CORAL GABLES Counseling CENTER

Welcome to our office! We are very pleased to be able to offer psychoeducational testing services. Our responsibility lies in administering the needed assessments in order to address our patient's academic and/or behavioral needs. Enclosed you will find additional 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 and agreed upon $150 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 therapy, 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 a reported act, which may endanger yourself or others.

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

INFORMED CONSENT AND AUTHORIZATION FOR SERVICES

I understand that I am requesting a private psychoeducational evaluation to be performed at my own expense by Cristina M. Olaechea, Ed.S., Licensed School Psychologist.

I am fully aware that some or all of the requested services may be available to me at no cost through the public school system.

I understand that a number of factors need to be considered in order for any evaluation to lead to appropriate educational programming. Such factors may include, but are not limited to, the following:

- While a school district must consider the results of a private evaluation, they are not required to accept the results and recommendations for eligibility decisions.
- The results of certain tests may not be valid if retesting occurs more frequently than recommended by test publishers.
- In order for tests to be utilized for eligibility determination, selected test instruments must be consistent with the local school district's procedures.

My signature below indicates that I am entering into this professional relationship freely and voluntarily, with full knowledge of the implications of the agreement. I have read and agree with the terms stated herein. Thus, I hereby consent to psychoeducational testing services.

______________________________	X______________________________
Patient Name (Please print)	**Cristina M. Olaechea, Ed.S.** **Licensed School Psychologist** **SS-966**
X______________________________	______________________________
Patient or Parent/Guardian Signature	**Date**

Patient's Name: ____ Date of Birth: ___________________

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, ______________________________________ (patient/patient's guardian), authorize a mutual exchange of information about the above mentioned patient between the Licensed School Psychologist at Coral Gables Counseling Center, Cristina M. Olaechea Ed.S., and the following recipient(s):

Name:	**Address**:	**Phone**:

This information includes, and is not limited to, medical records, therapy notes/reports, academic records, counseling information and other pertinent information used solely for the facilitation of services rendered to the above-named individual.

If we are requesting this authorization from you for your own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- We may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of this authorization.

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

Unless revoked earlier or otherwise indicated, this authorization will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.

Signed: ____ Date: _____________________

(Patient or Patient's Guardian)

Guardian's relationship to patient: ____

INSURANCE / BILLING INFORMATION

(IF APPLICABLE)

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

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/hours 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 is 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 services.

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

X ____________________________	______________________________	____________________
Patient or Parent/Guardian Signature	Patient or Parent/Guardian Printed 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 Signature	Patient or Parent/Guardian Printed Name	Date

FINANCIAL AGREEMENT

I, ________________________________, agree that the responsibility for the hourly charge of $ ____________ and/or full psychoeducational testing fee of $____ at the Coral Gables Counseling Center is mine. I understand that half of the testing fee is to be paid on the first day of testing and that the remaining balance will be paid upon the receipt of the written report at the feedback session.

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 services under these conditions.

X ______________________________ ______________________________ ______________________

Patient or Parent/Guardian Signature Patient or Parent/Guardian Printed Name Date

ELECTRONIC PAYMENT AUTHORIZATION

In an effort to avoid difficulties with your account, please provide credit/debit card information on the space below. This information will only be used in processing payments due to one or more of the following: testing/hourly rate balance, returned bank checks, other declined credit cards, missed or late cancelled appointments ($150 fee), 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: ___________________

Please indicate the name and address associated with the credit or debit card you wish to use.

Name: ____

Address: ______________________________ City: _________________ State: ___________ Zip: ____________

I agree to allow Coral Gables Counseling Center to charge my credit card above for the amount of $ ____________ per hour or the full testing fee of $___ until this authorization expires on ___________________________________.

X ____________________________ ____ ______________

Cardholder Signature Cardholder Printed Name Date

2600 S. Douglas Road Suite 1003 | Coral Gables, FL 33134 | 305.445.0477 | www.CoralGablesCounseling.com

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.

____
Patient Name (Please Print)

____
Date

X_______________________________________
Patient or Legal Guardian Signature

____
Printed Name of Legal Guardian,
if applicable

X_________________________________
Cristina M. Olaechea, Ed.S.
Licensed School Psychologist
SS-966

____
Date

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

_____ **Copy kept by School Psychologist** *You may request a copy at a later time*

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INTAKE INFORMATION

Thank you for taking the time to carefully complete this questionnaire and help us get to know you better!

Date: ________________

PATIENT INFORMATION:

Last Name: ______________________________ First Name: _________________________ MI: ______

Gender: _____ Age: ___ Date of Birth: __________ School: ________________________ Grade: _____

Marital Status (If Applicable): ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Living with significant other

Address: __________________________________City: _____________State: _______Zip: __________

Home Phone: ___________________Cell: ____________________Work: _________________________

Other: _________________ May we leave a message? YES / NO What is the contact method you prefer? _________

Email: ____ SS#: _________________________

Employer Name: _________________________________ Position: _____________________________

Address: _______________________________________ Phone: _____________________ Ext: ______

City: ___________________ State: _____ Zip: _____________ May we contact you at work? YES / NO

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.

Please tell us your reason for seeking IQ testing: ____

____

Who referred you to us? ____

MEDICATION HISTORY

Please indicate CURRENT medications the patient is taking:

Name of medication Dose & Frequency Date Started Reason Effectiveness

____

____

____

Who prescribes these medications? _____________________________ Date of last visit: _____________

Please also list any medications the patient has been on in the PAST:

Name of medication Dose & Frequency Date Started & Ended Reason Effectiveness

____

____

____

____

Who prescribed past medications? ____

Does the patient take any over the counter medications or supplements? Please describe: ____________

____

____

FAMILY HISTORY

What languages does the patient use (List PRIMARY language first)? ________________________

What other language is the patient exposed to? ______________________________________

With whom does the patient currently reside? _______________________________________

____

____

If patient is under 18, please complete the following information to the best of your ability *(even if you are not the biological parent)*.

Biological Mother's name: ______________________________________ Age: _______

Address: ____________________________ Phone: ______________ Email: __________________

Occupation: __________________________ Ethnic/Cultural Background: ______________________

Biological Father's name: ______________________________________ Age: _______

Address: ____________________________ Phone: ______________ Email: __________________

Occupation: __________________________ Ethnic/Cultural Background: ______________________

If the patient currently resides with parents OTHER than biological parents, please list them here.

Parent 1 Name: ____ Age: ______

Relationship to patient: ☐ Adoptive Parent ☐ Step-Parent ☐ Foster Parent ☐ Other: ___________

Address: ____________________________ Phone: __________ Email: __________________

Occupation: ________________________ Ethnic/Cultural Background: ________________________

PATIENT INTAKE FORM

Parent 2 Name: ____ Age: ______

Relationship to patient: ☐ Adoptive Parent ☐ Step-Parent ☐ Foster Parent ☐ Other: __________

Address: ________________________ Phone: ________ Email: ______________

Occupation: _____________________ Ethnic/Cultural Background: ________________

If patient does not live with BOTH biological parents, who has legal custody of the patient? _________

How often does the other biological parent see patient? _______________________________

Number of years married/together: ______ Approximate date of divorce/separation: ___________

Number of times married: Mother _____ Father _____

If patient is with ADOPTIVE parent, age patient was first in home: _____ Date of legal adoption: ___

What has the patient been told about the adoption? ___________________________________

If patient spends a significant amount of time with a caregiver other than someone described above (i.e., spends more than 4 hours/day) EXCLUDING school personnel, please complete the following information for that person here:

Name: ____________________________________ Age: _______________

Relationship to patient: _______________ Ethnic/Cultural Background: _______________

Occupation: ________________ Highest level of education: _____________________

Siblings: (please list whether the siblings live in the patient's home or not)

Name	Age	Sex	Full/Step/Half?	Grade	In patient's home?

Other occupants of patient's residence NOT listed above: ____________________________

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EDUCATION AND SOCIAL

Current school: ________________________________ School district: _____________________________

Has patient received an evaluation in the past? ☐ Yes ☐ No

(Please bring copy of reports to 1st appointment)

☐ Psychological/Cognitive – Date: __________ ☐ Academic – Date: _______________

☐ Speech/Language – Date: _______________ ☐ Other: ______________________ Date: _________

Does patient like school? ☐ Most of the time ☐ Sometimes ☐ Almost never

Does patient:
- Have problems with other children in class? ☐ Yes ☐ No
- Have problems making friends in school? ☐ Yes ☐ No
- Have problems getting along with teachers? ☐ Yes ☐ No
- Tend to get sick in the morning before school? ☐ Yes ☐ No

Describe the teacher's perspectives/comments about the patient's schoolwork or behavior: ____________

____

____

What do you feel are the patient's academic and /or personal strengths? ____________________________

____

____

What do you feel are the patient's academic and /or personal weaknesses? __________________________

____

____

What kind of grades has patient received in the past year?

☐ A's & B's ☐ B's & C's ☐ C's & D's ☐ D's & F's

☐ Outstanding ☐ Good ☐ Satisfactory ☐ Improvement needed ☐ Unsatisfactory

☐ Other grading system

SERVICES

School District

Is the patient on an IEP (Individual Education Plan)? ☐ Yes ☐ No

Patient's age when school special education services began: ______________________________________

Individual Education Plan (IEP) eligibility: ____

Which services is patient CURRENTLY receiving through the SCHOOL DISTRICT?

☐ Speech therapy ☐ Language therapy ☐ Occupational therapy

☐ Physical therapy ☐ Tutoring ☐ Counseling

☐ Other – describe: ____

____

____

(Please bring copies of your most recent Individual Education Plan (IEP))

Please list all of the schools, including preschools, the patient has attended:

Name of school	Age/grade attended	Hours per day	Days per week

Private Services (Please bring copies of relevant reports to your first appointment)

Are you or your insurance currently paying for services to address the patient's needs? ☐ Yes ☐ No

☐ Speech/Language therapy Provided by: ________________________ Age when began: ______

☐ Occupational therapy Provided by: ________________________ Age when began: ______

☐ Physical therapy Provided by: ________________________ Age when began: ______

☐ Adaptive Physical Education Provided by: ________________________ Age when began: ______

☐ Social Skills Provided by: ________________________ Age when began: ______

☐ Applied Behavior Analysis (ABA) Provided by: ________________________ Age when began: ______

☐ Psychological/Counseling Provided by: ________________________ Age when began: ______

☐ Psychiatric Provided by: ________________________ Age when began: ______

☐ Tutoring Provided by: ________________________ Age when began: ______

☐ Other - describe: ____

CORAL GABLES Counseling CENTER

ADDITIONAL INFORMATION

How would you describe the patient's emotional state (i.e. maturity, perfectionistic tendencies, attention span)? ____

____

____

____

____

Current eating behavior: ☐ Normal ☐ Picky ☐ Eats too much ☐ Weight loss/gain

Current sleeping behavior: ☐ Normal ☐ Problematic ☐ Difficult

Have there been any *hearing* concerns? ☐ No ☐ Yes Date of last hearing test: ________________

Have there been any *vision* concerns? ☐ No ☐ Yes Date of last vision test: __________________

Does patient wear eyeglasses? YES / NO Hearing aids? YES / NO

List patient's recreational activities, hobbies, and/or interests: ___________________________________

____

____

Future career aspirations: ____

____

Additional information or comments: ____

____

____

____

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