STAR POINT COUNSELING CENTER  
207 Morgan St. Brandon, Florida 33510  
419 W. Platt St. Tampa Florida 33606

TODAY’S DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF PERSON BEING SEEN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN SCHOOL \_\_\_\_\_ NAME OF SCHOOL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF UNDER 18, NAME OF PARENT OR GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SINGLE \_\_\_\_\_\_ MARRIED \_\_\_\_ DIVORCED \_\_\_\_ WIDOWED \_\_\_\_ IN SCHOOL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT US \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CONTACT PHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IS IT OK TO LEAVE A MESSAGE\_\_\_\_\_\_\_

SECONDARY PHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IS IT OK TO LEAVE A MESSAGE\_\_\_\_\_\_\_

EMERGENCY PNONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DRIVERS LICENSE NUMBER (please provide card) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE COMPANY (please provide card) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF MAIN POLICY HOLDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDERS ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDERS DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO YOU: SELF \_\_\_\_ SPOUSE/PARTNER \_\_\_\_ CHILD \_\_\_\_\_ OTHER \_\_\_\_\_\_\_\_

PATIENT OR AUTHORIZED PERSONS SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits, and government benefits, to Star Point Counseling Center. I authorize Star Point Counseling Center to see myself and/or my child.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian signature, if under 18 years

OFFICE POLICY REGARDING MISSED APPOINTMENTS:

UNLIKE MEDICAL DOCTOR’S WE RESERVE THE HOUR JUST FOR YOU TO SEE THE THERAPIST. IF YOU CANCEL OR DO NOT SHOW UP FOR YOUR APPOINTMENT THEN THE THERAPIST DOES NOT SEE ANY OTHER CLIENTS UNTIL THE NEXT HOUR AND IT DOES NOT ALLOW SOMEONE ELSE TO SEE THE THERAPIST. LET US KNOW AS SOON AS POSSIBLE IF YOU CAN NOT MAKE YOUR SCHEDULED APPOINTMENT, SO WE CAN SCHEDULE ANOTHER CLIENT IN YOUR RESERVED TIME SLOT. IF YOU CANCEL YOUR APPOINTMENT LESS THAN 36 HOURS BEFORE YOUR APPOINTMENT YOU WILL BE CHARGED A $35 CANCELLATION FEE. IF YOU DO NOT CALL OR SHOW UP FOR YOUR APPOINTMENT WE WILL NEED TO COLLECT THE $35 FEE BEFORE WE CAN SET YOUR NEXT APPOINTMENT. I UNDERSTAND AND AGREE TO THIS POLICY

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR COMING HERE TODAY (MARK ALL THAT APPLY)

