LAKE MARY
Counseling &
Wellness Center

INTAKE FORM

CLIENT INFORMATION

Date _____ Referred by _____ Therapist _____

Client Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Okay to leave voice message ? YES ____ NO ____ E-mail _____

Education _____ Occupation _____

Marital Status _____ Years Married _____ Previous Marriage _____

Religion _____ Active? _____

Emergency Contact _____ Phone _____ Relationship _____

INMEDIATE FAMILY

Name	Relationship	Age	Where Residing
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(OFFICE USE ONLY)

ICD-10
_____

COPAY:
_____

COUNSELING ISSUE

What is presenting the issue that brings you here today?

_____
_____
_____
_____

Previous Counseling / Psychotherapy (with whom and when)

_____

_____

MEDICAL INFORMACION

Primary Care Physician (PCP) _____ Phone _____

Current Medications

_____ _____ _____

_____ _____ _____

INSURANCE INFORMATION

Insurance Company _____ ID No. _____

Check for Private Payment _____

Our insurance assignment program is designed to keep your out of pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 90 days for payment. Please remember however, that you are ultimately responsible for payment. If the bill is not paid by your insurance company, you will responsible for the bill.

FINANCIAL POLICES

1. Counseling and Psychotherapy fees are $ _____ per 45-50 minutes. For sessions exceeding 50 minutes, you may be billed proportionally.
2. Telephone consultation and other professional activities rendered on behalf of the client are also billed. Short telephone "check in" or scheduling coordination phone calls are never billed.
3. Payment is due at the time of service.
4. Co-Payments are sometimes established by your insurance company and will be due at the time of service.
5. Missed appointments, other than a genuine emergency or illness, will be billed for missing unless notification is made 24 hours in advance. Appointments cancelled with less than 24-hour notice will be charged $30.00.
6. Court appearance are subject to a $300 fee for the first two hours and must be paid in advance. Letters, reports, and treatment summary release are subject to $70 per hour fee.
7. If the bill is not paid by your insurance company, we will charge your designated credit card for the balance that is due. We ask that you complete the credit card information below so that we may keep it on file for future billing if needed. If you have any questions, please let me know.

CREDIT CARD: AMEX VISA MASTERCARD DISCOVER
(Circle One)

CARDHOLDERS NAME: _____

CARD # _____EXP DATE _____ SECURITY CODE _____

I give _____, (therapist) the authorization to charge my credit card for any unpaid account balances or no show charges.

I understand that Lake Mary Counseling & Wellness Center is providing professional services to me and/or my family. I hereby agree to assume full financial responsibility for payment of all treatment charges incurred, as outlined above.

Signature of Responsible Party(s): _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This notice describes The Lake Mary Counseling & Wellness Center privacy practices and that of:

- All staff authorized to enter information into our file, or provide you with mental health services.
- All sub-contracted psychotherapists and providers of comprehensive assessments.

These entities may share your confidential health care information ("Information") with each other for treatment, payment or other purposes described in this notice.

Your information may be released to other mental health professionals affiliated with The Lake Mary Counseling & Wellness Center for the purpose of providing you with quality healthcare.

Your information may be released to Medicare, Medicaid, an HMO, or other third parties for the purpose of receiving payment for providing mental health services.

You and your legal guardian have the right to know who accessed your information and for what purpose, if that access was provide outside the normal treatment and administrative operations of The Lake Mary Counseling & Wellness Center.

You and your legal guardian have the right to obtain a paper copy of this Notice of Privacy Practices upon request.

The Lake Mary Counseling & Wellness Center is required by law to protect the privacy of your information. The information will be kept confidential, and you will be provided with a list of duties or practices that protect your information.

The Lake Mary Counseling & Wellness Center will only disclose your information when required to do so by Federal, State or Local law.

The Lake Mary Counseling & Wellness Center will abide by the terms of the notice. The Center reserves that right to make changes to the notice and continue to maintain the confidentiality of your information.

You have a right to complain to The Lake Mary Counseling & Wellness Center if you believe that your privacy rights have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

Lake Mary Counseling & Wellness Center
Attn: Adriana Rueda, LMHC
2500 West Lake Mary Blvd, Suite 103
Lake Mary, Florida 32746

I, _____ have been informed of the Lake Mary Counseling & Wellness Center Private Practices.

_____ _____
Client Date

_____ _____
Legal Guardian Date

_____ _____
Other Date

INFORMED CONSENT

I voluntary agree to participate in counseling sessions and/or consent to the participation of my child in counseling. I understand that my psychotherapist is a licensed professional in independent practice affiliated with The Lake Mary Counseling & Wellness Center.

I understand these sessions are confidential and the Counselor will keep confidential anything the Client says with the following exceptions: (1) The Client directs the Counselor to tell someone else, (2) The Counselor determines that the Client is a danger to self or others, (3) The law requires disclosure, such as in the case of child abuse, vulnerable adult abuse, prenatal exposure to controlled substances, or when ordered by a court disclose information, (4) Information shared in confidence with a supervisor or a professional colleague.

I understand that primary modality of therapy will be "Talk Therapy", but sometimes it could include Relaxation Exercises, Hypnotherapy, Eye Movement Reprocessing (EMDR), and/or Play Therapy.

I understand that health insurance companies often require advance notice of services and that the Client be given a diagnosis providing a medical necessity for counseling or psychotherapy. I consent to the release of information and notification of my insurance company to determine benefits and to secure payment. I understand that any diagnosis will become part of my permanent insurance records.

I understand that services will be rendered in a professional manner consistent with ethical standards of the profession and that I can discontinue counseling session at any time. I have had a chance to ask questions in advance and have my questions satisfactorily answered.

I also understand that all clinical information will be kept confidential, expect as stipulated in Florida Statutes 39,394, and Health Insurance Portability and Privacy Act, as described in the Privacy Notice. The clinical record is the property of and will be retained by the assigned counselor. Authorized personnel of the Lake Mary Counseling & Wellness Center may review my clinical record for the purpose of billing, clinical supervision, consultation, auditing, and compliance. Portions of my information will be used for billing and payment purposes. This notice will be kept for a period of seven (7) years.

I have knowledge of the Client's Rights and Responsibilities Policy. I may revoke my consent for any and all services at any time.

_____ _____

Client Signature Date

_____ _____

Parent or Legal Guardian Date