



Welcome to our office. We are pleased to be able to offer you and your family mental health services. As mental health professionals, our responsibility lies in offering you the needed diagnostic and therapeutic services for the emotional and behavioral difficulties you and/or your family are currently experiencing. Enclosed you will find some forms that will aid us in assisting you more effectively. Our professional staff will be glad to discuss with you our services, charges, insurance billing, appointments, as well as any other questions you may have.

If you cannot attend a scheduled appointment, kindly notify us as soon as possible. **Please be aware that you will be charged the full agreed upon fee for any appointment that is not cancelled twenty-four (24) hours in advance.** You will be solely responsible for this charge as we cannot bill an insurance company for a service not provided.

Confidentiality is of primary importance in mental health practice. Consequently, we adhere to very strict standards regarding the release of records and/or information related to you or your family for your own protection. All communication between us is confidential and privileged, with the following three exceptions:

1. In staff supervision and with consultants, as needed, in order to challenge and/or confirm decisions about diagnosis, treatment, and medication.
2. Should you choose to use insurance to cover the cost of your services, detailed treatment reports are frequently required by the managed care companies on a regular basis in order to access benefits and determine medical necessity.
3. By statutory law, "DUTY TO WARN", outweighs the limits of confidentiality and privilege in case of reported act, which may endanger yourself or others.

Finally, good communication is essential for successful treatment. Please feel free to share with us any of your concerns.

Informed Consent and Authorization for Treatment

I hereby consent to psychiatric evaluation and treatment. I have read and agreed with the terms stated herein.

Patient's Name

X _____
Eliza Karwowski, DO, MBA

X _____
Patient or Parent/Guardian's Signature

Date



INTAKE INFORMATION

DATE: _____

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

OTHER: _____ WHICH OF THESE IS YOUR PREFERRED CONTACT METHOD: _____

EMAIL: _____ SS#: _____

We'd love to keep you informed of any upcoming events, community resources and workshops as well as exclusive articles from our skilled clinicians. May we add you to our CGCC email database? Yes! No, thank you.

SEX: M F AGE: _____ DATE OF BIRTH: _____

MARITAL STATUS: MARRIED SINGLE DIVORCED SEPARATED WIDOWED
 LIVING WITH SIGNIFICANT OTHER

If the patient is a minor child, please fill out the parent(s)/guardian information below:

PARENT(S)/GUARDIAN INFORMATION:

NAME: _____ RELATION: _____ DOB: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL ADDRESS: _____

NAME: _____ RELATION: _____ DOB: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL ADDRESS: _____

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENTS):

NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL ADDRESS: _____

EMPLOYMENT INFORMATION (Check here if you are a student or unemployed):

EMPLOYER NAME: _____ OCCUPATION: _____

ADDRESS: _____ PHONE: _____ XT: _____

CITY: _____ STATE: _____ ZIP: _____ MAY WE CONTACT YOU AT WORK? YES / NO

PLEASE TELL US YOUR REASON FOR COMING IN TODAY: _____

WHO REFERRED YOU TO US? _____

This is a strictly confidential patient medical record.



PRESENT HOUSEHOLD

NAME	AGE	RELATIONSHIP	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OTHER SIGNIFICANT FAMILY MEMBERS NOT LIVING AT HOME

NAME	AGE	RELATIONSHIP	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ FAX: _____

ILLNESS/MEDICAL CONDITIONS: _____

PRESCRIPTIONS/OTC DRUGS: _____

ALLERGIES _____

TOBACCO, ALCOHOL, DRUG USE HISTORY: _____

PREVIOUS PSYCHOTHERAPY/PSYCHIATRIC TREATMENT? YES: ___ NO: ___

WITH WHOM: _____

HOW LONG: _____

This is a strictly confidential patient medical record.