RELATIONSHIP \_\_\_\_ COUPLES COUNSELING \_\_\_\_ FAMILY/PARENTING \_\_\_\_ STRESS/ANXIETY \_\_\_\_

SUBSTANCE ABUSE/ALCOHOL \_\_\_\_ HELP WITH EMPLOYMENT \_\_\_\_ COURT ORDERED \_\_\_\_ GRIEF & LOSS \_\_\_\_

SEPARATION/DIVORCE\_\_\_\_ TROUBLED TEENS \_\_\_\_ DOMESTIC VOILENCE\_\_\_\_   
PRESENT SYPTOMS (MARK ALL THAT APPLY)  
RELATIONSHIP PROBLEMS \_\_\_\_ DEPRESSED\_\_\_\_ CRYING A LOT, MOODY \_\_\_\_ EXCESSIVE EXERCISE \_\_\_\_  
CAN’T SLEEP/SLEEPING TO MUCH \_\_\_\_ CAN’T EAT/EATING TO MUCH \_\_\_\_ LOSING OR GAINING WEIGHT\_\_\_\_VOMITING ON PURPOSE \_\_\_\_LOSS OF SEXUAL INTEREST \_\_\_\_  
 MANIC, OVERLY HAPPY CAUSING TROUBLE \_\_\_\_RACING THOUGHTS \_\_\_\_ EXCESSIVE SPENDING \_\_\_\_ HYPERACTIVE \_\_\_\_ FEELING ANXIOUS\_\_\_\_FELLING PANIC \_\_\_\_   
SWEATING, SHAKING, FEEL LIKE A HEART ATTACK \_\_\_\_ NIGHTMARES \_\_\_\_HISTORY OF SEVERE TRAUMA \_\_\_\_ FEARFUL, STARTLE EASILY, FLASHBACKS \_\_\_\_ TROUBLE LEAVING HOUSE\_\_\_AVOIDS CERTAIN PLACES DUE TO FEAR OF PANIC \_\_\_\_ REPETITIVE, UNWANTED THOUGHTS \_\_\_\_REPETITIVE BEHAVIOR \_\_\_\_ COUNTING, CHECKING \_\_\_\_ FIXING, STRAIGHTENING THINGS \_\_\_\_ HEARING VOICES, SEEING THINGS OTHERS CAN’T \_\_\_\_ DISORGANIZED THOUGHTS \_\_\_\_ DELUSIONAL THINKING \_\_\_\_CUTTING, BURNING, SELF MUTILATION \_\_\_\_\_ FEELING OF EMPTINESS \_\_\_ FEAR OF BEING ALONE \_\_\_\_SUICIDAL THOUGHTS \_\_\_\_ SEVERE CHILDHOOD ABUSE\_\_\_\_ SEXUAL ABUSE \_\_\_\_ ALCOHOLISM \_\_\_\_HEAVY DRINKING, SOMETIMES \_\_\_\_ ILLEGAL DRUGS\_\_\_\_WHATKIND\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
FREQUENT BACKACHE \_\_\_\_ HEADACHES \_\_\_\_ STOMACHACHES \_\_\_\_ OFTEN TIRED, ACHY\_\_\_\_ILLEGAL ACTIONS, ARRESTS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PAST COUNSELING/HOSPITALIZATION \_\_\_\_\_\_\_\_\_MEDICAL PROBLEMS \_\_\_\_ WHAT KIND\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESENTLY TAKING MEDICATION \_\_\_\_ WHAT KIND \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONCERNS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDREN PROBLEMS IN SCHOOL \_\_\_\_ PROBLEMS WITH FRIENDS \_\_\_\_ BEHAVIORAL PROBLEMS AT HOME \_\_\_\_\_CHILD PRE-NATAL PROBLEMS \_\_\_\_\_\_\_\_\_\_\_\_\_ FULL TERM \_\_\_\_\_\_\_\_ PREMATURE \_\_\_\_\_\_\_\_\_

DEVELOPMENTAL MILESTONES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAYMENT:  
\_\_\_\_I WILL PAY THE FEE IN FULL   
\_\_\_\_INSURANCE IS PAYING AND I WILL BE RESPONSIBLE FOR ANY DEDUCTIBLES OR CO PAYMENTS   
\_\_\_\_I AM REQUESTING A SLIDING SCALE PROOF OF INCOME IS REQUIRED (PAY STUB, CHILD SUPPORT ETC)

WE WILL OFFER YOU A SLIDING SCALE FEE FOR CLIENTS THAT HAVE A HIGH DEDUCTIBLE OR THOSE THAT DO NOT HAVE INSURANCE. WE BASE THE FEE ON YOUR ENTIRE HOUSEHOLD INCOME, SO WE NEED PROOF OF INCOME FROM EVERYONE IN THE HOUSEHOLD, INCLUDING CHILD SUPPORT, UNEMPLOYMENT, SSI, SS ETC….

