Cheryl N. Coletta, Psy.D., P.A.

Licensed Psychologist FL # PY8588

5301 North Federal Highway
Suite 380, Box 428
Boca Raton, FL 33487
Office: 561-279-5599
Fax: 888-974-3548

Please complete all information for the identified patient.

Today's Date: _____ Age: _____

(Please Print)
Name First:_____Last:_____

Street Address: _____

City:_____ State:_____ Zip:_____

Home Phone#: _____ Cell# _____

Can a message be left? **Home** ☐ yes ☐ no **Cell** ☐ yes ☐ no **Work** ☐ yes ☐ no

Date of Birth: _____ ☐ Male ☐ Female ☐ Transgender ☐ Other _____

Social Security Number: _____ Race: _____

Status: _____ years ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Cohabitating

Occupation/Title: _____

Name, relationship, and phone number of who to contact in emergency for **Assistance:**

_____
I am giving permission to Dr. Coletta to speak with the above person in an emergency.

Name of Insurance and ID # (From Ins. card):_____

Authorization # from insurance company if needed: _____

Name of school if patient is a student: _____

Primary or Family Doctor and phone number: _____
I authorize the release of my treatment reports to my PCP or behavioral health practitioners. ☐ Agree ☐ Decline

This Box is for Office Use Only: Patient Name: _____ Patient I.D. _____

Please complete all information for the identified patient.

Who referred you?_____

Please state why you are attending therapy:

_____

_____

Children or stepchildren's name and ages: _____

_____

Who are you living with at home (please list names, ages, and relationships): _____

_____

Previous therapy ☐ Yes ☐ No If yes, when/how long _____

Are you under Psychiatric care: ☐ Yes ☐ No Psychiatrist: _____

Describe your alcohol use: ☐ Yes ☐ No _____ weekly average

Describe your nicotine use: ☐ Yes ☐ No _____ weekly average

Describe your other substances used: ☐ Yes ☐ No _____ weekly average

Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Deceased

Mother's age, health condition, if living, or age of death _____

Father's age, health condition, if living, or age of death _____

Brothers: names and ages _____

_____

Sisters: names and ages _____

_____

Describe the relationship you had with your grandmothers:

_____

Describe the relationship you had with your grandfathers:

_____

This Box is for Office Use Only: Patient Name: _____ Patient I.D. _____

Please complete all information for the identified patient.

Check any history of abuse for the patient: ☐ Physical ☐ Verbal ☐ Emotional ☐ Sexual

Any members in your family diagnosed with:

☐ Schizophrenia Who _____

☐ Depression Who _____

☐ Mania Who _____

☐ Bipolar Who _____

☐ Committed Suicide Who _____

☐ Alcohol or substance abuse Who _____

Describe any past or present health problems _____

_____

List any allergies if any_____

_____

Current medications and dosages: _____

_____

List all major life events and/or traumas with dates; if more room is needed, please attach a list.

_____

_____

List any pets, type and names _____

Education: Year completed Location

☐ Completed High School _____

☐ College _____

☐ Post Graduate _____

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OUTPATIENT SERVICES CONTRACT

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Please read all pages and sign all designated places

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. We can discuss any questions you have about the procedures at our next meeting. When you sign this document, it will also represent an agreement between us.

CONSENT AND CONFIDENTIALITY

I agree to seek treatment and/or evaluation for myself, child, spouse, or family, participate actively in treatment planning, provide information to Dr. Coletta, which will enable delivery of appropriate care and give permission for my signature to be on file. Laws protect confidentiality of communications between client and psychologist; information can only be released with a prior written authorization. Exceptions are: (a) in certain legal proceedings Dr. Coletta may be required to testify and/or release records. (b) Dr. Coletta is legally required to take action to protect patients and others from harm even though that requires revealing information about treatment and diagnosis. If there is evidence of a child, elderly person, or a disabled person being abused, Dr. Coletta must file a report with the appropriate state agency and/or police. (c) If Dr. Coletta believes a client is threatening serious bodily harm to another, Dr. Coletta is required to take protective actions, which may include notifying the potential victim, notifying the police and/or seeking appropriate hospitalization. If a client threatens to harm him/herself, Dr. Coletta may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection. Dr. Coletta may occasionally consult about a case with other professionals or may be required by your insurance company to consult. In these cases, every effort is made to avoid revealing the identity of the client. Consultants and insurance company are bound to keep the information confidential. As a parent you have the right to general information about treatment, but not necessarily the complete record or specific test scores and/or answers. This written summary of exceptions to confidentiality should prove helpful in, but you may discuss any questions or concerns you may have, these governing laws are complex, but since I am not an attorney, if you need specific advice, you should consult an attorney.

MEETINGS

Because time has been reserved exclusively for me and/or my family members, I AM REQUIRED TO PROVIDE AT LEAST **TWENTY-FOUR (24) HOURS'** ADVANCE NOTICE IF UNABLE TO KEEP THE SCHEDULED APPOINTMENT. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, Dr. Coletta will try to find another time to reschedule the appointment. In the event you do not provide the required notice prior to canceling, you will be charged rate of what my insurance company or the managed care company allows for the failed session or you will be discharged due to noncompliance. Payment must be received before

another appointment will be scheduled. All future appointments already scheduled will automatically be canceled. If you are late for an appointment, and no attempt is made to contact office, Dr. Coletta will see the next patient scheduled if they arrive during your scheduled appointment.

CONTACTING ME

Dr. Coletta is often not immediately available by telephone and probably will not answer the phone when with a patient. When Dr. Coletta is unavailable, the telephone is answered by voice mail that is frequently monitored. Dr. Coletta will make every effort to return your call on the same day you make it. If you are difficult to reach, please inform Dr. Coletta of some times when you will be available. If there is a **life threatening** emergency please call 911 immediately or go to the nearest hospital. If Dr. Coletta will be unavailable for an extended time, the doctor's name and number providing backup coverage will be on the voice mail. **DO NOT LEAVE TEXT MESSAGES ONLY VOICE MAILS ON THE OFFICE PHONE: 561-279-5599.**

BILLING AND PAYMENTS

You will be expected to pay for each session or co-payments at the time of the session or unless you have insurance coverage that requires another arrangement. You are responsible for any co-payments required or deductibles that must be met by you at the time of service. Payment for professional services you may require such as report writing, telephone conversations, and preparation of records will be charged at my hourly rate at the time these services are requested. If you become involved in litigation which requires my participation, you will be expected to pay for the professional time required even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement, I will charge my hourly rate for the preparation, for attendance at any legal proceeding, and travel portal to portal which is different and cannot be billed to the insurance company.

INSURANCE REIMBURSEMENT

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have for your treatment. Many HMO's and PPO's require advance authorization and are oriented toward short-term treatment approach designed to resolve specific problems. Dr. Coletta is required to complete some Managed Care Forms by the 1st or 2nd session pertaining to the therapy and will release such information necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes with representatives of my insurance or managed care company. Due to the specific nature of these forms, this information may be completed during the 1st session. Insurance and managed care companies may ask to review the entire record and file. By signing this form you are giving permission to send notes when they are requested, managed care forms, and claims with dates of service, diagnosis & **procedure codes. In addition, these companies require a release of records to your PCP and other behavioral health practitioners.**

PROFESSIONAL RECORDS

Both law and the standards of my profession require that I keep legible appropriate treatment records. Statue 456.057 states "when a patient's...chapter 490 psychological, or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's records shall be provided directly to a subsequent treating"...professional upon receipt of a signed release of records, Dr. Coletta will forward a copy or a summary (Statute 456.057) of your records to another appropriate professional. Clients will be charged an appropriate fee for any preparation time, which is required to comply with an information request and you will be informed by Dr. Coletta if there is any request for your information before any information is given out.

