4800 Rowan Rd • New Port Richey, FL 34653 • 727-847-0069 •
Fax 727-849-3780 • www.lifespanservices.com

CLIENT INFORMATION (PLEASE PRINT)

DATE: ____/____/____

CLIENT'S NAME: _____DOB:_____AGE:_____SEX:_____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP CODE:_____ SSN:_____-___

HOME PHONE:_____-_____WORK PHONE:_____-_____CELL:_____ -_____

CAN WE LEAVE A MESSAGE AT HOME? Y ____N____ AT WORK? Y ____N____ CELL? Y____N____

EMAIL ADDRESS: _____

PREFERRED METHOD OF APPOINTMENT REMINDERS:
_____TEXT _____EMAIL _____VOICEMAIL

MARITAL STATUS: M___S___D___ DRIVER'S LIC#_____

EMPLOYER: _____ ADDRESS: _____
_

NAME / ADDRESS / PHONE OF EMERGENCY CONTACT:_____

_____

RELATIONSHIP OF EMERGENCY CONTACT: _____

PERMISSION TO SHARE INFORMATION WITH EMERGENCY CONTACT: Y_____N_____

PRIMARY CARE PHYSICIAN NAME & PHONE NUMBER: _____

DO YOU WANT TO SHARE INFORMATION WITH YOUR PHYSICIAN? Y_____N_____
__

ARE YOU SEEING ANY OTHER MENTAL HEALTH PROVIDER? Y___ N___ NAME_____

DO YOU WANT TO PROVIDE A MENTAL HEALTH ADVANCE DIRECTIVE? Y_____ N_____

RELEASE OF INFORMATION:

IN ORDER TO PROCESS MY CLAIM, I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY FOR THIS PURPOSE ONLY.
I hereby assign all medical, including Major Medical benefits to which I am entitled, to the above named PROVIDER.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
THERAPIST SIGNATURE DATE

Thank you
We appreciate the opportunity to help enhance the quality of your life.

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INSURANCE INFORMATION MUST BE COMPLETED IN FULL

INSURANCE INFORMATION:

IS SCHOOL BOARD PAYING? ___YES ___NO
DOES CLIENT HAVE PRIVATE INSURANCE? ___YES ___NO
IS THE CLIENT A MINOR? ___YES ___NO
DOES CLIENT HAVE MEDICAID? ___YES ___NO
DOES CLIENT HAVE MEDICARE ?___YES ___NO
IF YES, PLEASE COMPLETE SECONDARY INSURANCE INFORMATION.

PRIMARY INSURANCE:

PRIMARY INSURED NAME:_____ DOB:_____ SEX:_____

SS# OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____ INSURANCE CO:_____

ADDRESS:_____

GROUP #:_____ POLICY #:_____

MEMBER ID #:_____

SECONDARY INSURANCE (IF APPLICABLE):

INSURED NAME:_____ DOB:_____ SEX:_____

SS# OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____ INSURANCE CO:_____

ADDRESS:_____

GROUP #:_____ POLICY #:_____

NAME AS PROVIDED ON CARD:_____ BILL ZIPCODE_____

Valid Credit Card: Number:_____ Expiration:_____/_____

__ DEBIT __ CREDIT __ DISCOVER __ MASTERCARD __VISA

"***ALL APPOINTMENTS MUST BE CHANGED OR CANCELLED 24 HOURS IN ADVANCE TO AVOID A*** **$50.00** ***CHARGE***"
I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS). I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I WILL NOTIFY YOU OF ANY CHANGES TO THIS INFORMATION. FOR YOUR CONVENIENCE, AFTER VISITS ARE DISCONTINUED, ANY REMAINING BALANCES WILL BE CHARGED TO YOUR CREDIT CARD ON FILE. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
THERAPIST SIGNATURE DATE

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Intake Questionnaire

Name: _____ Date: _____

Prior to beginning therapy with me, I request that all my clients complete this form. The questions are designed to help you clarify the changes you want to make in your life, and the expectations you have of the following counseling relationship. Please give these questions much thought.

1. Make a list of things you want to change in your life:

_____

_____

_____

_____

_____

2. Rewrite the above list from most important (#1) to least important (#12):

1. _____ 7. _____

2. _____ 8. _____

3. _____ 9. _____

4. _____ 10. _____

5. _____ 11. _____

6. _____ 12. _____

3. What are some your self-defeating behaviors? That is, what do you do that seems to make things worse? (or just does not help you): _____

_____

_____

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INITIAL INTAKE

How did you hear about us: _____ Education: _____

Problems with housing or daily living activities (eg: transportation, etc.) _____

Legal Problems: _____

Financial Problems: _____

Family Names _____ _____ Age _____ _____ Living/ Deceased

Parents _____.....____..... _____

_____.....____..... _____

Spouse _____.....____..... _____

Children _____.....____..... _____

_____.....____..... _____

_____.....____..... _____

_____.....____..... _____

Siblings _____.....____..... _____

_____.....____..... _____

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MEDICAL HISTORY

Family Physician: _____ Date of last physical: _____

Previous Hospitalizations:

Where (hospital/city)	When	How Long	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Are you presently taking medications? _____ Please list names & how often taken:

_____

_____

Any known allergies: _____

Please list any previous Psychological/Psychiatric treatment, or counseling:

_____

_____

Females: Any discontinued pregnancies? _____ How many? _____
Full term pregnancies? _____ How many? _____

Has anyone in your family (parents, brothers, sisters, cousins, aunts, uncles) had any of the following?
Please check all that apply:

_____ Kidney Disease	_____ Tuberculosis
_____ Heart Disease	_____ Mental Illness
_____ Cancer	_____ Drug/Alcohol Abuse
_____ Tumors	_____ Epilepsy
_____ Diabetes	_____ Nervous Disorders

Please check any of the following of which you had in the past, or are now experiencing:

PROBLEM	PAST	PRESENT	PROBLEM	PAST	PRESENT
Blurred Vision.....	_____	_____	Chest Pain.....	_____	_____
Double Vision.....	_____	_____	Blackouts.....	_____	_____
Severe Headaches.....	_____	_____	Seizures.....	_____	_____
Dizzy Spells.....	_____	_____	Hepatitis.....	_____	_____
Head Injury.....	_____	_____	Allergies.....	_____	_____
Vomited Blood.....	_____	_____	Pneumonia.....	_____	_____
Back Pain.....	_____	_____	Diabetes.....	_____	_____
Hearing Loss.....	_____	_____	Sleeping More.....	_____	_____
Mood Swings.....	_____	_____	Sleeping Less.....	_____	_____
Compulsions.....	_____	_____	Confusion.....	_____	_____
Excessive Blood Loss..	_____	_____	Extreme Sadness.....	_____	_____
Loss of Consciousness.	_____	_____	Stomach Pains.....	_____	_____
Jaundice.....	_____	_____			

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PROBLEM	PAST	PRESENT
Shortness of Breath		
Blood in Bowel Movements		
Heart Attacks		
Tuberculosis		
Smoker's Cough		
Kidney or Urine Infection		
Blood in Urine		
Menstrual Difficulties		
Swollen Ankles		
Bruise Easily		
Weakness in Arms and Legs		
Venereal Disease		
Reactions to Medications		
Blood Transfusions		
Broken Bones		
Sinus or Frequent Colds		
Weight Loss		
Weight Gain		
Appetite Changes		
Drug/Alcohol Abuse		
Irritability		
Excessive Worries		
Crying Spells		
Fears or Phobias		
Hallucinations		
Difficulty Concentrating		
Frequent Loss of Temper		
Extreme Nervousness		
Frequent Job Changes		
Bedwetting past age 6		
Fingernail Biting		
Blaming Others Frequently		
Lack of Self-Confidence		
Low Self-Esteem		
Indecisiveness		
Sexual Problems		
Extreme Loneliness		
Frequent Accidents		

_____ _____

CLIENT SIGNATURE DATE

_____ _____

THERAPIST SIGNATURE DATE

Lifespan Services, Inc.
4800 Rowan Rd
New Port Richey, FL 34653

Phone: 727-847-0069
Fax: 727-849-3780
www.lifespanservices.com

Counseling/Psychotherapy – all ages ●Children and Family Services ● Parent Education

CLIENT ORIENTATION

Program Rules:

1. Lifespan Services, Inc. will provide outpatient counseling, evaluation, information and/or referral.
2. No drug or alcohol screening or "search and seizure" methods will be employed.
3. Clients must not be under the influence of alcohol or illegal substances at the time of the scheduled session.

