Jacksonville Center for Counseling
3560 Cardinal Point Drive, Suite # 204
Jacksonville, FL 32257
Client Information Sheet

Name: _____ **Date of Birth:** _____

Name of person filling out this form, if different: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____

How would you like to be notified of your upcoming appointments?

Home _____ Cell _____ Text _____ Email_____ Can we leave a voicemail, text or email message? Y_____ N_____

Marital Status: Single _____ Married _____ Divorced _____ Widowed_____

How did you hear about our office? _____

Emergency Contact Information

Name: _____ Phone Number: (____) _____ Relation: _____

Employment Information

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: (____) _____ Ext: _____

Primary Care Physician/Psychiatrist

Name: _____ Phone Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

EAP – Employee Assistance Program

Name: _____ Authorization Number: _____ # of Authorized visits: _____

Insurance Information

Insurance Name: _____ Member ID: _____ Group Number: _____ Co-Pay: _____

***** (If other than self) Primary Insured's Information *****

Name of Primary Insured: _____ Relationship to client: _____

Insured's Soc Sec #: _____ Insured's Date of Birth: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorized the release of any information, medical or other information necessary to process this and all claims.

I also request all payments of government benefits either to myself or to the party who accepts assignment.

I authorize payments of medical benefits to Jacksonville Center for Counseling.

Signature: _____ Date: _____

Phone: (904) 737-7242 | **Fax:** (904) 737-7254
Jaxcenterforcounseling@gmail.com
www.jacksonvillecenterforcounseling.com

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FINANCIAL AND PAYMENT POLICY

We here at the Jacksonville center for counseling, Inc. would like to welcome you to our practice. We are pleased that you have chosen us to assist in your care. We are dedicated to providing caring and professional psychotherapy to you and/ or your family. As part of the delivery of psychotherapy services, we have established a financial policy which provides policies and options to all clients.

As a service to you, the office will bill your insurance company and other third-party payers, but cannot guarantee such benefits of the amounts covered, and is responsible for the collection of such payments.

Insurance deductibles and co-payments are due at the time of services. The parent or guardian accompanying a minor is responsible for payments for the child at the time of service.

Payment methods include Check (you will be charged the service charge on return checks), Cash, Visa, MasterCard, American Express, Debit Cards. You may use your charge card at each session or sign a secure document allowing the office to automatically submit charges to the card after each session. Any questions regarding the financial and payment policy can be answered by the office manager and can be reached at 904-737-7242.

FEE SCHEDULE

INDIVIDUAL THERAPY	$250.00	INITIAL ASSESSMENT SESSIONS
FAMILY THERAPY	$205.00	FOR EACH 45-60 MINUTE SESSIONS
SELF PAY RATES:		
INDIVIDUAL THERAPY	$125.00	FOR EACH 45-60 MINUTE SESSIONS
COUPLES THERAPY	$175.00	FOR EACH 45-60 MINUTE SESSIONS
FAMILY THERAPY	$200.00	FOR EACH 45-60 MINUTE SESSIONS
PHONE THERAPY	$125.00	FOR EACH 45-60 MINUTE SESSIONS
PHONE CONSULTATION (LONGER THAN 15 MINUTES)	$32.50	FOR EVERY 15 MINUTES INCLUDES: PARENTS, SCHOOLS, CASE MANAGERS, ETC
COURT APPEARANCES	$250.00	PER HOUR MINIMUM 2 HOURS & $50
OBSERVATION SESSIONS SCHOOL/ MEETING	$125.00	PER HOUR
TRAVEL FEES OTHER THAN COURT	$25.00	FOR FIRST 50 MILES, THEN .35 CENTS PER MILE THEREAFTER
DOCUMENTATION FOR COURT, FMLA ETC	$32.50	PER 15 MINUTES REQUIRED TO COMPLETE FORMS

Signature _____ Date _____

Witness _____

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CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use of disclosure of my protected health information by Jacksonville Center for Counseling, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Jacksonville Center for Counseling, Inc.

I understand that diagnosis or treatment of me by Jacksonville Center for Counseling, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Jacksonville Center for Counseling, Inc. is not required to agree to the restrictions that I may request. However, if Jacksonville Center for Counseling, Inc. agrees to a restriction that I request, the restriction is binding on Jacksonville Center for Counseling, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jacksonville Center for Counseling, Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Jacksonville Center for Counseling Inc. Notice of Privacy Practices prior to signing this document.

The Jacksonville Center for Counseling, Inc. Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Jacksonville Center for Counseling, Inc.

The Notice of Privacy Practices for Jacksonville Center for Counseling, Inc. is also provided at 3560 Cardinal Point Drive, Suite 204 Jacksonville, Florida 32257.

This Notice of Privacy Practices also describes my rights to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Jacksonville Center for Counseling, Inc. by calling the office at 904-737-7242 and requesting a copy or revised copy from the office manager and that a copy to be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative	Patient Name
Printed Name of Patient or Personal Representative	Witness

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EFFECTIVE JANUARY 4, 2016

If you are being seen under an EAP (Employee Assistance Program), we are no longer able to provide FMLA paperwork, short term disability, long term disability…

We are unable to provide this based on our contractual agreements with the EAP (Employee Assistance Program) companies.

