Counseling and Behavioral Solutions, Inc.
102 W. Dixie Ave
Leesburg, FL 34748
Telephone: 352-323-8872
Facsimile: 352-801-7376

Initial Client Information

Today's Date: ___________________________
Name: _______________________________________ Date of Birth: _____________________
Address: ____ City: ______________________________
State: _______________ Zip Code: ___________ Referred by: ____________________________________
Gender: M / F Marital Status: ________________________
Phone number: ____________________________ Cell: __________________________________
Employment: ____
Emergency Contact: _____________________________ Telephone Number: ___________________________
May Emergency Contact be called in an emergency? Yes No
Can you be contacted at either telephone: Yes No, and can a message be left: Yes No
Can a letter be sent to your address if needed: Yes No

Parents/Legal Guardian (if client is a minor):___________________________________
Address: ______________________________ City: ____________________________________ State: _____
Zip Code: ___________________________
Home Telephone: _____________________ Cell: ______________________ Work: ______________________

Insurance: _____________________________________
Whose insurance is it: ____Date of Birth: __________________________

____
Last Physical exam: _____________________________________ Primary Care Doctor: ___________________

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression	____ Elevated mood	____ Phobias/fears
___ Alcohol dependence	____ Fatigue	____ Recurring thoughts
___ Anger	____ Gambling	____ Sexual addiction
___ Antisocial behavior	____ Hallucinations	____ Sexual difficulties
___ Anxiety	____ Heart palpitations	____ Sick often
___ Avoiding people	____ High blood pressure	____ Sleeping problems
___ Chest pain	____ Hopelessness	____ Speech problems
___ Cyber addiction	____ Impulsivity	____ Suicidal thoughts
___ Depression	____ Irritability	____ Thoughts disorganized
___ Disorientation	____ Judgment errors	____ Trembling
___ Distractibility	____ Loneliness	____ Withdrawing
___ Dizziness	____ Memory impairment	____ Worrying
___ Drug dependence	____ Mood shifts	____ Other (specify): _________
___ Eating disorder	____ Panic attacks	___________________________

List any current health concerns: ____
List any recent health or physical changes: ____
____
Identify reason for seeking counseling: ____
____
____

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INFORMED CONSENT

While I expect benefits from this treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed. I understand that consistency of attending therapy appointments results in improved therapy outcomes. I have discussed the potential length of treatment, the potential outcomes of treatment, the methods of treatment, and the possible consequences. I have also had the opportunity to discuss and understand the following:

- I understand that if I am experiencing an emergency I will leave a message at the office, contact the suicide hotline (1800-273-Talk), or contact 911. The therapist will return emergency phone calls.
- I understand that I am free to discontinue treatment at any time. If I decide to end treatment I will notice the office.
- I understand that sessions are 45 minutes in length.
- I understand that I am financially responsible for the fees or any portion of the fees that are not covered by the insurance company. I agree to pay any fees not paid by the insurance, any co-payments, or any missed sessions fees.
- I understand that my unpaid balance (over 60 days) could be sent to a collection agency if it is not paid within a reasonable amount of time and no payment plan has been set up.
- I understand that the therapist does not accept gifts and that my healing is a gift in itself.
- I have been informed and understand the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threats of harm to myself or another person.
- I am not aware of any reason I (or my child) should not proceed with therapy and I agree to participate fully and voluntarily.
- I have had the opportunity to discuss all of the aspects of treatment fully, have had my questions answered, and understand the treatment planned. Therefore, I agree to comply with treatment and authorize the therapist to treat me or my child.

Attendance Police:

- I understand that regular attendance will produce the maximum possible benefits.
- I understand that if I do not cancel an appointment and have missed the session I will be charged a missed session fee of $50.
- I agree to contact this therapist 24 hours in advance to cancel an appointment. If I do not cancel my appointment with 24 hours notice I understand I will be charged a missed session fee of $50.
- I understand that 3 missed sessions or 3 consecutive cancellations in a 6 month period may be grounds for discharge from therapy.
- I understand that if I arrive late, 15 minutes or more I may be charged a missed session fee of $50.
- If I am aware of upcoming vacations, doctor's appointments, or extended leaves of absence and have to cancel scheduled appointments I will contact the office 3 days before the scheduled appointment.
- If I cancel an appointment, I understand that it is my responsibility to contact the office to re-schedule.

Name of Client: ____

Signature of Client/Parent/Guardian: ____ Date: _______

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Limits on patient confidentiality

We are required to disclose confidential information if any of the following conditions exist.

1. You are a danger to yourself or others.
2. Your therapist was appointed by the courts to evaluate you.
3. You are a minor and your psychotherapist reasonably suspects you are the victim of child abuse.
4. You are a person over the age of 65 or someone with developmental disabilities and your psychotherapist believes you are the victim of physical abuse. Your therapist may disclose information if you are the victim of emotional abuse.
5. You waive your rights to privilege or give consent to limited disclosure by your therapist.
6. Your insurance company paying for services has the right to review all records.

If you have any questions about these limitations, please discuss them with your therapist.

Signature: ____ Date: ______________

I am consenting to my (or my dependent) receiving outpatient treatment

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I have reviewed the HIPAA Guidelines and Duties and have had the opportunity to ask questions.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): ____

Signature: ____ Date: _____/_____/_____

Signed by: __client __guardian __personal representative