

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 in 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.

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

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Suite 102 / 7800 W. Oakland Park Blvd.
Sunrise, FL 33351
954-742-8400

**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

Contact Office: Hipaa Officer / Suite 102 / 7800 W. Oakland Pk Blvd. / Sunrise, FL 33351

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: _____