PATIENT INFORMATION SHEET

LAST NAME: ________________________________FIRST NAME:______________________MI______
ADDRESS:____
CITY:_______________________________________STATE:_________________________ZIP:_________
HOME PHONE: (   )_________________________ WORK PHONE: (   )________________________
DATE OF BIRTH: ___/___/___ SOCIAL SECURITY: _____-___-_____ SEX: MALE   FEMALE
MARITAL STATUS: SINGLE   MARRIED   OTHER
LEGAL GUARDIAN OF PATIENT UNDER 18 YEARS OF AGE:______________________________
RELATIONSHIP TO PATIENT:_________________ ____
EMPLOYER/SCHOOL NAME:____
CITY: _______________________________________STATE: ______________________ZIP: _________
DRIVER'S LICENSE NUMBER: ____STATE: _____________

INSURANCE INFORMATION
(PLEASE PRESENT INSURANCE CARD TO BE COPIED)

DOCTOR OR AGENCY REFERRED BY: ____
CITY: _______________________________________ STATE: _______________________ ZIP: ________
POLICY NAME HOLDER: _________________________________DATE OF BIRTH: _____________
GROUP NUMBER: ___________________________ SS#/ID # ___________________________________
EMPLOYER NAME AND PHONE: ____(   )_______________
INSURANCE PHONE NUMBER TO VERIFY BENEFITS: (   )___________________________________
NUMBER FOR PRE-CERTIFICATION:____

SECONDARY INSURANCE____
CITY: ______________________________________ STATE: _________________________ ZIP: ________
POLICY NAME HOLDER: _________________________________DATE OF BIRTH: _____________
GROUP NUMBER: ___________________________ SS#/ID # ___________________________________
EMPLOYER NAME AND PHONE: ____(   )_______________
INSURANCE PHONE NUMBER TO VERIFY BENEFITS: (   )___________________________________
NUMBER FOR PRE-CERTIFICATION: ____

READ & SIGN – I ACKNOWLEDGE I AM FINANCIALLY RESPONSIBLE FOR ANY SERVICES RENDERED BY FERN CREEK COUNSELING, INC. IF INSURANCE IS TO BE FILED, I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION MECESSARY TO PROCESS CLAIMS FOR SERVICES PROVIDED. I FURTHER AUTHORIZE THE RELEASE OF MEDICAL BENEFITS TO FERN CREEK COUNSELING. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE____DATE: _____/___/____

CLIENT INTAKE INFORMATION
(PLEASE PRINT ALL INFORMATION)

HIGHEST LEVEL OF EDUCATION: ELEMENTARY MIDDLE SCHOOL HIGH SCHOOL
COLLEGE OTHER
OCCUPATION: ______________________________
CHURCH AFFILIATION: ______________________________

HOW MANY TIMES HAVE YOU BEEN MARRIED: ______________________________
HOW MANY TIMES HAS YOUR SPOUSE (OR FIANCE) BEEN MARRIED: ______________
IF MARRIED NOW, HOW MANY YEARS: ______________________________

FAMILY MEMBERS: (INCLUDE SPOUSE) CHECK IF LIVING AT HOME (x)

NAME	AGE	D.O.B.	RELATIONSHIP	AT HOME
____________________	____	______	______________	
____________________	____	______	______________	
____________________	____	______	______________	
____________________	____	______	______________	
____________________	____	______	______________	
____________________	____	______	______________	

NAME OF EMERGENCY CONTACT: ______________________________
PHONE NUMBER: (   )____________________ RELATIONSHIP:______________________

PERSON RESPONSIBLE FOR ACCOUNT/BILL: ______________________________
ADDRESS: ______________________________
CITY: ______________________________ STATE: ________________ZIP: __________
PHONE NUMBER: (   )____________________ WORK NUMBER: (   )____________________
RELATIONSHIP: SELF SPOUSE PARENT LEGAL GUARDIAN
INSURANCE COMPANY: ______________________________
INSURED PERSON: ______________________________SOCIAL SECURITY _____/___/_____

JOB SATISFACTION

JOB SATISFACTION: HIGH OK LOW NONE
JOB STATUS: SECURE IN JEPORADY UNEMPLOYED RETIRED DISABLED
WORKERS COMP SOCIAL SECURITY
ARE YOU WORKING MORE THAN ONE JOB: YES NO OTHER
WHAT OTHER KINDS OF WORK ARE YOU QUALIFIED TO DO: ______________________________
____

GENERAL HEALTH

HOW WOULD YOU RATE YOUR OVERALL HEALTH:
EXCELLENT GOOD AVERAGE POOR
PHYSICIANS NAME: ____________________________________PHONE: ( )___________________
ADDRESS:____
_
CITY:____ STATE: __________________ ZIP:_________
DATE OF LAST PHYSICAL: ____

I AUTHORIZE FERN CREEK COUNSELING. TO SHARE INFORMATION WITH MY PRIMARY CARE PROVIDER. YES NO

LIST ALL MEDICATION BEING TAKEN AT THIS TIME:____________________________________
____
____
____
CONTINUE ON BACK IF NEEDED.

