Weston PsychCare, P.A.
12401 Orange Drive, Suite 224, Davie, Florida 33330

___ Seth Grobman, Psy.D. ___ Faith Grobman, Psy.D. ___ Terry Newell, Psy.D.
___ David Krasky, Psy.S. ___ Linda King, LMHC ___ Sammi Siegel, Ph.D.
___ Katie Lundin-Zemnovich, Ph.D. ___ Stacy Gordon-Studnik, M.S.
___ Crystal Anne England, Ph.D.

Patient Information

TODAY'S DATE: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ GENDER: _____ MARITAL STATUS: _____

PHONE NUMBER AUTHORIZED TO LEAVE MESSAGES: _____

EMAIL ADDRESS FOR CORRESPONDENCE: _____

PRIMARY CARE PHYSICIAN CONTACT INFO: _____

OCCUPATION/EMPLOYER: _____

OTHERS LIVING WITH PATIENT: _____

PRESENTING PROBLEM(S): _____

PSYCHOLOGICAL/PSYCHIATRIC TREATMENT HISTORY:

_____

_____

CURRENT MEDICATIONS:

_____

EMERGENCY CONTACT INFO (DO NOT LEAVE BLANK): _____

_____

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Psychological or Counseling Services Agreement

Please initial that you have read and agree with the following information:

____ I am choosing to enter into psychological services with:
___ Dr. Seth Grobman ___ Dr. Faith Grobman ___ Dr. Terry Newell

OR

___ I am choosing to enter into counseling services with:
___ Linda King, M.A. ___ Dr. Katie Lundin ___ Dr. Sammi Siegel
___ Stacy Sudnick, M.A. ___ Dr. Crystal Ann England

___ I understand that a 45 minute session has been reserved for me (or a minor for whom I am responsible) to keep my scheduled appointment or cancel with 24 hours notice or I WILL BE CHARGED FOR THE ENTIRE SESSION. I UNDERSTAND THAT MY INSURANCE WILL NOT BE CHARGED FOR FAILED APPOINTMENTS AND I WILL BE RESPONSIBLE FOR THE ENTIRE CONTRACTED COST OF THE SESSION.

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

___ I understand that if I wish to use my insurance coverage, I will provide this information PRIOR to my appointment as this information is necessary to obtain evaluation/treatment authorization

___ 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 diagnosis and treatment to a case manager in order to secure authorization and payment for services rendered

___ I authorize payments to be assigned to my healthcare provider

___ 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 billing statements, balances due, or appointments.

___ I understand that all clinicians who practice in 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 psychotherapy, counseling, intake, or assessment sessions are considered to be confidential. Both verbal information and written records about a client/patient cannot be shared with any other party without the written consent of the client or the clients's legal guardian. There are times your provider has a legal obligation to release information without consent and they are the following:

1. Duty to Warn and Protect: When a client discloses intention or plan to harm another person, a healthcare provider is required to warn the intended victim and report this information to legal authorities. In such cases in which the client discloses or implies a plan for suicide, the healthcare provider 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 is either 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 healthcare professional is required to resort this information to the appropriate social service agency or legal authority.
3. In the event of a client's death: The spouse or parents of the deceased client have a right to access the client's record.
4. Professional Misconduct: Healthcare professionals are required to report professional misconduct by a healthcare professional. In cases in which a professional or legal disciplinary meeting is being held regarding the healthcare professional's actions, related records may be released in order to substantiate disciplinary concerns.
5. Court Orders: Healthcare 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 a right to access a client's record.

Leaving messages via voicemail or text messaging: If we need to reach you about your appointment or provide you with information, we wish to preserve your privacy and confidentiality. Indicate below THE BEST WAYS to reach you for the purpose stated.

PRIMARY CONTACT NUMBER: _____

SECONDARY CONTACT NUMBER (IF APPLICABLE): _____

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I have read the Limits of Confidentiality outlined above:

_____ _____

PATIENT 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 Informaiton" and understand its contents.

_____ _____

PATIENT NAME SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE