Siegel Counseling Services

Welcome to this office. I am pleased to be able to offer you and your family mental health services. As a Licensed Mental Health Counselor, my 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 me in assisting you more effectively. I am happy to discuss with you my services, charges, insurance billing, appointments, as well as any other questions you may have.

If you cannot attend a scheduled appointment, kindly notify me 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 I cannot bill an insurance company for a service not provided.

Confidentiality is of primary importance in mental health practice. Consequently, I 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 reported act, which may endanger yourself or others.

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

* *

Informed Consent and Authorization for Treatment

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

_____	_____
Patient's Signature	Therapist's Signature
_____	_____
Parent/Guardian's Signature	Date

5900 SW 73rd Street Suite 207
South Miami, FL 33143

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INTAKE INFORMATION

PATIENT INFORMATION

NAME: _____, _____ DATE: ____-_____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____

EMAIL: _____

SEX: M___ F___ AGE:_____ DATE OF BIRTH: _____

MARITAL STATUS: MARRIED___ SINGLE ___ DIVORCED ___

SEPARATED ___ WIDOWED ___

LIVING WITH SIGNIFICANT OTHER ___

REFERRED BY: _____

REASON FOR REFERRAL: _____

_____

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATION TO YOU: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PRESENT HOUSEHOLD

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

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OTHER SIGNIFICANT FAMILY MEMBERS NOT LIVING AT HOME

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

PRIMARY CARE PHYSICIAN:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

MEDICAL HISTORY:

ILLNESS/MEDICAL CONDITIONS: _____

_____

PRESCRIPTION/OTC DRUGS: _____

_____

ALLERGIES AND MEDICATION: _____

_____

TOBACCO, ALCOHOL, DRUG USE HISTORY: _____

_____

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

WITH WHOM: _____

HOW LONG: _____

WITH WHOM: _____

HOW LONG: _____

INSURANCE/ BILLING INFORMATION (IF APPLICABLE):

INS CO: _____ AUTH/REFERRAL# _____

INSURED/RESP.PARTY: _____ D.O.B. _____

ADDRESS (IF DIFFERENT): _____

CITY: _____ STATE: _____ ZIP: _____

SS# _____ HOME PHONE: _____

EMPLOYER: _____ WORK PH: _____

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

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FINANCIAL AGREEMENT

I, _____ agree that the responsibility for the hourly charge of $_____ and/or a co-payment of $_____ at Siegel Counseling Services is mine. I agree to assign to Siegel Counseling Services 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 understand and have discussed the above conditions. I am willing to accept treatment under these conditions.

_____ _____

Date Patient

_____

Parent or Guardian

This office accepts payments using Zelle and Venmo, as well as credit cards, cash, and checks. If you choose to use a credit card for your payment, please provide that information in the space below. Understand there may be a service charge when using a credit card.

Also, in the event of a denial of insurance payments, outstanding balances, late cancellations, or missed appointments, this credit card information will remain on file.

Please rest assured that every effort will be made to discuss your account prior to using this avenue to bring your balance up to date. This information will ONLY be used after communicating with the card holder. Thank you for your understanding and your cooperation.

CREDIT CARD MASTERCARD VISA AMEX DISCOVER

CARD NUMBER __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

EXP. DATE: _____ / _____ CVV: _____

I agree to let Siegel Counseling Services charge my credit card above after each session for the amount of $ _____ per session until this authorization expires on _____.

SIGNATURE: _____

PRINT NAME: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our signatures below acknowledge that we have reviewed and discussed the "Notice of Privacy Practices" and acknowledge that the client and/or the client's legal guardian 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 CLIENT) DATE

_____
(SIGNATURE OF CLIENT OR LEGAL GUARDIAN)

_____ _____
(NAME OF THERAPIST) DATE

_____

(SIGNATURE OF THERAPIST)

____ Copy accepted by Client **___ Copy kept by Therapist**

This is a strictly confidential client medical record

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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 I accept assignment of insurance benefits for payment of your bill I am 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, I 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 psychotherapy.

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

_____
Patient

_____
Date

_____
Parent or Guardian

SIGNATURE ON FILE AND ASSIGNMENT OF BENEFITS AGREEMENT

I understand that Siegel Counseling Services 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 Siegel Counseling Services of the insurance benefits otherwise payable to me for their professional services. I understand that I am financially responsible to Siegel Counseling Services for all charges not covered by this assignment

SIGNED: _____
Patient

SIGNED: _____
Insured

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