Susan Capitano, MS. LMHC

FirstStep CounselingCenter

Patient Registration Form

Patient Information

Last Name:	First Name:	M.I.	Referral Source:
Mailing Address:	Apt #:		
City/State/Zip:			
Home Phone:	Cell Phone:	Cell Carrier (text reminders):	
Date of Birth:	Sex: ☐ Male ☐ Female	Family Physician:	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Person responsible for the bill (ONLY IF DIFFERENT THAN THE PATIENT):

Last Name:	First Name:	
Date of Birth:	SSN #:	Phone:
Address of Person Responsible (if different from patient):		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL FIELDS BELOW):

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ **Yes** ☐ **No**
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Russian ☐ Sign Language ☐ Spanish ☐ Other

Current and Past Psychiatric Medications Prescribed:

Insurance Information

Primary Policy Holder Information (ONLY IF DIFFERENT THAN THE PATIENT OR RESPONSIBLE PARTY):

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Relationship to Patient:	Policy Holder Relationship to Patient:
Policy Holder Address:	Policy Holder Address:

I have read and agree to First Step Counseling Center's (FSCC) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to FSCC all money to which I am entitled for medical expenses related to the services performed from time to time by FSCC, but not to exceed my indebtedness to FSCC. I understand that failure to pay outstanding balances within 60 days of notification of the amount due will result in submission to an outside collection agency.

I have reviewed a copy of Fist Step Counseling Center's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X_____ Date_____

Printed Name of Responsible Party:_____

109 Nature Walk Parkway Ste 104
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Privacy Notice

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Susan Capitano, MS. LMHC, of First Step Counseling Center, keeps medical information about you. This protected health information (PHI) includes but is not limited to medical records and other health information describing your health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. This information will be treated as private and confidential and will not be released without your written permission, our discussion or as dictated by the law.

There are several ways I may need to or request to use this information. First, the information is used when I treat you or refer you for treatment. For example, I might ask permission to discuss aspects of your care with your family or significant other. If a physician referred you, I may ask to thank them for the referral or discuss aspects of your treatment. All requests will be discussed with you first and you have every right to refuse with the following exceptions: I am legally and ethically bound to break confidentiality if I believe that you are in imminent danger to yourself and/or someone else (i.e. suicidal, child abuse, sexual abuse, homicidal threats, etc.) Secondly, I may use or share your PHI to obtain payment for your health care services, including to a collection agency or credit bureau. This includes information required by your insurance company to secure authorizations for treatment and submissions of claims for mental health services. Finally, I use this information to conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).

Under the law, each patient has certain rights to the medical information kept by First Step Counseling Center.

The rights are briefly summarized below.
- Access. You can ask to look at your record.
- Restriction. You can ask to limit who sees your information. You can ask to limit what information is sent out.
- Accounting. You can ask to see the list of places where your information has been sent.
- Amending. You can ask to change medical information if it is incorrect.

A complete notice with explanations of uses, disclosures, rights and information on how to file a privacy complaint is available at the following: In person at the office or by phone at (904) 610-6276.

A patient also has the right to file a complaint regarding privacy with the Secretary of Health and Human Services, toll free at 1-877-696-6775.

Florida statutes: Florida statutorily grants patients the right of access to medical records maintained by health care practitioners. The disclosure of patient information by providers is generally prohibited without the patient's consent, subject to specified exceptions. Florida has numerous laws protecting the confidentiality of health information held by a variety of entities and government agencies.

Signature of Patient or Representative Date

Susan Capitano, MS. LMHC Date

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FirstStep CounselingCenter

Financial Policies

Please carefully read the information found below detailing our financial policies. It is important to us that you have a complete understanding of these policies. We reserve the right to amend or make changes to these policies and will notify you in writing. If you have any questions or concerns, please let us know.

List of Fees & Services

Initial evaluation: $130; therapy session (45 minutes): $110; therapy session (60 minutes): $130; missed appointment fee: $75; form and letter completion: $80; phone support over ten minutes: $25/15 minutes

Cancellation/Rescheduling & Arrival Time Policy

If you are unable to make your scheduled appointment, please contact the office 24 hours in advance. If you do not show for an appointment or do not give proper notice of cancellation or need for rescheduling, you will be charged a $75 fee. This is a fee to you as insurance companies do not pay for missed appointments. Also, note that if you arrive late for your appointment, you are forfeiting that time. You are required to complete the attached credit/debit card form for First Step Counseling Center to safely keep on file before your first session.

Court Services

Court services are not part of mental health treatment. If you require involvement in any court proceedings, additional fees will apply. Court related fees are not covered by insurance. Court appearances and depositions are billed to the individual requesting the testimony. The fee for these services is $250/hour with a required minimum fee of $750 paid 24 hours in advance. Payment is accepted in Cash, as a Money Order or by Credit Card. There are no refunds. Report writing is billed at $110 per hour and requires 2 hours be paid in advance. A charge of $1 per page will be made for coping of any records.