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According to the Florida Psychological Association, "records could be deficit" if there is no attempt by the psychological provider to "obtain past mental health records". It is the obligation of you the patient, parent or guardian to obtain copies of all these health records and provide copies of these records or have these records sent to Cheryl N. Coletta, Psy.D., P.A. at the office address in Boca Raton.

Based on Florida medical laws for records, Dr. Coletta, therefore would like as many past records as you might be able to acquire; thus you must **sign** one of these lines:

☐ There are no past psychological or psychiatric records _____

☐ I refuse to release past psychological or psychiatric records _____

☐ I will have past psychological or psychiatric records forwarded _____

I have read the information in this document, agree to abide by its terms during our professional relationship, my signature authorizes payment of medical benefits to Dr. Coletta for services rendered. I am aware that the privacy rule gives the right to request restrictions on uses of my protected health information. I can request a copy of the Privacy Practices from Dr. Coletta. I am giving permission for Dr. Coletta's office to call me and leave a message to confirm an appointment and if necessary send a bill to my home address. If I do not agree, I need to contact Cheryl Coletta, Privacy Officer to request changes. By signing this form I am giving consent for my behavioral healthcare practitioner to release the information to my active Insurance or Managed Care Company until the period of time at which I am no longer an active. I understand that my records are protected under the Federal and/or State Confidentiality Regulations. This authorization may be revoked at any time except to the extent that action has already occurred. If I do not revoke it, this consent will expire one (1) year after I have terminated treatment with Dr. Coletta. This consent is given of my own free will.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____

Client's, Patient, Parent/Guardian Signature **Date Signed**

_____

Print Name that was signed

_____

Client's, Patient, Parent/Guardian Signature **Date Signed**

_____

Print Name that was signed

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Patient Name: First _____ Last _____

Date Form Completed: _____ Completed by: First: _____Last: _____

Relationship to patient: _____

Please indicate whether any of the following apply to you by **CIRCLING YES** or **NO**.

1. Have had a loss of reputation?..... **YES** **NO**
2. Have had feelings of emptiness? ..... **YES** **NO**
3. Are you having worsening depression?..... **YES** **NO**
4. Feeling rejection, hopeless and/or helpless?..... **YES** **NO**
5. Feeling guilty or want to punish someone?..... **YES** **NO**
6. Feeling isolated and withdrawn from the world? ..... **YES** **NO**
7. Feeling detached from yourself, or unreality, feeling you are "going crazy", losing control, or feeling paranoia?..... **YES** **NO**
8. Have had a loss of ability to meet obligations? ..... **YES** **NO**
9. Have you been suffering from a chronic illness?..... **YES** **NO**
10. Have you been giving away important belongings?..... **YES** **NO**
11. Have had an unplanned pregnancy or recent abortion?..... **YES** **NO**
12. Have you made efforts to get help that have been unsuccessful?..... **YES** **NO**
13. Have you had thought that you want to change what is happening in your life by leaving?.. **YES** **NO**
14. Do you tend to be extremely accident-prone?..... **YES** **NO**

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15. Do you tend to avoid taking care of your health? ..... **YES** **NO**

16. Do you tend to be reckless and do not think about risks? ..... **YES** **NO**

17. Intense anger or controlling anger, temper problems, recurrent fighting with others and then feel guilty? ..... **YES** **NO**

18. Tend to use drugs or alcohol to change bad feelings? ..... **YES** **NO**

19. Tend to over use or over dose with either drugs or alcohol?..... **YES** **NO**

20. Has something stressful happened recently that has made you feel negative about life?..... **YES** **NO**

21. Are guns, throwing knives, knives as weapons, brass knuckles, swords, or other weapons in the home?..... **YES** **NO**

22. Do you tend to listen to music, movies, videos, or books about death?..... **YES** **NO**

23. Do you dwell on issues of death or have an attraction or obsession to death?..... **YES** **NO**

24. Thinking you would like to go to sleep and not wake up? ..... **YES** **NO**

25. Has anybody close to you died recently and you had thoughts of wishing it were you or joining him/her? ..... **YES** **NO**