Thank you for understanding.

By signing below you are acknowledging that you understand the provided information above.

_____ _____

Signature **Date**

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BIOPSYCHOSOCIAL HISTORY

Patient Name: _____ **Date:** _____

How much do the following problems bother you?	Not at all	A little	Somewhat	A lot
Feeling sad or blue				
Feeling hopeless about the future				
Feeling everything is an effort				
Feeling no interest in things				
Nervousness or Shakiness				
Heart pounding or racing				
Trouble Sleeping				
Feeling fearful or afraid				
Difficulty at home				
Difficulty at work/school				
Social difficulties				

How much do you agree with the following?	Strongly Agree	Agree	Neither Agree / Disagree	Disagree
I feel good about myself				
I can deal with my problems				
I have friends/family that I can count on				
I am able to accomplish the things I want				
I have thoughts of harming myself or others				
I have harmed myself or others before				

Please answer the following questions:

1. In general, would you say your health is: Excellent: ____ Good: _____ Fair: ____ Poor: ____

2. In the past month, how many days were you unable to work or function throughout the day due to your physical or mental health? # _____ **of days.**

Please answer the following questions:	Yes	No
Have you noticed a change in your weight?		
Do you drink? If so how much per day/month?		
In the past month have you ever felt that you should cut back on your drinking or drug use?		
Have you felt annoyed by people criticizing your drinking or drug use?		
Have you felt bad/guilty for your drinking/drug use?		
Have you or anyone in your family been admitted for inpatient psychotherapy?		
Have you or anyone in your family received outpatient psychotherapy?		

3. Current/Prior Medication usage? (List medication, dosage, frequency, start/end date, prescribing doctor and side effects). _____

4. Are you allergic to any medications?

_____

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Which of the following would you like to concentrate on during counseling?

My three most important goals are (write in numbers from above):

☐ 1.	Reducing my fear of:	☐ 26.	Improving my sleep
☐ 2.	Having more pleasurable activities	☐ 27.	Reducing my sensitivity to criticism
☐ 3.	Improving communication with spouse/children/friends/coworkers/others	☐ 28.	Learning problem solving/decision making
☐ 4.	Expressing myself more assertively	☐ 29.	Talking out a pending decision
☐ 5.	Learning to relax	☐ 30.	Reducing family difficulties
☐ 6.	Better manage my health (specify):	☐ 31.	Reducing work/school difficulties
☐ 7.	Better tolerate my mistakes	☐ 32.	Better managing my temper
☐ 8.	Better tolerate others mistakes	☐ 33.	Taking initiative more often
☐ 9.	Feeling less guilty	☐ 34.	Receiving medication help
☐ 10.	Feeling less depressed	☐ 35.	Decreasing procrastination
☐ 11.	Better accepting the loss/death of:	☐ 36.	Better managing time
☐ 12.	Increasing my conversational skills	☐ 37.	Decrease trying to be perfect
☐ 13.	Learning how I come across to others	☐ 38.	Not reacting so emotionally
☐ 14.	Not taking disappointment so hard	☐ 39.	Allowing myself to better express my feelings
☐ 15.	Doubting myself less	☐ 40.	Feeling more self-confident
☐ 16.	Thinking more positively	☐ 41.	Discussing thoughts of harming myself
☐ 17.	Improving my sexual relationship	☐ 42.	Discussing thoughts of harming others
☐ 18.	Controlling my eating or weight	☐ 43.	Adjusting to a recent change (specify):
☐ 19.	Controlling my alcohol use	☐ 44.	Adjusting to a past incident (specify):
☐ 20.	Reducing uncomfortable thoughts (specify):	☐ 45.	Becoming more optimistic
☐ 21.	Controlling my use of drugs	☐ 46.	Improving my self-awareness
☐ 22.	Better managing my pain	☐ 47.	Adopting a healthier attitude about:
☐ 23.	Learning how to improve friendships	☐ 48.	Worrying less about:
☐ 24.	Changing my habit of:	☐ 49.	
☐ 25.	Learning more effective parenting skills	☐ 50.	

First _____ Second _____ Third _____

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CREDIT CARD GUARANTEE

You are responsible for full payment at the time of services. As a convenience to you, we will automatically charge your designated card below on the day of services.

We charge a **missed appointment fee of $50** in the event that you **cancel, reschedule** or **miss an appointment** without giving **24 hours' notice.**

Services may be discontinued due to excessive missed, canceled or rescheduled appointments.

****As of January 1, 2019 you will be <u>REQUIRED</u> to have a card on file for any missed, canceled or rescheduled appointments without 24 hours' notice.****

I agree to the above terms and authorize you to charge my card.

_____ _____
SIGNATURE DATE

CREDIT CARD: _____ AMEX _____ VISA _____ MC _____ DISCOVER

CARDHOLDER'S NAME _____

BILLING ADDRESS _____

_____

CARD # _____ EXP DATE _____

THREE DIGIT CCV CODE _____

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