Weston PsychCare, P.A.
12401 Orange Drive, Suite 224, Davie, Florida 33330 (954) 385-4696

___ Seth Grobman, Psy.D. ___ Faith Grobman, Psy.D. ___ Terry Newell, Psy.D.
___ David Krasky, Psy.S. ___ Linda King, L.M.F.T.
___ Katie Lundin-Zemnovich, Ph..D. ___ Sammie Siegel, Ph.D.

PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME: _____

PATEINT ADRESS_____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ GENDER: _____

PHONE NUMBER (AUTHORIZED TO LEAVE MESSAGES): (_____) _____

EMAIL ADDRESSES FOR COMMUNICATION: _____

MARITAL STATUS: _____

PHYSICIANS/CONTACT INFO: _____

OCCUPATION/EMPLOYER:_____

OTHERS LIVING WITH PATIENT: _____

PRESENTING PROBLEM(S): _____

HISTORY OF PRESENTING PROBLEM(S); _____

_____

PSYCHIATRIC/PSYCHOLOGICAL TREATMENT HISTORY: _____

_____

CURRENT MEDICATION: _____

EMERGENCY CONTACT INFORMATION (DO NOT LEAVE BLANK): _____

_____

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Psychological or Counseling Services Agreement

Please initial that you have read and agree with this information

_____ I am choosing to enter into psychological services with
_____Dr. Seth Grobman _____Dr. Faith Grobman _____David Krasky _____ Dr Terry Newell

OR

_____I am entering into counseling services with
_____Linda King, LMFT _____Dr. Katie Lundin-Zemnovich _____ Dr. Sammie Siegel

_____I understand that a 45 minute session has been reserved for me (or a minor for whom I am responsible) and that I am responsible to keep my scheduled appointment or cancel with 24 hours advanced noticed or I WILL BE CHARGED THE ENTIRE FEE FOR THE SESSION. I understand that my insurance will not be billed for such a situation

_____I understand that the amount that I am to pay is due at the time services are rendered

_____I understand that if I want to use my insurance coverage, I will provide this information prior to my appointment as this information may be necessary to obtain treatment authorization.

Insurance Company: _____ ID Number _____ Group Number _____
Policy Holder: _____ Birth Date _____
Employer _____ Relationship to Insured _____

_____I understand that the office will file claims for IN NETWORK services only. I will be responsible for any unpaid balances not covered by my insurance company. Insurance payments are never guaranteed.

____I authorize my identified provider to submit claims to my insurance company. I understand that s/he may be required to provide information about my treatment to a case manager in order to secure authorization and payment for services rendered.

_____I authorize insurance payments to be assigned to my healthcare provider

Based upon the information provided to me and subject to verification,

_____I agree to a copay or fee of $ _____ for the initial visit
_____I agree to a copay or fee of $ _____ for subsequent 45 minute sessions.
_____I understand that I might have a deductible which I must satisfy with my healthcare professional

_____I understand that if fees are not paid in a timely manner, my account may be sent to a collection agency or court and that I will be required to pay the costs incurred to collect the unpaid balance.

_____I agree to accept email correspondence regarding statements, balances due, or appointments

_____I understand that all clinicians who practice with Weston PsychCare, P.A. are independent contractors and that each clinician maintains their own independent practice.

I fully understand and agree to the above policies and conditions.

_____ _____ _____
PATIENT NAME SIGNATURE OF RESPONSIBLE PARTY DATE

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Limits of Confidentiality

The content of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of your provider not to release any information or written records about a client with another party without the written prior consent of the client or the clients' legal guardian. It is the policy of this provider not to release any information about a client without a signed release of information. There are times your provider has a legal obligation to release information and they are the following:

1. Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, a health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

2. Abuse of Children or Vulnerable Adults: If a client states or suggests that he or she either is abusing/neglecting or has abused/neglected a child or vulnerable adult, or has knowledge of an identifiable child or vulnerable adult being abused or neglected, the health care professional is required to report this information to the appropriate social service agency or legal authority.

3. In the event of a clients death: The spouse or parents of the deceased client have a right to access the client's records

4. Professional Misconduct: Health care professionals are required to report professional misconduct by a health care professional. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

5. Court Orders: Health care professionals are required to release client records when a court order has been placed

6. Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access a client's record.

Leaving Voice Messages: If we need to reach you about your appointment or provide you with information, we want to be able to preserve your confidentiality. Indicate below the best way to reach you and whether we can leave a message:

Home: _____ Leave Message? _____

Work: _____ Leave Message? _____

Cell: _____ Leave Message? _____

……

I have read the Limits of Confidentiality outlined above

_____ _____ _____

Patient's Printed Name Signature of Patient or Legal Guardian Date

I have reviewed the document on the office website (www.westoncare.com) "Notice of Health Professionals' Policies and Practices to Protect the Privacy of Your Health Information" and understand its contents.

_____ _____ _____

Patient's Printed Name Signature of Patient or Legal Guardian Date