MEDICAL HISTORY

LIST ALL PROBLEMS, ALLERGIES, & SURGERIES INCLUDING DATES:______________________
____
____
____

HAVE YOU EVER HAD PREVIOUS THERAPY OR BEEN HOSPITALIZED FOR A NERVOUS OR MENTAL DISORDER: YES NO IF YES WHEN:______________________________
WHERE: _________________________________FOR HOW LONG: __________________________
WHO WAS YOUR DOCTOR OR THERPAIST: ____
HAVE YOU EVER ATTEMPTED SUICIDE: YES NO
IF YES WHEN:_________________________

REFERRAL SOURCE: FRIEND MD ATTORNEY COURT AGENCY
FORMER CLIENT YELLOW PAGES EMPLOYER
EAP ☐ OTHER____________________

CANCELLATION/ NO SHOW POLICY

A cancelled appointment delays our work. When you must cancel, please give me at least 24 hours notice (you may contact me by email at lizkunz@msn.com, I will confirm receipt of the email and cancellation, or by telephone at 407-894-4030).
I am rarely able to fill a cancelled session unless I know at least 24 hours in advance. If you are unable to provide at least 24 hours notice when you cancel, you will be charged a "No Show/Cancellation" Fee of $60 unless I am able to fill it with another client. The credit card that you have on file will be charged. Most insurance companies do not typically reimburse for missed appointments. The only time I will waive this fee is in the event of serious or contagious illness or emergency.
I have read the above attendance policy with regard to cancellations and "no shows" for scheduled therapy visits.

____________________________________ ________________
Signature Date

____________________________________ ________________
Parent/guardian Signature Date

DESCRIPTION OF THE PROBLEM: THE FOLLOWING IS A LIST OF AREAS IN WHICH YOU MAY BE EXPERIENCING SOME DIFFICULTY. PLEASE CHECK ANY OF THE SYMPTOMS THAT MAY APPLY TO YOU OR WHICH HELP DESCRIBE A PROBLEM YOU ARE HAVING.

A. PYHSICAL CONCERNS

1. CHANGE IN
SLEEP
APPETITE
PHYSICAL ENGERY
GENERAL HEALTH
WEIGHT
INTEREST IN ACTIVITY

2. INCREASED USE OF:
ALCOHOL
DRUGS
PAIN RELIEVERS
ANTACIDS
LAXATIVES
DIET PILLS
SLEEPING PILLS

3. RECENT HISTORY OF:
NAUSEA & VOMITING
DIARRHEA
FEVER
CHEST PAIN
SHORTNESS OF BREATH
PALPITATIONS(POUNDING HEART)
RAPID BREATHING
SEVERE HEADACHES
HEAD INJURY
LOSS OF CONSCIOUSNESS
LOSS OF MEMORY
CHANGE OF VISION
DIFFICULTY IN SPEECH
LOSS OF BALANCE
SWOLLEN JOINTS
CHILLS
SKIN RASH
MISCARRIAGE
ABORTION
SIEZURE(S)
NUMBNESS
PARALYSIS
DIZZINESS
TINGLING
BLACKOUTS
DELIRIUM TREMORS
FLASHBACKS
ILLNESS
HOSPITALIZATION
BLEEDING
INFECTION
SWEATS

B. PSYCHOLOGICAL CONCERNS:

1.THOUGHTS OF:
SUICIDE
HARMING SELF
HARMING OTHERS

2. EXPERIENCE OF:
VIVID DREAMS
NIGHTMARES
DECREASED NEED FOR SLEEP
HEARING VOICES
SEEING VISIONS
BEING OUT OF BODY
THOUGHT CONTROL
RACING THOUGHTS

3. FEELINGS OF:
ANXIETY
DEPRESSION
DREAD
DESPAIR/HOPELESSNESS
LOW SELF WORTH
JEALOUSLY
TENSION
RAGE
PERSECUTION
BOREDOM
LONELINESS
GUILT
HIGH ENERGY

4. FEAR OF:
LOSS OF CONTROL
DEATH
BEING ALONE
OBJECTS
ANIMALS
PLACES
SITUATIONS
BEING POSSESSED
BEING INSANE
CANCER
AIDS
EXPOSURE
PUNISHMENT

C. SOCIAL/OCCUPATIONAL CONCERNS:
SPOUSE
FAMILY MEMBER
CHILD
FRIEND/PEER
WORK SUPERVISOR

2. PROBLEM WITH:
FINANCES
LEGAL AUTHORITIES

3. VICTIM OF:
BAD ACCIDENT
RAPE
PHYSICAL ABUSE
SEXUAL ABUSE
HARRASSMENT
SLANDER
MALPRACTICE
DISFIGUREMENT
VIOLENT CRIME
WAR INJURY
NATURAL DISASTER
WITNESS TO VIOLENCE/DEATH
SPOUSE ABUSE/CHILD ABUSE
CULT GROUP/PRACTICE
DISCRIMINATION
VANDALISM

4. DEVELOPMENTAL HISTORY:
WEEKS GESTATION __________
BIRTH WEIGHT ______________
APGAR ____(1 MIN) _____(5 MIN)

CHECK ALL THAT APPLY:
☐ PREG/DELIVERY PROBLEMS
☐ IN UTERO ALCOHOL/DRUG USE
☐ FAILURE TO THRIVE
☐ SMOKING DURING PREGNANCY
TYPE OF LABOR:
☐ SPONTANEOUS ☐ INDUCED
TYPE OF DELIVERY:
☐ NORMAL ☐ BREECH ☐ CESAREAN
AGES FOR DEVELOP. MILESTONES:
SITTING ___________________
CRAWLING ________________
TALKING __________________
WALKING _________________
POTTY TRAINING __________
EATING SOLIDS ____________
USING SIPPY CUPS __________
USING 2 WORD PHRASES ____
NO PROBLEMS ______________

ON THE SCALE BELOW, PLEASE ESTIMATE THE SEVERITY OF YOUR PROBLEM:
MILD MODERATE SEVERE EXTREME INCAPACITATING

ADDITIONAL COMMENTS:____
____
____
____
____
____
____
____
____
____
____
____

CONSENT FOR PSYCHOTHERAPY AND/OR BEHAVIORAL HEALTH TREATMENT
INFORMED CONSENT

I HEAREBY CONSENT TO ENTER TREATMENT WITH FERN CREEK COUNSELING. I UNDERSTAND THAT ALL INFORMATION DISCLOSED DURING THE COURSE OF THERAPY WILL BE HELD IN CONFIDENCE WITH THE EXCEPTION OF INTERVENTION WITH THREATS OF HARM TO MYSELF OR OTHERS, ALLEGATIONS OF CHILD ABUSE OR NEGLECT AND/OR COURT ORDERED DISCLOSURES. I UNDERSTAND THAT FERN CREEK COUNSELING HAS A LEGAL AND ETHICAL OBLIGATION TO DISCLOSE THIS INFORMATION AND WILL MAKE EVERY EFFORT TO DISCUSS THIS WITH ME SHOULD THE NEED ARISE. I UNDERSTAND THAT ALL INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND WILL NOT BE RELEASED TO ANYONE WITHOUT MY PRIOR SPECIFIC WRITTEN PERMISSION.

I UNDERSTAND THAT I WILL EXPECT TO BE AN ACTIVE PARTICIPANT IN MY TREATMENT. I WILL COMMIT MYSELF TO KEEPING MY APPOINTMENTS AS SCHEDULED. I ACKNOWLEDGE THAT THERE IS NEVER A GUARANTEE IN THE OUTCOME OF MY THERAPY.

I UNDERSTAND THAT PAYMENT ARRANGEMENTS FOR SERVICES ARE MY RESPONSIBILITY. I UNDERSTAND THAT I WILL BE EXPECTED TO NOTIFY THE OFFICE OF THE NEED RESCHEDULE AN APPOINTMENT AT LEAST 24 HOURS IN ADVANCE.

SIGNED:____ DATE: ________________

WITNESSED:____ DATE: ________________

OFFICE POLICIES

IT IS IN THE POLICY OF THIS OFFICE TO FILE YOUR INSURANCE. IT IS THE RESPONSILITY OF THE PATIENT TO OBTAIN AUTHORIZATION FOR YOU FIRST VISIT. IF YOU HAVE NOT OBTAINED AUTHORIZATION FOR THIS VISIT, YOU WILL BE RESPONSIBLE FOR THE ENTIRE CHARGE. PLEASE NOTIFY US IF YOU HABE NOT RECEIVED AN AUTHORIZATION AND WE WILL RESCHEDULE.

IF YOU HABE UNITED HEALTHCARE MEDICAID HMO, YOU MUST CALL UNITED BEAHVIORAL HEALTH FOR AUTHORIZATION FOR YOUR FIRST VISIT. IF YOU HAVE NOT OBTAINED AUTHORIZATION FOR THIS VISIT, YOU WILL BE RESPINSIBLE FOR THE ENTIRE CHARGE. PLEASE NOTIFY US IF YOU HAVE NOT RECEIVED AN AUTHORIZATION AND WE WILL RESCHEDULE.

IT IS THE POLICY OF THIS OFFICE THAT CO-PAYMENTS ARE DUE PRIOR TO SEEING THE THERAPIST. IF YOU HAVE FORGOTTEN YOUR CO-PAYMENT, YOU WILL BE REQUIRED TO PAY YOUR CO-PAYMENT, PLUS THE MISSED CO-PAYMENT AT YOUR NEXT VISIT TO THE OFFICE. IF YOU ARE UNABLE TO PAY YOUR CO-PAYMENT AT THAT TIME, YOU WILL BE ASKED TO RESCHEDULE.

I HAVE READ AND UNDERSTAND THE ABOVE.
SIGNED:____ DATE: ________________

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

PATIENT NAME: ____
DATE OF BIRTH: ___/___/___ SOCIAL SECURITY NUMBER: _____/___/_____

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND HAVE BEEN GIVEN AN OPPORTUNITY TO READ A COPY OF THE FERN CREEK COUNSELING NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE ANY QUESTIONS REGARDING THE NOTICE OR MY PRIVACY RIGHTS, I CAN CONTACT FERN CREEK COUNSELING AT 407.894.4030.

____
SIGNATURE OF PATIENT/CLIENT DATE

____
SIGNATURE OF PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE* DATE

IF YOU ARE SIGNING AS A PERSONAL REPRESENRARIVE OF AN INDIVIDUAL, PLEASE DESCRIBE YOUR LEGAL AUTHORITY TO ACT FOR THIS INDIVIDUAL (POWER OF ATTORNEY, HEALTHCARE SURROGATE, ETC.)

____
____
____

PATIENT OR CLIENT REFUSES TO ACKNOWLEDGE RECEIPT.

____
SIGNATURE OFSTAFF MEMBER DATE

RELEASE OF INFORMATION

REQUEST AND AUTHORIZE:

Fern Creek Counseling
Elizabeth Kunz, LCSW
2475 Aloma Avenue
Winter Park, Florida 32792

TO RELEASE INFORMATION TO AND FROM: (NAME/ADDRESS OF AGENCY, OFFICE OR PERSON)

____
____
____
____

REGARDING PATIENT: ___________________________DATE OF BIRTH________
ADDRESS: ____
____
____
____

THE INFORMATION TO BE RELEASED FOR A PERIOD OF 12 MONTHS FROM THE DATE SIGNED.

I AUTHORIZE THE ABOVE NAMED AGENCY(S), PERSON, OR OFFICES TO EXCHANGE VERBAL (TELEPHONE) AND WRITTEN INFORMATION. AS SPECIFIED ABOVE FOR THE PURPOSE AND TREATMENT PERIOD INDICATED. I HOLD HARMLESS FERN CREEK COUNSELING IN REGARD TO THE USE OF INFORMATION AUTHORIZED FOR RELEASE OF EXCHANGE. I UNDERSTAND THAT THIS FORM IS NOT REQURIED AS A CONDITION FOR TREATMENT AND THAT IT MAY BE REVOKED BY ME IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. IN THE ABSENCE OF REVOCATION, THIS CONSENT WILL EXPIRE 12 MONTHS FROM THE VALID SIGNATURE. A COPY OF THIS AUTHORIZATION IS AS AUTHENTIC AS THE ORIGINAL SIGNED AUTHORIZATION OF RELEASE. AN ORIGINAL WILL BE RETAINED IN THE MEDICAL REPORT.

PATIENT SIGNATURE:____DATE: ______________

LEGAL RESPONSIBLE OTHER SIGNATURE: _________________________ DATE: _____________

WITNESS: ____DATE: ______________

FOR OFFICE USE ONLY

Clinical Impression

Diagnosis	DSM/ICD Code
Axis I	
Axis II	
Axis III	
Axis IV	
Justification of Primary Diagnosis	

Statement of Clinical Impression:

Clinician Signature and Credentials **Date**