The Family Room Psychotherapy Associates

ADULT INTAKE

Date:____/_____/_____

Name:_____Date of Birth:____/____/_____Age:_____Sex: M F

ETHNIC ORIGIN: ☐ White ☐ Hispanic ☐ Haitian ☐ African American ☐ Other:
_____

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Hebrew ☐ Other:
_____

Address:_____

City/State/Zip:_____

Phone: Home: (_____)_____-_____ Work:(_____)_____-_____ Cell:(_____):_____-_____

Phone number to call for session reminder:(_____):_____-_____

E-mail: _____ May we email you for session reminders updates? Yes___ No____

Emergency Contact: Name:_____ Phone:(_____)_____-_____

Please describe what your goals are:
_____

_____

_____

Referred by: _____

FAMILY HISTORY

Place of Birth: City _____ State _____ Country _____

Religion raised in: _____ Actively Practicing: ☐ Yes ☐ No

MARITAL STATUS: ___ Single ___ Cohabiting ____Married/Partnership, # of years _____
Separated ___Divorced (Time since _____)
Name of spouse/significant other: _____ Age: _____

PARENTS: Mother: _____ Living **Y/N** Father:_____ Living **Y/N**

CHILDREN Name	Age	Lives with You?
1.		**Y N**
2.		**Y N**
3.		**Y N**
4.		**Y N**

SIBLINGS Name	Age	Living Y/N
1.		
2.		
3.		
4.		
5.		

History of Physical Abuse/Family Violence or Neglect: ☐ No ☐ Yes Has abuse been reported? ☐ Yes ☐ No

Charges Pending? ☐ Yes ☐ No
Explain:_____
_____

History of Sexual Abuse/Trauma: ☐ No ☐ Yes Has abuse been reported? ☐ Yes ☐ No

Charges Pending? ☐ Yes ☐ No
Explain_____
_____

History of Violence: ☐ No ☐ Yes, toward: ☐ People ☐ Property ☐ Other: _____
Explain:_____
Do you own____ and/or legally conceal carry____ any firearms or any other weapon.
*If you do legally conceal carry, please leave in your vehicle before entering the building.
History of Arrest, Restraining Orders or Incarceration: ☐ No ☐ Yes, please explain with dates
_____
_____
Gang Involvement: ☐ No ☐ Yes Charges Pending? ☐ No ☐ Yes, explain:
_____

MEDICAL & ACADEMIC HISTORY

General Health: □ Excellent □ Fair □ Poor, explain: _____
History of significant Medical Conditions/Illnesses or hospitalizations: _____
_____

Describe past and present problems with the following:

Health (physical, headaches, pain, etc.): _____
_____

Sleeping: _____
_____

Eating: _____
_____

Focus/Concentration/
Mood:_____
_____

Energy: _____
_____

Social/Friends: _____
_____

Work/Employment: _____
_____

Drug and/or alcohol use: _____
_____

Current frequency of use: _____

ACADEMIC HISTORY:
□ Excellent □ Good □ Poor, describe: _____

Highest level of education (grade, degree): _____

MENTAL HEALTH HISTORY

Previous counseling/psychotherapy: □No □Yes, when: _____

Previous therapist's name: _____

How helpful was it? _____

Family History of Mental Illness, Alcohol/Substance Abuse:_____
_____

Have you been hospitalized for psychiatric care? □No □Yes, when & where? _____

Do you have a history of suicidal thoughts and/or attempts?
□No □Yes, describe including date: _____

_____

Name of Psychiatrist (if applicable): _____

Address: _____

Phone: _____

Previous medications taken under psychiatrist's care: _____

_____

Current medications:

1. _____ Dose:_____ For:_____
2. _____ Dose:_____ For:_____
3. _____ Dose:_____ For:_____

PLEASE ADD ANY OTHER RELEVANT INFORMATION YOU THINK WILL BE HELPFUL:

_____
_____
_____
_____

The information I have provided herein is accurate to the best of my ability and knowledge.

_____ Date: _____
PRINT NAME

_____
SIGNATURE

Client Rights and Responsibilities, and Psychotherapy Consent for Treatment

Client Name:_____ Date:_____

As a potential client of The Family Room Psychotherapy Associates, I understand that I am assured humane and dignified treatment at all times and the following rights, and I agree to the following responsibilities.

Rights:

1. Right to refuse and/or terminate treatment at any time.
2. Right to informed consent.
3. Right to confidentiality whereby the information revealed by me during treatment will be kept strictly confidential (understanding that any pertinent information relative to my care will be documented in a The Family Room Psychotherapy Associates contact record) and will not be revealed to anyone without my written authorization. The law provides the following exceptions to this provision.
    a. If The Family Room Psychotherapy Associates has knowledge of client's intent to harm self or others.
    b. If The Family Room Psychotherapy Associates has knowledge of child abuse, neglect or exploitation.
    c. If The Family Room Psychotherapy Associates receives a court-order to the contrary.
    d. If client enters into litigation with The Family Room Psychotherapy Associates
    e. If medical emergency necessitates disclosure.
    f. If The Family Room Psychotherapy Associates has knowledge of client's intentional spreading of communicable disease.
4. Right to request second opinion.
5. Right to treatment without regard to race, color, sex, age, religion, national origin, disability or sexual orientation.

Parent/Legal Guardian/Client Responsibilities:

1. To keep predetermined appointment and to notify The Family Room Psychotherapy Associates at least 24 hours in advance of canceling or rescheduling an appointment.
   A Cancellation fee will be charged with less than 24 hour notice as stated in the Credit Card Authorization Form.
2. To participate and follow agreed upon treatment.
3. To maintain confidentiality pertaining to group therapy, when applicable.
4. To assume responsibilities for payment of the assessed and agreed fees for services.
5. To inform The Family Room Psychotherapy Associates of any change in address and phone numbers.

Consent for Neuro-Emotional Technique

Neuro Emotional Technique/NET is a mind-body technique that uses a methodology of finding and removing neurological imbalances related to the physiology of unresolved stress. NET is a tool that uses muscle testing and the Chinese Medicine meridians to help improve many behavioral and physical conditions and is not a psychotherapy technique.

NET Practitioners address the physical and behavioral stress-related conditions of their patients. These conditions include headaches, body pains, phobias, general anxiety, self-sabotaging behaviors, and so much more. It's important to note that NET does not cure or heal the patient, but rather, NET removes blocks to the natural vitalism of the body, "allowing" the body to repair itself naturally.

Part of the NET process is using Homeopathy. Homeopathic remedies help safely activate your body's natural healing abilities. NET has selected the most essential ingredients which have consistently proven to be helpful in restoring your body to optimal health. Therapeutically, the NET Remedies multiple-potency approach provides continuous support as your body's needs change during your overall healing process.

All of the NET Remedies alcohol-free products are natural, non-habit forming and free of sugar, yeast, gluten and sodium and comparative products can be bought over the counter at natural health food store yourself. They are also compatible with vitamins, supplements, herbs and medicines (including prescription drugs). That makes NET Remedies safe and effective for just about everyone — babies, children, pregnant and nursing mothers, the elderly, and pets. NET Remedies formulas can support your body to naturally heal, repair, strengthen and prevent future illness.

There are NET Technique and Homeopathy brochures available to you in the waiting room for your review and for you to take with you for your records.

More information can be found on the website www.netmindbody.com and you can ask your practitioner directly if you have any questions during the time of treatment. 456.41 (3B)

NET is considered a Complementary Or Alternative Health Care Treatment and as per Florida law 456.41 " citizens should be able to make informed choices for any type of health care they deem to be an effective option for treating human disease, pain, injury, deformity, or other physical or mental condition. "

Also, clients should "be able to choose from all health care options, including the prevailing or conventional treatment methods as well as other treatments designed to complement or substitute for the prevailing or conventional treatment methods."

Jason Wasser, LMFT, a NET Certified Practitioner, has completed multiple trainings in *Neuro Emotional Technique* including their Basic, Advanced, Success and Certification workshops (110 hours as of January 2015) as well as a 33 Clinical Hour training in *Sequential Acupressure for Clearing Negative Emotions: Meta-Energetics* through the University of Miami Miller School of Medicine: iCamp, Integrative and Complementary Academic Medicine Program. 456.41 (3A)

Based on this information, I have reviewed the NET brochures and consent to Jason Wasser, LMFT to utilize Neuro-Emotional Technique during our sessions. 456.41 (3C)

Consent for Treatment:

I understand and voluntarily agree to the above, and I authorize evaluation and/or treatment by The Family Room Psychotherapy Associates. I understand that this consent can be repealed in writing at any time during the treatment period.

Name of the Client/Parent/Legal Guardian: _____Date:___/___/___
Signature:_____Date:___/___/___

Names and Signatures of additional clients over the age of 18 participating in therapy:

_____

_____

_____

Financial Responsibility Agreement

Client Name: _____

The following is a statement of our financial policy, which we require you to read and sign prior to receiving non-emergent care.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience, we accept Visa, MasterCard, cash, money orders or checks. Non-payment of fees may result in the interruption of your services.

I understand that I am responsible to meet my insurance deductible and make co-payments as required by my plan in addition to any services provided that are not covered by my insurance carrier. This will be explained to me prior to my first appointment if possible. I also understand that if I am using an insurance plan, payment by an insurance company may not be guaranteed. Therefore, in the event that my insurance carrier refuses to make payment against claims made for services rendered to myself and/or my family I understand that I am responsible for prompt payment (within 2 weeks of written notice) for these services received. Additionally, if I receive any insurance payments directly from my insurance carrier for services performed on my behalf, I will immediately pay over such payments to The Family Room Psychotherapy Associates.

I understand that in order to receive the best clinical services, my therapist may be available for brief phone sessions to speak with me or other professionals involved in my care when necessary. In addition, my therapist may prepare letters, treatment summaries, preparation of records, or other services I request. I understand that these services and time are not billable to my insurance carrier and therefore I am responsible for payment for services lasting more than 15 minutes. My therapist or office staff will advise me of any fees applied to my account. I understand that I will be billed a pro-rated fee for these services based upon my therapist's customary session fee of $200 per hour.

I understand that scheduled appointments are reserved specifically and exclusively for me and/or my family. Please, help us serve you better by keeping scheduled appointments. Therefore, *unless my appointment is cancelled with at least 24 hours in advance, I may be charged a $200 fee for missed appointments*. *This is our full cash rate for our therapists.* We may make exceptions and waive the fee, at our discretion, for emergency or unusual circumstances. It is important to remember that insurance carriers do not provide reimbursement for cancelled or missed appointments. Additionally, repeated missed appointments may result in termination of therapy. We will always make every effort to notify you and reschedule any appointments that your therapist may need to cancel in case of an emergency.

The Family Room Psychotherapy Associates reserves the right to refer any unpaid balance to an outside collection agency and to take appropriate legal action to collect unpaid balance. You will be responsible for payment of all fees and costs associated with these collection efforts, including payment of any court costs and attorney's fees.

A photocopy of this authorization is as valid as if it were an original executed document. I authorize the release of payments and medical information necessary to process my and/or family members' insurance claims and related claims. I hereby authorize payment directly to my therapist or to The Family Room Psychotherapy Associates of the insurance benefits otherwise payable to me for all professional services received.

I have read the financial policy and had an opportunity to have questions answered. I understand and voluntarily agree to this financial policy.

Name of Client/Guardian: _____ Date: ___/___/___

Signature: _____ Date: ___/___/___

Notice of Privacy Acknowledgement

The Family Room Psychotherapy Associates

2028 Harrison Street. Suite 207
Hollywood, FL 33020
954-620-1283

Client Name:_____Date of Birth____/____/____

Social Security Number ____-____-____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessment and physician/non-physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of health information. I understand that this organization has right to change it **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or other healthcare operations. I also understand that you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Parent/Legal Guardian Signature: _____Date___/___/___

Credit Card Payment Consent Form

Patient Name: _____

Name on card if different: _____

By initialing, I authorize The Family Room Psychotherapy Associates to charge my credit card for professional services as follows:

_____ Reservation of Intake Session- Your session time has been blocked out specifically to provide clinical services for you. To hold your scheduled spot for your initial session, we require a credit card to be on file. In the case of a late cancellation or no show you will be billed $200 for out of pocket clients or your full contracted rate based on your panel for insurance clients.

_____ To charge my card for the balance of fees **not paid by my insurance company** within 60 days, as indicated above.

_____ To charge my card in the amounts stated above for visits missed or cancelled without the required 24 hours notice (unless it's an emergency situation as approved by our staff).

Type of Card: ☐ Visa ☐ MasterCard ☐ AMEX Expiration Date _____

Credit Card Number _____ - _____ - _____ - _____ CVV Number _____

Card Holder's Billing Address for Credit card statements

_____

Street City State Zip

Card Holder Signature _____ Date: _____

OUTPATIENT PSYCHOTHERAPY INSURANCE BENEFITS

Patient's Name_____ DOB:_____

Patient SS# (if different than ID#) _____

Insured's Name_____ DOB:_____

Address: _____

_____

Phone: _____

Name of Employer_____

Insurance Company_____ Phone#_____

ID#_____ Policy# / Group#_____

Effective Date of Policy:_____

****

Benefits are for: **In-Network** [ ] *or* **Out-of-Network** [ ]

Deductible Amt: Individual ded? $_____ Ded. Met (How much)?_____

Family ded? $_____ Ded. Met (How much)?_____

What is the COPAY Amount-$ _____ or % covered per visit? _____

Is there a Max # of Visits?: N Y If yes #_____ How many used?_____

Is there an Annual Amount ($) Max?:_____ Lifetime Amount ($) Max?:_____

Is more than one charge per day allowed ? Y N

Do you cover the following procedure codes? (circle or cross out)

Psychotherapy: 90806 90808 90837 90846 90847

Pre-Certification or Authorization Required? Y N

If YES: #_____ Valid Dates of certification: _____

Do you have an Electronic Payer # ? _____

Name & Address to send claims: _____

_____

Name of person contacted (and date verified): _____