Best Listeners

Patient Information

Date:_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____

Age;_____ Birth Date;_____ Marital: M S W D P

Occupation:_____ Employer:_____

Employer's Address:_____ Phone: _____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____ Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Phone:_____

How were you referred to our office?_____

Family Medical Doctor (first and last name): _____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

PAYMENT INFORMATION:

____ Self Pay Other Arrangements _____

Please check any and all insurance coverage that may be applicable in this case:

___ Major Medical ___ In Network ___ Out of Network ___ Medicare
___ Medical Savings Account ___ Flex Plan Other _____

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

HISTORY OF PRESENT PROBLEM:

Purpose of this appointment:_____

_____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:

_____

PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ____ Yes ____ No

If yes, describe: _____

What medications or drugs are you taking? (List name and dosage)

_____

_____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?_____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
Do you sleep well at night? _____ If no, why not? _____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

FAMILY HISTORY:

Parents:
Father: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____

Mother: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____

Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? _____ If so, please list: _____

_____

FAMILY DISEASES (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety
__ Depression
__ Anger
__ Abandonment
__ Alcoholism
__ Drug Addiction
__Eating Disorder
__ Post Traumatic Stress Disorder
__ Adoption Issues
__ Other. List: _____
__ Other. List: _____
__ HIV Positive

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

FINANCIAL AND MISSED APPOINTMENT POLICY

FINANCIAL POLICY FEES:

Counseling sessions are 60 minutes long. The fee for a 60-minute session, either face-to-face or by phone, is _____. A first-time patient is charged **50% of Session Fee** by credit card to hold their appointment time. This fee is non-refundable but it is deducted from your first visit. Payment is collected at the first of the session. We also ask you to place a credit card on file for future billing.

Insurance Patients. If you have health insurance, **Best Listeners** will file your insurance for you. If your insurance covers a portion of your therapy, we will wait up to 90 days for your insurance to pay their portion. You will, however, be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company.

Self-Pay Patients. Patients without insurance, with high deductibles, or who choose not to use their insurance are responsible for the cost of care. Payment is expected at the time of service.

Methods of Payment. Best Listeners accepts cash, checks, and major credit cards.

MISSED APPOINTMENT POLICY: Twenty-four hour notice is required for the cancellation of an appointment. Appointments canceled with less than 24 hours notice will be charged a non-negotiable **$65** fee. Please remember, it is your responsibility to make and keep your appointments without a reminder call **I have read and agree to the above conditions.**

Signature _____ Date _____

Best Listeners

MANDATORY REPORTING REQUIREMENTS

Patient records are protected by law under federal law. At Best Listeners we keep our patient records in a locked record storage area. Your records will not be shared without your permission.

However, **therapists are required by law to report to authorities certain activities** that their patients report to them. Those activities include:

- Any statements, suggestions or innuendoes that **the patient plans to hurt himself or herself.**
- Any statements, suggestions or innuendoes that **the patient plans to hurt someone else.**
- Any statements, suggestions or innuendoes that **the patient is being harmed.**
- Suspected **child abuse or neglect.**
- Suspected **abuse of the elderly** or the other incapacitated adults.
- The **threat of suicide or homicide.**

In addition to these harmful situations, Best Listeners may also be **required to release your information** if:

- It is needed by medical personnel in a **medical emergency.**
- **Crimes** are committed on the Best Listeners premises or against Best Listeners.

I have read and understand the above information.

Patient's Name: _____ Date: _____

Witness: _____ Date_____

Best Listeners
Counseling Informed Consent

CONFIDENTIALITY: Everything you say is these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required by law. _____ **Initial**

WHEN DISCLOSURE IS REQUIRED BY LAW: Disclosure is required or may be required by law when there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, or to property, or is gravely disabled; or when a family member communicates to me that the client presents a danger to others. Disclosure may also be required by the courts. I will not release records to any third party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client. _____ **Initial**

EMERGENCY: If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet. _____ **Initial**

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier. _____ **Initial**

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires that I keep treatment records for at least 6 years. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any agency/person you specify unless I feel that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment. _____ **Initial**

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call us at (561)-373-0077. If I do not answer, I will return your call as soon as possible. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call 911 or go to your nearest emergency room. _____ **Initial**

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for, but it takes effort on your part. I want you to be open and honest. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we expect change, there is no promise that this therapy will yield a positive

result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. I do not prescribe drugs.

_____ **Initial**

TREATMENT PLANS: On approximately your second visit, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask and I will explain it to you. You also have the right to ask about other treatments for your condition and their risks and benefits. _____ **Initial**

TERMINATION: After the first meeting, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In that a case, I will give you a number of referrals whom you can contact. If at any point during therapy you are non-compliant, I will terminate treatment. In such a case, I will give you a number of referrals that may be of help to you. Upon your request, I will provide her or him with the essential information needed. You have the right to terminate therapy at any time. _____ **Initial**

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves any dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some areas multiple relationships are unavoidable. I will never publicly acknowledge working with your without written permission. I will not accept you as a patient if I feel a significant dual or multiple relationship exists. It is your responsibility to advise me if any dual or multiple relationship becomes uncomfortable for you in any way. I will always listen carefully and respond to your feedback and will discontinue the dual relationship if you find it is or may interfere with the effectiveness of the therapy or your welfare. You may do the same at any time.

_____ **Initial**

SOCIAL NETWORKING AND INTERNET SEARCHES: At times, I may conduct a web search on my clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss them with me. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites. _____ **Initial**

I have read the above policies. I understand them and agree to comply with them:

Client's Signature _____ **Date** _____

Therapist's Signature _____ **Date** _____

Best Listeners

200 Knuth Rd. Suite 232, Boynton Beach, FL 33436

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgment.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (please provide specific details) _____

_____

_____ _____
Therapist Signature Date

Best Listeners - Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Best Listeners

CREDIT CARD GUARANTEE

[ ] SELF-PAY PATIENTS

If you:

- Are uninsured
- Have insurance that does not cover the cost of mental health counseling,
- Or choose to pay out-of-pocket for other reasons,

then you are responsible for full payment at the time of services. As a convenience to you, we will automatically charge your designated card below on the day of services.

We charge a **missed appointment** fee of _____**$65**_____ in the event that you miss an appointment without giving **24-hours' notice**.

[ ] INSURANCE PATIENTS

You are responsible for meeting your **deductible** and making **co-pays** or **co-insurance** payments at the time of service. As a courtesy to you, we will bill your health insurance provider on your behalf for the balance and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment.

On Day 90, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payments made on these claims thereafter will be immediately refunded to you.

Your insurance provider does not pay for missed appointments. If you miss an appointment without giving **24-hours' notice**, you will be charged a **missed appointment fee** of _____.

I agree to the above terms and authorize you to charge my card.

_____ _____

SIGNATURE DATE

CREDIT CARD: ☐ AMEX ☐ VISA ☐ MC ☐ DISCOVER

CARDHOLDER'S NAME _____

BILLING ADDRESS _____

_____

CARD # _____ EXP. DATE _____

THREE DIGIT CID NUMBER _____