lk counseling, llc

1133 louisiana avenue, #202
winter park, fl 32789
407.894.4030
lklcsw@lizkunz.com

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 lk counseling, llc. 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 lk counseling. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE_____DATE: _____/___/____

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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: _____
_____

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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 lk 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_____

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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 lklcsw@lizkunz.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. 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

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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

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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:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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CONSENT FOR PSYCHOTHERAPY AND/OR BEHAVIORAL HEALTH TREATMENT
INFORMED CONSENT

I HEAREBY CONSENT TO ENTER TREATMENT WITH lk 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 lk 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: _____

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OFFICE POLICIES

IT IS THE POLICY OF THIS OFFICE THAT PAYMENTS ARE DUE PRIOR TO SEEING THE THERAPIST. IF YOU HAVE FORGOTTEN YOUR PAYMENT, YOU WILL BE REQUIRED TO PAY YOUR PAYMENT, PLUS THE MISSED PAYMENT AT YOUR NEXT VISIT TO THE OFFICE. IF YOU ARE UNABLE TO PAY YOUR PAYMENT AT THAT TIME, YOU WILL BE ASKED TO RESCHEDULE. THE COST FOR A 45-50 MINUTE SESSION IS $150.

IT IS THE POLICY OF THIS OFFICE THAT A CREDIT CARD WILL BE KEPT ON FILE FOR ALL APPOINTMENTS. IF YOU WISH TO HAVE ARECEIPT OR SUPERBILL EMAILED TO YOU, PLEASE LET THE THERAPIST KNOW AT THE TIME OF THE APPOINTMENT.

I HAVE READ AND UNDERSTAND THE ABOVE.
SIGNED:_____ DATE: _____

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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 lk counseling NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE ANY QUESTIONS REGARDING THE NOTICE OR MY PRIVACY RIGHTS, I CAN CONTACT lk 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

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1133 louisiana avenue, #202
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lklcsw@lizkunz.com

RELEASE OF INFORMATION

REQUEST AND AUTHORIZE:

lk counseling, llc
Elizabeth Kunz, LCSW
1133 Louisiana Avenue, #202
Winter Park, Florida 32789

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 lk 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**