26. Know anyone that has committed suicide and you had thoughts of wishing it were you or joining him/her? ..... **YES** **NO**

27. Have or had fantasies of jumping off a building? ..... **YES** **NO**

28. Have or had thoughts that you might drown yourself? ..... **YES** **NO**

29. Have or had fantasies of seeing yourself dead surrounded by others alive?..... **YES** **NO**

30. Have or had thoughts about hanging yourself or using a gun on yourself or others?..... **YES** **NO**

31. Have or had thoughts about using the car to harm yourself in an accident or by carbon monoxide? ..... **YES** **NO**

32. Have or had any other suicidal behaviors, thoughts about killing, gestures, self-mutilation, plans, or threats? ..... **YES** **NO**

33. Are here because you tried to hurt yourself? ..... **YES** **NO**

34. Received treatment for self harm in the past? ..... **YES** **NO**

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35. Is there a specific time you think you will die? ..... **YES** **NO**

36. Feel you need to keep yourself safe from yourself to avoid doing self-harm? ..... **YES** **NO**

37. Over the **<u>past six (6) months</u>** have you ever said any of the following:

a. "I am a loser"..... **YES** **NO**
b. "I am a failure" ..... **YES** **NO**
c. "I hate my life" ..... **YES** **NO**
d. "I am worthless" ..... **YES** **NO**
e. "I have no future" ..... **YES** **NO**
f. "I wish I were dead" ..... **YES** **NO**
g. "I wish I did not exist" ..... **YES** **NO**
h. "I have nothing to lose" ..... **YES** **NO**
i. "I have nothing to live for" ..... **YES** **NO**
j. "I have nothing in my life" ..... **YES** **NO**
k. "I will be dead soon anyway" ..... **YES** **NO**
l. "I would be better off not alive" ..... **YES** **NO**
m. "I am going to have a heart attack" ..... **YES** **NO**
n. "I am worth more dead than alive" ..... **YES** **NO**
o. "I am going to blow my brains out" ..... **YES** **NO**
p. "I am to blame for all my troubles" ..... **YES** **NO**
q. "If I die, so what" ..... **YES** **NO**
r. "I'll show them" ..... **YES** **NO**
s. "Life is not worth living" ..... **YES** **NO**
t. "My family would be better off without me" ..... **YES** **NO**
u. "Nobody needs me" ..... **YES** **NO**
v. "Nobody cares anyway" ..... **YES** **NO**
w. "There is no reason to keep living" ..... **YES** **NO**

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Patient Name: First _____ Last _____

Date Form Completed: _____ Completed by: First: _____Last: _____

Relationship to patient: _____

Please indicate whether any of the following apply to you by **CIRCLING YES** or **NO**.

A. You experience an <u>abrupt</u> surge of intense fear or intense discomfort that reaches a peak within minutes.

	YES	NO
For example:		
1. Heart pounds, palpitates, or accelerates.	**YES**	**NO**
2. Sweating.	**YES**	**NO**
3. Shaking or trembling.	**YES**	**NO**
4. Feels like you are short of breath or smothering.	**YES**	**NO**
5. Choking feeling.	**YES**	**NO**
6. Chest pain or discomfort.	**YES**	**NO**
7. Nausea or abdominal distress.	**YES**	**NO**
8. Feeling dizzy, unsteady, light-headed or feeling faint.	**YES**	**NO**
9. Chills or heat sensations.	**YES**	**NO**
10. Numbness or tingling sensations.	**YES**	**NO**

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11. Feelings of unreality or feeling detached from yourself. **YES** **NO**

12. Fear of losing control or "going crazy". **YES** **NO**

13. Fear of dying. **YES** **NO**

B. At least one of these episodes is followed by 1 month (or more) of:

1. Persistent concern or worry about experiencing another episode or their consequences (for example: losing control, having a heart attack, "going crazy"). **YES** **NO**

