healthcare operations of CALM. I understand that diagnosis by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. CALM is not required to agree to the restrictions that I may request. However, if t CALM agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that CALM has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a responsible base to believe the information may identify me.

These forms describe the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of CALM. The Privacy of Protected Health Information also describes my rights and CALM's duties with respect to my protected health information.

If you have asked us to file health insurance for you, we send only the minimum information required to obtain payment from your insurance company. We do not release any information to anyone about your treatment nor do we acknowledge that you are a patient here (even to your immediate family or other healthcare providers) without your expressed written consent. If you wish us to communicate with anyone about your treatment, please ask for a release of information form.

CALM reserves the right to change the policies that are described in these forms. I may obtain a revised copy of these forms by calling the office and request a revised copy to be sent in the mail or by asking for one at the time of my appointment.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

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INFORMED CONSENT FOR TREATMENT

- I understand the concepts and conditions of informed consent, privacy and confidentiality.
- I understand that I have the opportunity to discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
- I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and counseling/treatment.
- I understand that the process of counseling, Psychotherapy, and evaluation is an interview process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcomes for the therapy/treatment.
- I have the right to refuse or withdraw from any counseling, psychotherapy, or evaluation procedure; unless otherwise specified by law.
- I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
- I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with the specified release of information. I understand that if my provider is a resident or inter, then the treatment will be discussed with the supervising professional.
- I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.

EXCEPTION TO PRIVACY, PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY

Any unusual circumstances information that the client discloses maybe released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else;
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse;
- The client is required to undergo a court-ordered examination;
- The client discloses information about abuse, neglect, or exploitation of a minor;
- The client discloses information about abuse, neglect, or exploitation of an aged or disabled adult;
- The client's mental or emotional condition is used as a legal defense;
- A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action.

I hereby give my consent for service to be provided under these conditions.

_____ _____

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FINANCIAL POLICIES

- Your co-payment, deductible or any non-covered charge is due at the time of service.
- Your insurance card(s) may be copied each time you are seen. We must verify correct insurance information at each visit.
- Benefits quoted by your insurance company are **NOT** a guarantee of payment. **You will be asked to pay any charges not paid by your insurance company.**
- We bill your insurance as a courtesy. If you disagree with any amount your insurance pays or they do not pay, you are responsible for the terms of that agreement.
- Your insurance contract is an agreement between you and the insurance company and as the subscriber, you are responsible for the terms of that agreement.
- You are responsible for confirming with your insurance company that the providers you're seeing are in your network. **This office does not file claims out of network.**

- **You will be billed $35 for late cancellations without 24 hours notice and $50 for a missed appointment.**

- You may be billed up to $50 for all letters you request and up to $100 for all forms your request.
  ****Letter and Form fees are payment for the provider's preparation and research time to complete them.**

I have read and understand the policies above and agree to abide by them. I understand that I am financially responsible for payment for all services at the time services are rendered. I agreed to be liable for any costs incurred in the collection of any unpaid balance, including any and all reasonable attorney fees. I understand a finance charge of $50 will be assessed if my account is turned over to a collection agency.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

I authorize the Counseling Associates of Lake Mary to release any medical and/or psychiatric information acquired in the course of my examination or treatment to my health insurance company to facilitate payment for medical services rendered. I authorize payment of medical benefits to Counseling Associates of Lake Mary.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE