BEACHSIDE THERAPY
& ASSESSMENT CENTER

I. Patient Information

Name: _____ Date: _____ Age: _____

Gender: _____F ____M_____ Social Security Number: _____

Date of birth: _____

Address: _____

City:_____ State:_____ Zip: _____

Phone: _____ Email: _____

*** Please check one of the following:

____ I may be contacted by mail, email and phone number listed above.

____ I may be contacted by _____ or _____ only.

Emergency Contact(s) with whom you grant your therapist_____
permission to contact in case of emergency.

Name:_____ Phone:_____ Relationship:_____

II. Insurance Information. PLEASE READ CAREFULLY.

You are financially responsible for **all** services offered at Beachside**.** Your insurance is billed as a **courtesy** to you. **BUT** if your insurance does not pay us, or if the information they give us is incorrect, i.e. they tell us you have no co-pay but then they come back and tell us your co-pay is $15.00**, then you are financially responsible to pay the balance owed.**

Similarly, if your insurance comes back and refuses to pay us for some reason, again you are responsible for that payment. If you do not pay us, your invoice will go to collections. WE STRONGLY SUGGEST YOU ALSO CALL YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS. By signing this, you understand and agree to our insurance policy. A photocopy of this authorization is valid as the original.

Signature: _____ Date:_____

Name: _____ DOB: _____

III. Cancellations

Once our times are scheduled, the session is yours and yours alone. If you cannot attend your session and I can fill your time you will not be charged for the missed session. Or, if I have another session time available during the same week then we will reschedule your session time. *You are responsible for your session fee (not just your co-pay), as insurance companies do not provide reimbursement for cancelled sessions.*

Cancellation Fees:

MFT/LCSW: $60 due before next session or whatever insurance reimburses –We charge whichever fee is lower.

Ph.D. /PSY: $70 due before next session or whatever insurance reimburses –We charge whichever fee is lower.

N.P. $150 due before next appointment or whatever insurance reimburses –We charge whichever fee is lower.

N.P. $75 for medication management appointment due before next appointment or whatever insurance reimburses –We charge whichever fee is lower.

MD: $250 due before next appointment or whatever insurance reimburses –We charge whichever fee is lower

MD: $125 for medication management appointment due before next appointment or whatever insurance reimburses –We charge whichever fee is lower.

With more than 48 hours notice: (vacations birthdays, rock concerts, etc.)

As this is a treatment and not just an appointment, by signing this agreement you are agreeing to attend therapy, at a minimum, once a week. If you cancel that session in advance, the fee for the missed session will be negotiated between you and your therapist. At a minimum, you will be charged an administration fee of $18.00 to cover therapist office rental.

By signing below you are agreeing to our cancelation policy.

_____ _____

Signature **Date**

Name: _____ DOB: _____

IV. Electronic and Social Media

Email Communications

I use encrypted email for communication with you, and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that all text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication,
I only accept text messages regarding changes to appointments. So, please do not text message me about anything other than appointment times, unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook.

Websites

We have a website that you are free to access. We use it for professional reasons to provide information to others about Beachside and its therapists. You are welcome to access and review the information that we have on our website and, if you have questions about it, we should discuss this during your therapy sessions.

V. Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), **neither you (the patient) nor your attorney, nor anyone else acting on your behalf will call on any therapist from Beachside Adult & Family Therapy Inc. to neither testify in court, nor at any other proceeding, nor will a disclosure of the psychotherapy records nor process notes be requested.**

If, however, you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, the center charges $ 350.00 per hour for preparation, travel, and attendance at any legal proceeding. Payment must be made to me in full by the party requesting my presence, by *certified check at least* one week in advance of the court date. I agree to the fees listed above should I require my therapist to prepare, travel and/or attend any legal proceeding. I understand this fee is not covered by insurance and that I must pay this fee one week in advance of court date.

Name: _____ DOB: _____

VI. Contacting Us

We have a receptionist during normal working hours to take messages. However, we are not an urgent care center. If you are having a clinical emergency and you are unable to reach your therapist please call the police (911), your family physician, or go to the nearest emergency room. If you are calling regarding an existing appointment please call my cell phone.

VII. Patient Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. I am happy to discuss any of these rights with you. You will be provided with a HIPAA document.

VIII. Mediation and Arbitration

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement by a representative of Beachside Adult & Family Therapy Inc. and you, the patient, or your legal guardian or representative. The cost of such mediation, if any, shall be split equally, unless otherwise agreed.

CLINICAL INFORMATION

I. Presenting Issues

Please state the principal reason you are requesting a consultation or treatment:

_____

_____

Referred by: ___Self ___Other: _____

2. Psychological/Psychiatric Treatment story

Place & Provider:_____ Dates:_____

Reason for Treatment: _____

Name: _____ DOB: _____

3. **List current health concerns:**

_____

List recent health or physical changes: _____

Please check if there have been recent changes in the following:

__ Sleep patterns ___Eating patterns ___Weight ____Activity level

4. Medical History

Please Check all that Apply:

AIDS/HIV	Alcoholism	Abdominal pain	Abortion
Allergies	Anemia	Arthritis	Asthma
Bed wetting	Chest pain	Chronic pain	Constipation
Dizziness	Drug abuse	Seizure Disorder	Eating Problems
Diabetes	Fatigue	Heart Attack	Headaches
Hearing problems	Hepatitis	High blood pressure	Kidney/Bladder
Neurological disorders	Nose bleeds	STDs	Sleep disorders
Strokes	Sexual Problems	Hormone problems	Vision problems
Cancer			

Other (describe): _____ _____

Is there a history of any of the following in the family?

Tuberculosis	Heart disease
Birth defects	High blood pressure
Emotional problems	Alcoholism
Behavior problems	Drug abuse
Thyroid problems	Diabetes
Cancer	Alzheimer's disease/dementia
Stroke	Mental retardation

Name: _____ DOB: _____

Other chronic or serious health problems:

Allergies to:

_____

_____

Significant injuries:

_____

_____

Chronic, serious health problems:

_____

5. Family History

FATHER			**MOTHER**		
Full name:			Full name:		
Occupation:			Occupation:		
Education:			Education:		
General health:			General health		
Age:			Age:		
Living/deceased:			Living/deceased:		
Affectionate:	y	n	Affectionate:	y	n
Married	y	n	Married:	y	n
Divorced	y	n	Divorced	y	n
Remarried	y	n	Remarried	y	n

Name: _____ DOB: _____

Siblings Names	Age	Relationship: close or distant
1.		
2		
3		
4		

6. Personal Relationships

Check how you generally get along with other people: (check all that apply):

__ Affectionate ___ Aggressive ____ Avoidant ___ Fight/argue often ___ Follower

__ Friendly ___ Leader ____ Outgoing ___ Shy/withdrawn ___ Passive

Living Status

Single
Co-habiting
Married
Divorced
Separated
Widowed

Sexual Orientation

Gay
Lesbian
Trans
Bisexual
Straight
Rather not say

Living situation

Housing adequate

Housing overcrowded

Homeless

Dependent on others for housing

Employment

Employed and satisfied
Unemployed
Retired

Employed but dissatisfied
Coworker conflicts
Unstable work history

Name: _____ DOB: _____

7. Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

YOUR SIGNATURE: _____

Thank you for completing this form. This information will be kept strictly confidential.