Insurance and Payment Agreement

I acknowledge that it is my responsibility to know and understand my insurance plan benefits.
I will notify First Step Counseling Center, Inc. of any changes in my insurance coverage or participation and provide proper documentation.
I understand that all fees for services, co-pays, co-insurance amounts and deductibles are due at the time of the service.
I understand that there is a $25 fee for a returned check. I understand checks may no longer be accepted if a check is returned for insufficient funds-payment will need to be cash or by credit/debit.
I understand an account is considered delinquent if there has not been a payment made within 30 days following written notification of the balance due. I understand that the unpaid balance will then be subject to a monthly finance charge of 15%. Any portion of the account balance over 30 days past due will be submitted to a collection agency and continue to accrue interest. I also agree to pay all collection costs on any unpaid balance on my account, generally 50% of balance.
I acknowledge responsibility for any payments due to First Step Counseling Center for services provided or fees as previously outlined above.

I have read and agree to the above financial policies.

Name (Print) Signature Date

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Credit Card Authorization Consent Form

Clients are required to keep a valid credit card number on file. This credit card will only be used for missed appointments, late cancellations (not made at least 24 hours in advance of appointment time), or delinquent balances (balances more than 60 days past due). This card will not be used for any other reasons than the above stated terms.

Patient Name (print):_____

Cardholder's name:_____

Card Type (circle one): Visa MasterCard American Express Discover

Card Number: _____

Expiration Date:____/_____(mm/yy)

3 Digit CVC/Security Code_____

Credit Card Billing Zip Code:_____

I have read and understand terms of this credit card authorization form. I authorize First Step Counseling Center to keep my credit card number and my signature on file and to charge my credit card listed above for missed appointments and/or late cancellations at the session rate of $75, and for any delinquent balances more than 60 days past due.

Cardholder's Signature:_____Date_____

Therapist Signature:_____

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Life History Questionnaire: Adult (1 of 8)

The purpose of this questionnaire is to obtain an understanding of your life experience and background. Once complete, we can begin to develop a comprehensive treatment program suited to your specific needs. Please complete this fully and bring to your first appointment.

Name:_____Date:_____

DOB:_____Age:_____Place of Birth:_____

Relationship Status:

Single / Married / Divorced / Engaged / Remarried / Widowed / Separated / Committed Relationship

Are you currently seeing a Psychiatrist? Yes / No (Name of doctor:_____)

Clinical Information

State in your own words the nature of your problem/concerns and how long they have been present:

_____

_____

_____

What do you expect to accomplish from therapy? _____

_____

How long do you expect therapy to last? _____

How would you describe the severity of your problems? (Circle One)

Mildly Upsetting / Moderately Severe / Very Severe / Extremely Severe / Incapacitating

Have you previously undergone mental health counseling? Yes / No Length of time:_____

Please explain your experience and results with previous counseling: _____

_____

_____

Have you been hospitalized due to mental health concerns? Yes / No

If yes, please explain: _____

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Life History Questionnaire: Adult (2 of 8)

Clinical Information (continued)

Circle all that apply to you:

Headache / Dizziness / Fainting Spells / Palpitations / Stomach Trouble / Anxiety / Easily Agitated

Decreased Energy / Appetite Loss / Anger / Always Tired / Insomnia / Nightmares / Panicky / Lonely

Tense / Feeling of Helplessness / Tremors / Shaking / Depressed / Suicidal Thoughts / Feeling of Guilt

Unable to Relax / Sexual Problems / Overly Ambitious / Shy / Unable to Make Friends / Inferiority

Unable to Make Tough Decisions / Unable to Keep a Job / Aggressive / Short-Term Memory Loss

Long Term Memory Loss / Perfectionist / Excessive Sweating / Poor Concentration / Cowardly

Please list additional problems or difficulties:_____

_____

_____

_____

Put an "X" next to the following statement that you think may apply to you:

_____I feel some degree of being worthless, useless, like a nobody and that my life is empty.

_____I feel inadequate, stupid, incompetent, naive and that I can't do anything right.

_____Sometimes I feel evil, morally wrong, have horrible thoughts or hate myself or somebody else.

_____I often feel ugly, deformed, unattractive or repulsive.

_____I'm depressed, lonely, feel unloved and misunderstood.

_____I feel bored and restless.

_____I feel I'm attractive.

_____I feel I'm considerate of others.

_____I feel I'm self-confident.

_____I feel I'm intelligent.

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Life History Questionnaire: Adult (3 of 8)

Clinical Information (continued)

List your three main fears: 1)_____ 2)_____ 3)_____

Describe any fearful/distressing past experiences and how old you were when they occurred. They can be feelings/experiences of any kind, including emotional, physical, sexual, neglect, regret.

_____

_____

_____

_____

List any situations which make you feel calm or relaxed? _____

_____

Have you ever lost control (temper, crying or aggressions)? Yes/ No

If yes, please describe: _____

_____

Do you currently have thoughts of suicide? Yes / No

Have you had thoughts of suicide in the past? Yes / No

Have you ever attempted suicide? Yes / No

If yes to any of the above three questions, please explain and include ages:

_____

_____

_____

_____

_____

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Life History Questionnaire: Adult (4 of 8)

Clinical Information (continued)

Do you drink alcohol? Yes / No

How often do you drink? Daily / Every Other Day / Weekly / Monthly / Special Occasions / Other

When I do drink, I most often drink: Beer / Wine / Liquor

I average the following number of above drinks during one sitting: 1 / 2 / 3 / 4 / Other:_____

Put an "X" next to the all of the following statements that apply to you in regards to alcohol:

_____I drink socially to fit in.

_____I drink by myself.

_____I can drink one or two drinks and be fully functional afterwards.

_____I'm inebriated every time I consume alcohol.

_____I never drink just one drink.

_____I drink to relax.

_____I drink when I know I shouldn't.

_____I'm often belligerent, angry and mad as a result of drinking.

_____I think I might have a problem with alcohol consumption.

Have you ever used illicit drugs? Yes / No

If yes, what drugs (include prescription drug abuse) and if you currently abuse each:

_____

List the drug and at what age you were when you abused each drug: _____

_____

Do you smoke? Yes / No If yes, how many cigarettes do you smoke per day?_____

Do you drink caffeine (coffee, tea, sodas) Yes / No If yes, how many drinks a day?_____

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Life History Questionnaire: Adult (5 of 8)

Clinical Information (continued)

Are you taking any medications? Yes / No

If yes, what, how much and for what condition (include over-the-counter):_____

_____

Are you allergic to any medications? Yes / No If yes, what drugs?_____

Do you have any current medical problems? Yes / No If yes, please describe:

_____

_____

Does any member of your family suffer from alcoholism, substance abuse, or anything which can be considered a "mental" disorder such as depression or anxiety? Yes / No

If yes, explain who the family member is and what they suffer from: _____

_____

Personal Background

My childhood was: Happy / Unhappy If unhappy, please explain:_____

_____

During childhood, I was: Healthy / Unhealthy List illness history:_____

_____

My father is: Living / Deceased If alive, present age:_____

Father's occupation:_____Father's health:_____

My mother is: Living / Deceased If alive, present age:_____

Mother's occupation:_____Mother's health:_____

# of Siblings:___# of Brothers:____Ages:_____# of Sisters:_____Ages:_____

My relationships with my brothers and sisters is: Poor / Average / Excellent / Other:_____

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Life History Questionnaire: Adult (6 of 8)

Personal Background (continued)

Parents divorced? Yes/No How Old were you when they divorced?_____

If divorced, did either remarry and how did this effect you?_____

_____

Give a description of your father's personality and his attitude toward you:_____

_____

Give a description of your mother's personality and her attitude toward you:_____

_____

In what ways were you punished by your parents as a child?_____

Were you ever bullied or severely teased? Yes/No If yes, please explain:_____

_____

Give an impression of your childhood home atmosphere:_____

_____

Were you and your siblings compatible with your parents? Yes / No If no, please explain:

_____

Did you feel loved and respected by your parents? Yes/No If no, please explain:_____

_____

What is your educational background and highest degree earned?_____

_____

What is your occupation?_____Employer:_____

Does your present work satisfy you? Yes/No If no, how are you dissatisfied?_____

_____

List your career ambitions and goals:_____

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Life History Questionnaire: Adult (7 of 8)

Personal Background (continued)

Do you have any financial concerns? Yes / No If yes, please explain:_____

_____

Describe your living situation (who you live with and relations):_____

Who are the most important people in your life?_____

Present interests, hobbies or activities:_____

_____

What is your religion and/or spirituality (presently and in childhood):_____

Have you ever been arrested? Yes / No If yes, why and at what age:_____

_____

Are you or were you ever in the military? Yes / No If yes, branch and years served:_____

_____

Relationship History

Are you currently married?_____How many times have you been married?_____
Are you currently in a relationship? Yes / No If yes, how long:_____

How are you getting along with your partner/spouse? Yes / No If no, please explain:_____

_____

If married or in a relationship, what is your partner's name, age, occupation?_____

_____

Describe the personality of your current spouse/partner:_____

How many children do you have?_____Gender and ages:_____

Do any of your children present specific mental health problems?_____

Do you have any step-children? Yes / No If yes, how many and gender/ages:_____

Any history of: Miscarriage / Abortions / Infertility If yes, explain_____

_____

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Life History Questionnaire: Adult (8 of 8)

Self-Description

The most important thing that happened in my life was_____

All my life I wanted_____

Ever since I was a child, I_____

One of the things I feel proud of is_____

It's hard for me to admit_____

One of the things I can't forgive is_____

One of the things I feel guilty about is_____

If I didn't have to worry about my image_____

One of the ways people hurt me is_____

My mother was always_____

What I needed from mother and didn't get was_____

My father was always_____

What I wanted from father and didn't get was_____

One of the things I'm angry about is_____

Which three words best describe you:_____

Any other information you would like me to know about you?_____

_____

_____

Name (Print) Signature Date

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