IF YOU DO NOT HAVE INCOME THEN YOU WILL HAVE TO SUBMIT A STATEMENT SAYING YOU DO NOT HAVE ANY HOUSEHOLD INCOME. OUR SLIDING SCALE FEE IS AS FOLLOWS: OUR NORMAL FEE IS $100 PER SESSION

UNDER $25,000 PER YEAR IS $50 PER SESSION (REGISTERED MENTAL HEALTH COUNSELOR INTERN)  
$25,000 TO $35,000 IS $55 PER SESSION (REGISTERED MENTAL HEALTH COUNSELOR INTERN)  
$35000 TO $50,000 IS $60 PER SESSION (REGISTERED MENTAL HEALTH COUNSELOR INTERN)  
$50,000 TO $55,000 IS $70 PER SESSION ( LMHC, LCSW or LMFT)  
$55,000 TO $75,000 IS $85 PER SESSION (LMHC, LCSW or LMFT)  
OVER $75,000 IS $100 PER SESSION (LMHC, LCSW or LMFT)  
I AUTHORIZE STAR POINT COUNCELING CENTER TO BILL MY INSURANCE COMPANY. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CHECK WITH MY INSURANCE COMPANY ON BENEFIT DETAIL. I ALSO UNDERSTAND THAT IF MY INSURANCE COMPANY DENIES ANY CLAIMS I WILL BE RESPONSIBLE FOR PAYMENT IN FULL, UP TO THE ALLOWED AMOUNT OF THE INSURANCE COMPANY. IF MY INSURANCE COMPANY REJECTS ANY PAYMENT I HAVE THE OPTION OF THE SLIDING SCALE.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I HAVE RECEIVED AND UNDERSTAND THE CONFIDENTIALITY NOTICE ON THE FOLLOWING PAGES

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT COPY TO KEEP CLIENT COPY CONFIDENTIALITY NOTICE:

Contents of all therapy sessions are considered to be confidential. Both verbal  
Information and written records about a client cannot be shared with another party  
Without the written consent of the client or the client’s legal guardian. Noted exceptions  
Are as follows:

DUTY TO WARN AND PROTECT  
When a client discloses intentions or a plan to harm another person, the mental health  
Professional is required to warn the intended victim and report this information to legal  
Authorities. In cases in which the client discloses or implies a plan for suicide, the health care  
Professional is required to notify legal authorities and make reasonable attempts to  
notify the family of the client.

ABUSE OF CHILDREN AND VULNERABLE ADULTS

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has

recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of

abuse, the mental health professional is required to report this information to the appropriate

social service and/or legal authorities.

PARENTAL EXPOSURE TO CONTROLLED SUBSTANCE

Mental Health care professionals are required to report admitted prenatal exposure to

controlled substances that are potentially harmful.

MINORS/GUARDIANSHIP

Parents or legal guardians of non-emancipated minor clients have the right to access the

clients’ records.

INSURANCE PROVIDERS (WHEN APPLICABLE)  
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

If you would like us to release information we will have you fill out and sign a Consent To Release form.

OFFICE POLICY REGARDING MISSED APPOINTMENTS: UNLIKE MEDICAL DOCTOR’S WE RESERVE THE HOUR JUST FOR YOU TO SEE THE THERAPIST. IF YOU CANCEL OR DO NOT SHOW UP FOR YOUR APPOINTMENT THEN THE THERAPIST DOES NOT SEE ANY OTHER CLIENTS UNTIL THE NEXT HOUR AND IT DOES NOT ALLOW SOMEONE ELSE TO SEE THE THERAPIST. LET US KNOW AS SOON AS POSSIBLE IF YOU CAN NOT MAKE YOUR SCHEDULED APPOINTMENT, SO WE CAN SCHEDULE ANOTHER CLIENT IN YOUR RESERVED TIME SLOT. IF YOU CANCEL YOUR APPOINTMENT LESS THAN 36 HOURS BEFORE YOUR APPOINTMENT YOU WILL BE CHARGED A $35 CANCELLATION FEE. IF YOU DO NOT CALL OR SHOW UP FOR YOUR APPOINTMENT WE WILL NEED TO COLLECT THE $35 FEE BEFORE WE CAN SET YOUR NEXT APPOINTMENT. I UNDERSTAND AND AGREE TO THIS POLICY