   Should client be under the influence of substances other than prescribed medication, the session will be cancelled by the counselor and the client will be expected to pay for the session at the usual, agreed upon fee.
4. ***All appointments must be changed or cancelled 24 hours in advance to avoid a $40.00 charge.***

Program Procedures:

1. Client's rights to confidentiality will be observed at all times, with the following exceptions:
   - In cases of probable imminent danger to self or others, in cases of child abuse, including sexual abuse.
   - Communicable diseases must be reported by the counselor to the appropriate county health department.
   - When you, the client, request that we release information.
   - Information is only shared with other outside entities (ie: doctors, attorneys, etc.) when you request it by signing an Authorization to Release Information form. In accordance with HIPPA privacy regulations, any information shared will reveal only the basic minimum information necessary.
   - When your therapist would like to consult with another Lifespan therapist (who has additional expertise in a certain area) for information that may be of help in your treatment. No names are ever used during his consultation.
2. We reserve the right to release only a Treatment Summary instead of detailed case notes.
3. A minimum requirement of 72 hours is needed for medical records, once a written request is received.
4. The undersigned will neither individually nor jointly involve the therapist or Lifespan Services (and its staff) in any litigation. The undersigned will neither request nor require that Lifespan Services or the therapist provide testimony in court. The reason for this is so that treatment is not compromised, the therapeutic relationship with the family is maintained, and a child can experience his or her play therapist in a clear, consistent, therapeutic role and not as an assessor or detective. If the services of a mental health professional are desired for court purpose, the services of a person outside of Lifespan Services, Inc. must be enlisted.
5. *Counseling Recordings/Artwork:* The use of video/audio taping or photography is sometimes necessary in therapy. Any type of recording is used to provide feedback to you, the client, or for therapist's training purposes. Your confidentiality is protected and recordings are erased after each session unless your permission is given for another use. In the case of video or audio taping, you would be informed ahead of time and your written permission would be needed. The use of photography typically involves pictures of children's play structures (i.e.: sand trays, block building, etc.) or pictures of the children

children's play structures (i.e.: sand trays, block building, etc.) or pictures of the children with our therapy pet. Art work is sometimes used for training purposes, but the child's identity is protected.

If you have any questions about the above, please ask your therapist.

Hours of operation: Business office hours are M-F from 9:30am-4:00pm and closed for lunch from 1:00 -2:00pm. Available hours vary with each therapist and some nights and weekends may be available.

After Hours Emergencies:
In the event of a behavioral health emergency contact:

- **911**
- National Suicide Prevention Line at: **1-800-273-TALK**
- or go to the nearest crisis center:

Bay Care Behavioral Center (Adults)
8002 King Helie Blvd. New Port Richey, Fl 34653 (727) 841-4430 (727) 841-4439

Morton Plant North Bay Hospital Recovery Center 21808 S.R. 54, Lutz, FL 33549
Phone: (813) 428-6100

Hernando County Outpatient / Inpatient 7074 Grove Road Spring Hill, Fl 34609
(352) 540-9335

Morton Plant Mease Behavioral Health Care 300 Pinellas Street, Clearwater, Florida 33756
(727) 462-7000

Medical Center of Trinity West Pasco Campus 5637 Marine Parkway, New Port Richey, Florida 34652
727-845-9180 24 hour inpatient intake line (727) 298-6402

Payment of Fees for Service:

1. We accept cash, check, Visa, or insurance reimbursement.
2. All co-pays and private pay fees are due at the time counseling services are provided.
3. Client is expected to pay for services when services are rendered. If for any reason payment of services is received back from client's financial institution (e.g. NSF fee from bank) there will be a $20.00 fee collected prior to next appointment.

Acknowledgement/Consent:

1. I authorize the Release of Medical information necessary for my insurance company to process my claim. I also authorize the payment of benefits to Lifespan Services, Inc.
2. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.
3. I certify all information on the counseling intake forms is true and correct to the best of my knowledge. I will notify Lifespan Services of any changes to my insurance information, address, telephone numbers, and any other relevant changes.

By signing this form I am acknowledging receipt of a copy of this paper and agreement to the Orientation terms and conditions as provided by Lifespan Services, Inc.

_____ _____

Print Client's Legal Name Signature Parent/Guardian/Representative

_____

Date