ASSOCIATES IN BEHAVIORAL COUNSELING

7800 W. OAKLAND PARK BLVD STE 102
SUNRISE, FLORIDA 33351

PATIENT INFORMATION

PLEASE PRINT CLEARLY DATE_____

NAME_____ DX (OFFICE USE ONLY)_____

ADDRESS_____ CITY_____

STATE_____ ZIP_____ OCCUPATION_____

HOME PHONE_____ WORK PHONE_____

EMAIL_____ CELLULAR_____

THE BEST WAY TO REACH ME IS: HOME PHONE___ WORK PHONE___ CELLULAR___ EMAIL___

IT IS **OK**___ OR **NOT OK**___ TO LEAVE A MESSAGE REGARDING APPOINTMENT TIMES, ETC.

SOC. SEC.#_____ DATE OF BIRTH_____ SEX_____

AGE_____ (CHECK ONE:) SINGLE___ MARRIED___ WIDOWED___ DIVORCED____

EMPLOYED BY_____ CITY_____ STATE_____

SPOUSE, PARENT, EMERGENCY CONTACT_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE_____

NAME OF REFERRAL SOURCE:_____

(CHECK ONE:) INSURANCE __ YELLOW PAGES__ DOCTOR__ LAWYER__ JOB__ EAP__ ADVERTISEMENT__ OTHER__

---------- INSURANCE PAYMENT ORDER ----------

INSURED NAME (IF DIFFERENT THAN ABOVE)_____

DOB_____ INSURED SS#_____ POLICY #_____

I hereby assign and direct you to pay directly to

DR. STANLEY B. SEIDMAN, PH.D., P.A. / DBA- ASSOCIATES IN BEHAVIORAL COUNSELING
Belle Terre Medical / Sunrise
Suite 102, 7800 W. Oakland Park Blvd.
Sunrise, Florida 33351

benefits due me out of indemnity under the terms of my policy issued by your company. Payment is authorized upon your receipt of an itemized statement for services rendered me. This policy was in full force and effect at the time that these services were rendered. Payment of this amount as herein directed, in whole or part, shall be considered the same as if paid by your company directly to me.

Authorizations:

I authorize Stanley B. Seidman, Ph.D. P.A. and/or Associates in Behavioral Counseling

I. To release pertinent psychological information to insurers in order to obtain payment. My signature reflects that I have signed a release allowing such information to be transmitted.

II. My signature reflects and confirms my request for professional services and responsibility for all charges incurred.

Name _____

Legal Signature_____ Date_____

(If patient is a Minor, Parent or Guardian must sign.)

INFORMED CONSENT FOR TREATMENT

This provides some basic information about psychological treatment and your protected health information (PHI). Please read and sign at the bottom to indicate that you have reviewed this information.

LENGTH OF TREATMENT

Psychotherapy typically involves regular sessions, usually one appointment per week. However, at times the frequency may change depending on the severity of the problem. The duration of treatment varies attending on the nature of the problem and your individual needs.

CONFIDENTIALITY

Information shared with a psychologist is kept strictly confidential and is not disclosed without your written provision. However, confidentiality is not guaranteed in cases of (a) danger to yourself or others (e.g., homicide or suicide), or (b) situations it which children are endangered (e.g.,sexual or physical abuse or neglect). With my consent, Associates in Behavioral Counseling may call (including leaving voice messages), mail, or e-mail my home regarding items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders and insurance items.

FEE POLICIES

If you carry mental health insurance coverage, our office will bill your carrier and assist with insurance reimbursement. However, please be aware that charges are the patient's responsibility. In addition, any copayment necessary should be made at the time of the session. Yearly deductibles will also be the patient's responsibility.

IF YOU NEED TO CANCEL AN APPOINTMENT, 24 HOURS NOTICE IS APPRECIATED. OTHERWISE, CANCELLATION CHARGES MAY BE INCURRED (FULL FEE FOR SESSION); PLEASE BE AWARE THAT INSURANCE CARRIERS WILL NOT COVER CANCELLATION CHARGES.

Telephone consultations, preparation of records, and correspondence are billed pro-rata if substantial time is required. Court testimony and psychological testing charges are variable; please discuss these as necessary.

Our office reserves the right to engage the services of a collection agency in the event of unpaid balances; charges for collection efforts also become the patient's responsibility.

EMERGENCIES

When the office is closed, arrangements can be made for coverage or telephone contact as necessary. Our answering service describes the emergency procedure to get in touch with emergency services.

PHYSICIAN CONTACT

Physical and psychological symptoms often interact, and we encourage you to seek medical consultation if warranted. In addition, medication may sometimes be helpful for psychological disorders. When appropriate, referral for psychiatric or other medical consultation can be arranged.

FREEDOM TO WITHDRAW

You have the right to end therapy at any time and are obligated only to pay for completed sessions. If you wish, we will provide you with names of other qualified psychotherapists. If you have paid in advance for services, a refund of the unused portion of treatment appropriately prorated will be refunded.

INFORMED CONSENT

I have read and understood the preceding statements, have had the opportunity to ask questions about them, and agreed to begin treatment at Associates In Behavioral Counseling.

DEDUCTIBLE, CO-PAYMENT, AND/OR NON-INSURANCE RESPONSIBILITY

I understand that I will be required to pay the deductible, co-payment, and non-insurance fees for the Professional Services provided and this deductible, co-payment, and/or non-insurance fee is due when services are rendered.

As reported by my insurance company, my yearly deductible is: $_____ and $_____ is met.

I am responsible for $_____ of my deductible. My insurance will pay for _____ sessions per year.

My copayment or non-insurance fee for each session is: $_____.

Name:_____ Date:_____

Signature:_____

PATIENT INFORMATION SHEET - ADDENDUM

Presenting Problem: (Why are you seeking treatment at this time?)

Primary Care Physician: (If you are under the care of more than 1 doctor, list all of them)

Medical Problems or Disabilities:

Current Medication or Allergies: (Name, Dosage, and Prescribing Physician)

History of Psychological/Psychiatric Care: (List names of treatment providers and dates)

Education: (Highest grade/degree attempted/completed; Write name of current school)

Family Information: (List all individuals living with you)

Name	Age	Relationship

Additional Information:

SYMPTOM CHECKLIST

Name: _____ Date: _____

Please check those items that have applied to you during the past 6-12 months.

_____ Difficulty falling asleep
_____ Fear of being alone
_____ High blood pressure
_____ Recurrent negative thoughts
_____ Waking in the middle of the night
_____ Fear of public places
_____ Allergies
_____ Waking earlier then intended
_____ Fear of crowds
_____ Asthma
_____ Concern over your health
_____ Legal problems
_____ Pain (in back, neck or shoulders)
_____ Financial problems
_____ Feeling bored
_____ Feeling hopeless
_____ Family violence
_____ Feeling helpless
_____ Tension headaches
_____ Migraine headaches
_____ Increased smoking or drinking
_____ Blood sugar problems
_____ Preoccupation with details
_____ Serious illness
_____ Panic attacks
_____ Marital problems
_____ Teeth grinding/clenching
_____ Problems with children
_____ Feeling worthless
_____ Feelings of guilt
_____ Temper outbursts
_____ Sweaty palms
_____ Feeling "burned out"
_____ Work stress
_____ Loss of interest in sex
_____ Preoccupation with sex
_____ Thoughts of death or suicide
_____ Face or jaw pain
_____ Vomiting
_____ Tearfulness or crying
_____ Nightmares
_____ Feeling lonely
_____ Diarrhea
_____ Frequent urination
_____ Heart racing or palpitations
_____ Knots in stomach
_____ Driving phobia
_____ Impatient with people
_____ Poor appetite
_____ Overeating
_____ Social isolation
_____ Painful urination
_____ Indigestion
_____ Feeling emotional
_____ Significant weight gain or loss
_____ Chest pains or tightness
_____ Moodiness
_____ Dizziness
_____ Not being assertive enough
_____ Feeling inadequate
_____ Loss of interest in things
_____ Tingling/numbness in hands or feet
_____ Use of medications
_____ Feeling frustrated
_____ Loss of energy (fatigue)
_____ Feeling hostile
_____ Cold hands or feet
_____ Loss of concentration
_____ Inability to relax
_____ Family stress
_____ Feeling faint
_____ Dwelling on the past
_____ Excessive worry
_____ Restlessness
_____ Seizures or passing out
_____ Feelings of emptiness
_____ Suspicious of people
_____ Feeling life is unfair
_____ Nail biting or hair pulling
_____ Feeling loss of control over life
_____ Loss of self-confidence
_____ Recurrent colds & coughs
_____ Difficulty making decisions
_____ Memory lapses
_____ Feeling angry
_____ Feeling of time pressure
_____ Sleeping too much

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

Contact Office: _____

I, _____, have received a copy of this office's Notice of Privacy Practices.

NAME: _____

SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other _____

SIGNATURE: _____

DATE: _____