INSURANCE/ BILLING INFORMATION (IF APPLICABLE):

PLEASE HAVE AVAILABLE YOUR INSURANCE CARD IN ORDER FOR US TO PHOTOCOPY

RE: Patient Name: _____

INSURANCE CO. NAME: _____ ID: _____

INSURED/SUBSCRIBER NAME: _____ D.O.B. _____

SS# _____ EMPLOYER: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL ADDRESS: _____

PRIOR AUTHORIZATION NUMBER if applicable (EAP cases, for example): _____

INSURANCE CONSENT

Your insurance benefits may be limited by the number of visits granted per calendar year or by the total dollar amount available. Furthermore your insurance company may impose limits on the number of visits you receive based on their definition of medical necessity.

When we accept assignment of insurance benefits for payment of your bill we are in effect acting as the insurance company's agent or provider. It's also important for you to understand that when you sign an authorization to release information on your insurance form, we may be asked to discuss, in a verbal or written report, information related to your case with a case manager. A case manager is a clinical representative of the insurance company and will not reveal information to your employer. This contact may be necessary to facilitate continuing payment for your treatment.

I understand and have discussed the above conditions. I am ready to accept treatment under these conditions.

X _____
Patient or Parent/Guardian Patient or Parent/Guardian Name Date

SIGNATURE ON FILE AND ASSIGNMENT OF BENEFITS AGREEMENT

I understand that Coral Gables Counseling Center will use my signature below as a *signature on file*. I authorize the release of any medical information necessary to process my or my family member's claim or related claims.

I hereby authorize payment directly to the Coral Gables Counseling Center of the insurance benefits otherwise payable to me for their professional services. I understand that I am financially responsible to the Coral Gables Counseling Center for all charges not covered by this assignment.

X _____
Patient or Parent/Guardian Patient or Parent/Guardian Name Date

This is a strictly confidential patient medical record.



FINANCIAL AGREEMENT

I, _____ agree that the responsibility of \$ _____ per follow-up visit and/or a co-payment of \$ _____ at the Coral Gables Counseling Center is mine. The initial visit is \$ _____.

I agree to assign to the Coral Gables Counseling Center any insurance benefits available to me. However, should said insurance not provide for the expected coverage, I am fully responsible for the full agreed upon fee. I also understand that if I have not paid my balance within 60 days, Coral Gables Counseling Center will turn my account over to an outside collection agency without further notice. I agree to be responsible for any additional collection fees that may occur in this event.

I understand and have discussed the above conditions. I am willing to accept treatment under these conditions.

Patient Name: _____

X _____
Patient or Parent/Guardian Patient or Parent/Guardian Name Date

CREDIT CARD AUTHORIZATION

In an effort to avoid difficulties with your account, please provide credit card information on the space below. This information will only be used in processing payments due to one or more of the following: co-payment/fee per visit balance, returned bank checks, other declined credit cards, missed or late cancelled appointments (\$ _____ each), denial of expected coverage by insurance companies, and phone/Skype sessions.

Please rest assured that we will make every effort to discuss your account before using this avenue to bring your balance up to date. Thank you for your cooperation.

CREDIT CARD TYPE MASTERCARD VISA AMEX DISCOVER

CARD NUMBER _____ - _____ - _____ - _____

EXP. DATE: _____ / _____ CVV: _____ ZIP: _____

I agree to let Coral Gables Counseling Center charge my credit card above after each session for the amount of \$ _____ per follow up visit (Initial Visit: \$ _____) until this authorization expires on _____.

(Auth. exp. for Amex only)

X _____
Cardholder Signature Cardholder Name



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our signatures below acknowledge that we have reviewed and discussed the “Notice of Privacy Practices” attached to the intake packet and, if requested, acknowledge that the patient and/or the patient’s legal guardian(s) has/have received a copy of the document.

I have read this document and have been given the opportunity to ask any questions and receive any clarification.

(NAME OF PATIENT)

DATE

X _____
(SIGNATURE OF PATIENT OR LEGAL GUARDIAN)

NAME OF LEGAL GUARDIAN, IF APPLICABLE

Eliza Karwowski, DO, MBA

DATE

X _____
(SIGNATURE)

____ **Copy accepted by PATIENT/LEGAL GUARDIAN**

____ **Copy kept by Doctor** *You may wish to request a copy at a later time.*