2. Changes in your behavior related to the episode (for example: behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations). **YES** **NO**

H. Your fear, anxiety, or avoidance is not due to the effects of a substance (for example: medications or illicit drug use). **YES** **NO**

I. Does your fear or anxiety ONLY occur when public speaking or performing in public? **YES** **NO**

J. Please complete the following if you are currently prescribed medication for treatment of the above symptoms:

Name of Prescribing Doctor	Medication	Dosage (e.g. mg)	Frequency/Day	Date Medication Started

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Patient Name: First _____ Last _____

Date Form Completed: _____ Completed by: First: _____Last: _____

Relationship to patient: _____

Please indicate whether any of the following apply to you by **CIRCLING YES** or **NO**.

A. Excessive anxiety and worry, about a number of events or activities (for example: work or school) occurring almost every day for several months. **YES** **NO**

B. Difficulty controlling the anxiety and worry. **YES** **NO**

C. The anxiety and worry are associated with any of the following symptoms:

1. Restlessness, feeling keyed up or on edge. **YES** **NO**
   Nearly every day for the past 6 months? **YES** **NO**

2. Being easily tired. **YES** **NO**
   Nearly every day for the past 6 months? **YES** **NO**

3. Difficulty concentrating or mind going blank. **YES** **NO**
   Nearly every day for the past 6 months? **YES** **NO**

4. Irritability. **YES** **NO**
   Nearly every day for the past 6 months? **YES** **NO**

5. Muscle tension. **YES** **NO**
   Nearly every day for the past 6 months? **YES** **NO**

6. Sleep difficulties (falling asleep, staying asleep, or restless unsatisfying sleep). **YES** **NO**
   Nearly every day for the past 6 months? **YES** **NO**

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D. The anxiety, worry, or physical symptoms causes you significant distress or impairment in your social, occupational/school, or other important areas of functioning.

YES NO

E. Your symptoms are not due to the effects of a substance (for example: medications or illicit drug use).

YES NO

F. Please complete the following if you are currently prescribed medication for treatment of the above symptoms:

Name of Prescribing Doctor	Medication	Dosage (e.g. mg)	Frequency/Day	Date Medication Started

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Please indicate whether any of the following apply to you by **CIRCLING YES** or **NO**.

A. Please indicate whether any of the following **9** items have occurred during the **same TWO (2) week period**:

1. You experience depressed or irritable mood (for example: feeling sad, empty, hopeless, others noticing you are tearful or sad) for most of the day, nearly every day.

YES NO

2. You experience decreased interest or pleasure in all, or almost all, activities that you usually enjoy for most of the day, nearly every day.

YES NO

3. Weight loss (# pounds _____) or weight gain (# pounds _____) over a period of one month and not due to dieting.

YES NO

Decrease in appetite nearly every day. **YES NO**

Increase in appetite nearly every day. **YES NO**

4. Insomnia (problems falling asleep, problems staying asleep) nearly every day. **YES NO**

Hypersomnia (sleeping too much) nearly every day. **YES NO**

5. Agitation/restlessness nearly every day. **YES NO**

Slow moving, slowed down nearly every day. **YES NO**

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6. Fatigue or loss of energy nearly every day. **YES** **NO**

7. Feeling worthless or guilty nearly every day. **YES** **NO**

8. Less able to think, decreased concentration, difficulty with making decisions nearly every day. **YES** **NO**

9. Thinking/wishing for death, suicidal thoughts, harming oneself, planning/attempting to harm oneself. **YES** **NO**

B. Your symptoms cause significant distress or impairment in your social, occupational/school, or other important areas of functioning. **YES** **NO**

C. Your symptoms are not due to the effects of a substance (for example: medications or illicit drug use). **YES** **NO**

D. Please complete the following if you are currently prescribed medication for treatment of the above symptoms:

Name of Prescribing Doctor	Medication	Dosage (e.g. mg)	Frequency/Day	Date Medication Started