Office of Sandy Canfield, LMHC, P.A.
Psychotherapy

2150 Park Avenue North **407-645-2545**
Winter Park, Florida 32789

Contact and Billing Information:

1. **Date_____2. SS#_____3. D.O.B._____**
4. **Name(print)_____**
5. **Address_____**

   City_____ Zip Code_____+
6. **Home Phone_____ Ok to call?_____**
7. **Work Phone_____ Ok to call?_____**
8. **Cell Phone_____Ok to call?_____**
9. **Who referred you?_____May we thank this person? Yes___No___**
10. **Please list any previous counseling (name and date)**
    _____
    _____
    _____

Current Household Information
Indicate who lives at the above address and include yourself. Write a couple of key words to describe those persons listed below. **(Quiet, Angry, Sad, etc.)**

Name	**Relation**	**Age**	**Key Words**

Have you been in a committed relationship or marriage previously? Yes___ No___
If yes, how many times?____

PARENTS AND SIBLINGS INFORMATION

List the family members with whom you were raised. If someone is deceased put the date they died under "age". Again, write a couple of key words.

NAME	RELATION	AGE	KEY WORDS

MEDICAL INFORMATION

Has a physician ever told you that you had any of the following (please indicate "NO", "YES" or "SUSPECTED" and if yes, when it first occurred)?

Hepatitis

Nephritis

Tuberculosis

Bronchitis

Pneumonia

Pleurisy

Sinusitis

Asthma, Hay Fever

Malaria

Rheumatic Fever

Chorea (St. Vitus Dance)

Venereal Disease

Cancer (specify site/type)

Coronary Heart Disease

Phlebitis (inflamed vein)

Peptic Ulcer (specify site)

Gall Bladder disease

Colitis

Anemia

Rheumatoid Arthritis

Gout

Diabetes

Thyroid Disease (specify)

Skin disease (specify)

Epilepsy

Nervous or Mental Disorder

Drug Allergies

Fractured bones/serious injuries

Any other serious conditions for which you required treatment? No ___ Yes ___

If yes, what? _____

Name of Current Physician _____

Last Medical Exam _____

What medical problems or conditions do you currently have?

What medication(s) are you taking?

KEY INFORMATION

1. Have you ever-attempted suicide?
Yes____ No____

2. Are you currently suicidal?
Yes____ No____
3. Have you ever been psychiatrically hospitalized?
Yes____No____
4. Do you use illicit drugs?
Yes____ No____
5. How much alcohol do you drink a week? _____
6. Have you ever been in trouble for threatening or harming others?
Yes____No____
7. What problems bring you in for services and how long have you had them?

_____

8. What changes do you plan on making in therapy?

Regarding yourself:

_____

In relation to others:

_____

In relation to work:

_____

CONSENT FOR TREATMENT

I, the undersigned, have voluntarily applied for and agree to participate in counseling and/or psychotherapy services. Please indicate your understanding and acknowledgement of the foregoing information by signing below.

_____

PATIENT/PARENT/GUARDIAN SIGNATURE

_____

TODAY'S DATE

RIGHTS, PROFESSIONAL FEES AND RESPONSIBILITIES OF PATIENT

for Office of Sandy Canfield, LMHC

IMPORTANT

-Please read carefully and initial or sign where indicated -

RIGHTS

As a patient, you have the right to receive available services individualized to your specific needs and provided in the least restrictive manner. You have the right to seek information about and to approve of therapeutic practices.

With limited exceptions, information discussed and recorded is confidential. You will be asked to provide written consent if information is to be released to third parties. The exceptions this written consent and strict maintenance of confidentiality include: 1) information that is shared on a need to know basis during clinical supervision of the therapist's work; 2) imminent physical danger to self or others; 3) child abuse; 4) information legitimately ordered by a court of law; and 5) information required by your insurance company in order to process a claim made by you.

We are committed to providing you with the best possible care. Please ask if you have any questions about our fees, policies, or your responsibility.

PLEASE INITIAL _____

APPOINTMENTS AND CANCELLATIONS

YOU MUST GIVE AT LEAST 24 HOURS NOTICE IF YOU NEED TO CANCEL AN APPOINTMENT. YOU WILL BE CHARGED IN FULL FOR THE APPOINTMENT--EVEN IF YOU DO NOT ATTEND--IF LESS THAN 24-HOUR NOTICE IS GIVEN.

Appointments can be scheduled as my hours become available. Traditionally, an "hour is considered to be approximately **45** minutes. The length and frequency of therapy sessions depend on many factor and you may discuss this during your initial session.

PLEASE INITIAL _____

PROFESSIONAL FEES AND INSURANCE

Responsible Party

You are responsible for the fees that you incur with Sandy Canfield, and NOT your insurance company or other third party. Thus, if your insurance company fails to pay in whole or in part for whatever reason within the time limits described below, you must pay any remaining balance. You are also always responsible for any co-payment and deductible. Parents/guardians are responsible

for payment of a minor. If you fail to pay on your account, we have the right to turn your account over to a collection agency or attorney for collection. If this account is assigned to an outside collection agency, an additional fee of 40% of the total amount owed will be added.

Please Initial _____

Payment Due and Insurance

Payment is due in full at the time of service. No insurance is accepted for your first visit unless we have a contract with your insurance company. There is a $30.00 charge for checks returned for insufficient funds.

As a courtesy, we may accept your insurance and file your insurance if you discuss this with you therapist and get approval. However, if your insurance company fails to pay for any reason, any portion of the claim within 60 days after we file the claim, you must remit the remaining balance.

Please Initial _____

I have read the above statement of "Rights, Professional Fees and Responsibilities of Patient" for the office of Sandy Canfield, LMHC, P.A.
I understand its contents and conditions. I give my consent to such and agree to be bound by them.

_____ _____ _____

Patient/Parent Name Signature Date

_____

Witness

INSURANCE INFORMATION

INSURANCE COMPANY _____

PHONE # FOR INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

_____

Street City State Zip

POLICY/CONTRACT #_____

EMPLOYER _____

SUBSCRIBER'S NAME _____ SOC. SEC. #_____

PATIENT'S NAME _____ D.O.B._____

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any information to my insurance carrier by telephone, letter, or fax for the purpose of validating and determining benefits payable.

_____

Signature

_____

Today's Date

Sandy Canfield, LMHC, P.A.

Psychotherapy

2150 Park Avenue North
Winter Park, Florida 32789

407-645-2545
407-539-2447 (Fax)

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB:_____

SSN:_____

I hereby acknowledge that I have received, and have been given an opportunity to read, a copy of Sandy Canfield, LMHC, P.A.'s, Notice of Privacy Practices. I understand that if I have any questions regarding the Notice, or my privacy rights, I can contact Sandy Canfield, LMHC, P.A. at 407-645-2545.

_____Date_____
Signature of Patient/Client

_____Date_____
Signature of Parent, Guardian or Personal Representative*

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____Patient/Client Refuses to Acknowledge Receipt:

_____Date_____
Signature of Staff Member