

# Coral Springs Annex LLC

5571 N. University Drive Suite 101

Coral Springs, Florida 33067

954-906-0884

## INTAKE AND HISTORY FORM

(Confidential Information)

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Responsible Party (if patient is a minor) \_\_\_\_\_

Insured's Name (if other than patient) \_\_\_\_\_

SS# of insured: \_\_\_\_\_ Insured's Birth Date: \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

May we text you a reminder of your appointment? \_\_\_\_\_ Yes \_\_\_\_\_ No  
(Note: Phone company charges may apply for texting).

Marital Status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Currently Employed? \_\_\_\_\_ Yes \_\_\_\_\_ No Patient's Occupation: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Email address: \_\_\_\_\_

Are you interested in receiving our monthly newsletter via email? \_\_\_\_\_ Yes \_\_\_\_\_ No

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## **CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

As a condition of providing treatment to you, a therapist from Coral Springs Annex LLC may request your consent to use and disclose protected health information about you to carry out treatment, payment, and health care operations.

You may revoke this consent at any time by notifying Coral Springs Annex LLC, *in writing*, except to the extent that the provider has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information (“Privacy Notice”) for a more complete description of the uses and disclosures that Coral Springs Annex LLC may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent.

Coral Springs Annex LLC have reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice.

You have the right to request that Coral Springs Annex LLC restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Coral Springs Annex LLC is not required, however, to agree to such requested restrictions. If, however, Coral Springs Annex LLC agree to the requested restriction, they will honor the request and it will be binding.

I hereby consent to the use and disclosure by Coral Springs Annex LLC, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

Signature: \_\_\_\_\_

Signature of Personal Representative of  
Patient: \_\_\_\_\_

Representative’s Authority to Act on Behalf of  
Patient: \_\_\_\_\_

Date: \_\_\_\_\_

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## INSURANCE BILLING POLICY AND FINANCIAL RESPONSIBILITY

Our fees generally fall within the reimbursement guidelines for psychotherapy in this area. However, there is no guarantee that your insurance company will cover the entire fee. You may have an insurance policy that has payment limitations, makes payments based on a set fee schedule, or makes payments on approved visits through managed care. The insurance you have is a contract between you and your insurance carrier; you should be aware of your policy and its limitations.

As a courtesy, we will contact your insurance company to verify benefits. You are responsible for payment of all deductible, co-payment and coinsurance amounts. If your insurance company does not pay in accordance with our telephone verification, you will be responsible for payment in full. Please be aware that we file your insurance claim as a courtesy to you. You are responsible for keeping track of all of your therapy sessions including those with other providers, and how many visits your insurance coverage allows per calendar year combined. Should your benefits be exhausted for the year, you will be responsible for any unpaid services and for future visits until benefits resume.

In circumstances where benefits are exhausted through your insurance company, or if there is no longer insurance coverage in effect, it is your responsibility to notify your therapist in order to establish the total fee that is your responsibility for ongoing visits.

It is your responsibility to keep your appointments as scheduled. Failure to keep an appointment and/or failure to notify the office of an appointment cancellation at least 24 hours prior to the appointment will incur a **\$50.00** fee on your account. Please discuss any concerns about a cancellation fee with our office staff.

Checks returned from your bank for any reason will incur a **\$45.00** fee on your account. The payment of the original check amount and the \$45.00 fee must be made by cash or credit card only.

In the event that outstanding balances on my account remain unpaid and I fail to arrange a payment plan, I understand that collection procedures will begin. I will be responsible for any interest accrued and the costs of collection, including attorney's fees.

\_\_\_\_\_  
Print patient's name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's signature (parent if minor)

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## NOTICE OF PRIVACY PRACTICES

### **THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our office except when the release is required by law or regulation.

### **ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE**

You will be asked to provide a signed acknowledgement of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

**By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.**

Signature: \_\_\_\_\_

Signature of Personal Representative of Patient: \_\_\_\_\_

Description of Representative's Authority to Act on behalf of patient: \_\_\_\_\_

Date: \_\_\_\_\_

### **CLIENT STATEMENT OF UNDERSTANDING**

I understand that confidentiality of records and information about me will be held in accordance with state laws regarding confidentiality. I understand that by law confidential information may be provided under the following circumstances:

1. If I give written permission requesting release of information.
2. If a court orders the release of my records.
3. If I raise my mental status or competency in a legal proceeding.
4. If there is reason to believe that I may be a danger to myself or to others.
5. If there is evidence or reason to suspect child abuse or neglect of a child or an incompetent or disabled person.

I have read and understand the above.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **SIGNATURE ON FILE**

I authorize the release of any payment and medical information necessary to process my or my family member's claim and related claims. Please accept a photocopy of this authorization as if it were an original authorization. My signature below acts as a signature on file.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **ASSIGNMENT OF BENEFITS**

I hereby authorize direct payment of insurance benefits to Coral Springs Annex LLC for professional services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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## CHILDHOOD HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Presenting problem: \_\_\_\_\_

\_\_\_\_\_

## EARLY CHILDHOOD INFORMATION

Birth: Normal? \_\_\_\_\_ Weight: \_\_\_\_\_ Length: \_\_\_\_\_

Unusual events at birth: \_\_\_\_\_

\_\_\_\_\_

Adoption? At what age? \_\_\_\_\_ Circumstances: \_\_\_\_\_

\_\_\_\_\_

Growing up: Normal? \_\_\_\_\_ Problems? \_\_\_\_\_

\_\_\_\_\_

Parents: Married \_\_\_\_\_ Alive? \_\_\_\_\_ Quality of their relationship: \_\_\_\_\_

\_\_\_\_\_

Siblings: \_\_\_\_\_ Quality of Relationship? \_\_\_\_\_

\_\_\_\_\_

Do any siblings have disabilities or developmental problems? \_\_\_\_\_

\_\_\_\_\_

Describe Childhood: \_\_\_\_\_

\_\_\_\_\_

Describe Adolescence: \_\_\_\_\_

\_\_\_\_\_

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Any Issues or Traumatic Events? \_\_\_\_\_

\_\_\_\_\_

Describe Father's Personality and relationship to him: \_\_\_\_\_

\_\_\_\_\_

Describe Mother's Personality and relationship to her: \_\_\_\_\_

\_\_\_\_\_

Other significant information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **SCHOOL HISTORY**

Type of Student/Typical Grades: \_\_\_\_\_

\_\_\_\_\_

Any identified learning problems? \_\_\_\_\_

\_\_\_\_\_

Any difficulties doing/with homework? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any suspensions/expulsions? \_\_\_\_\_ When? \_\_\_\_\_ Why? \_\_\_\_\_

\_\_\_\_\_

Previous Schools Attended and Teacher Reports: \_\_\_\_\_

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Describe Current School/Activities/Honors: \_\_\_\_\_

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Describe Any Behavior Problems: \_\_\_\_\_

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Other Information: \_\_\_\_\_

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## **WORK HISTORY**

Current Job: \_\_\_\_\_

Prior Jobs: \_\_\_\_\_

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## **PREVIOUS PSYCHOLOGICAL TESTING**

When? \_\_\_\_\_ By Whom? \_\_\_\_\_

Results: \_\_\_\_\_

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## **MEDICAL HISTORY**

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Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Unusual Illnesses: \_\_\_\_\_

\_\_\_\_\_

Medications and prescribed by: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous medications: \_\_\_\_\_

Previous psychotherapy: When? \_\_\_\_\_ With whom? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there any family history of mental illness? \_\_\_\_\_ Whom? \_\_\_\_\_

\_\_\_\_\_

Eating problems? \_\_\_\_\_

\_\_\_\_\_

Sleeping problems? \_\_\_\_\_

\_\_\_\_\_

Suicide attempts? \_\_\_\_\_ How many times? \_\_\_\_\_ When? \_\_\_\_\_

What happened/methods used? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any current suicidal thoughts? \_\_\_\_\_

Any self-mutilating/cutting behaviors? \_\_\_\_\_



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## **ALCOHOL/DRUG HISTORY**

Age of First Alcohol Use: \_\_\_\_\_ Current use: \_\_\_\_\_

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Drugs used and age started: \_\_\_\_\_

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Current alcohol/drug use: \_\_\_\_\_

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Is there abuse of prescription drugs? \_\_\_\_\_ Which? \_\_\_\_\_

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Other information: \_\_\_\_\_

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## **SOCIAL LIFE**

Are there friends and how many? \_\_\_\_\_

What are the social activities with friends? \_\_\_\_\_

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Has there been any community service? \_\_\_\_\_ What? \_\_\_\_\_

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Have there ever been any arrests? \_\_\_\_\_

\_\_\_\_\_

Are there any legal problems? \_\_\_\_\_

\_\_\_\_\_

Are there any financial problems? \_\_\_\_\_

\_\_\_\_\_

What are spare time activities? \_\_\_\_\_

\_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_

## **PERCEPTIONS**

Describe how you see your child: \_\_\_\_\_

\_\_\_\_\_

How do they handle stress? \_\_\_\_\_

\_\_\_\_\_

What makes them feel angry? \_\_\_\_\_

\_\_\_\_\_

What makes them feel nervous? \_\_\_\_\_

\_\_\_\_\_

What makes them feel sad? \_\_\_\_\_

\_\_\_\_\_

What makes them feel happy? \_\_\_\_\_

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What do they worry about? \_\_\_\_\_

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Other information/Additional comments: \_\_\_\_\_

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