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.

____________________________________	X____________________________________
Patient’s Name	Doctor’s Name: ______________________
X____________________________________	____________________________________
Patient or Parent/Guardian’s Signature	Date

PATIENT INTAKE FORM

CORAL GABLES Counseling CENTER

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:

MOTHER'S NAME: _____________________________ RELATION: ________________ DOB: ___________

ADDRESS: ____________________________________ CITY: _____________ STATE: ____ ZIP: __________

PHONE: _________________________ EMAIL ADDRESS: ____

FATHER'S 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.

CORAL GABLES Counseling CENTER

PATIENT INTAKE FORM

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

PATIENT INTAKE FORM

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 fees. 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 Date

X____ ________________________________

Patient or Parent/Guardian Signature Parent/Guardian's Name (if applicable)

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/video 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:$_________). This authorization expires on______________.

(Auth. exp. for Amex only)

X ____________________________________ X____

Cardholder Name Cardholder Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The signature(s) 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

X____________________ (Doctor's SIGNATURE)

____________________ DATE

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

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