Susan Capitano, MS. LMHC

Patient Registration Form

FirstStep CounselingCenter

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
Augustine, FL 32092
www.FirstStepCounselingCenter.com
susan@firststepcounselingcenter.com
Phone: (904) 610-6276
Fax: (904) 512-0474

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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Consent (1 of 2)

Parental Consent and Treatment Agreement for a Child or Adolescent

You or your son or daughter is requesting counseling services at the First Step Counseling Center Because (s)he is under 18 years of age, parental consent is necessary for her/him to receive counseling and psychological services. The purpose of this form is to inform you about the counseling process and you and your child's rights and responsibilities regarding clinical services.

The process for arranging counseling involves your child's scheduling an appointment to meet with a counselor. Before the appointment, you and your child will be asked to complete forms. The forms (s)he will be asked to complete are extensive, but provide the counselor with important information about the child's background. However, a counselor-client relationship is not created until your child has visited with a counselor in person.
Your child's first meeting with one of our counselors will be an initial assessment. In the initial assessment, the counselor will help your child clarify her/his concerns and discuss services that are most likely to be helpful. At each session, we ask that the parent participates by meeting with the counselor individually or with the child.

Confidentiality: First Step Counseling Center adheres to strict confidentiality standards according to Florida Law. While your child is a minor, you have rights to discuss your child's counseling with her/his counselor. After your child becomes 18, you can have her/him give the counselor written permission to allow two-way communication between yourself and the counselor. If your child does not sign such a release at that time, you can communicate information to the counselor, but the counselor will not be able to confirm whether or not your child is continuing in counseling or talk to you about your child's counseling experience. Please note that although you have rights to your child's counseling information until they become 18, it is often in the best interest of college-aged clients if their parents are only involved when requested by the client and/or counselor

First Step Counseling Center will maintain confidentiality about the fact that your child is in counseling, the information your child discloses in counseling, and your child's counseling records. If you or your child wants us to provide information about your child's counseling to your pediatrician or other professional, we will do so with your child's written authorization. Until your child is 18 years old, your written permission is also necessary.

There are several instances when information may be released. First, in an effort to provide her/him with the best service, the counselor may share information about her/him with a licensed colleague for the purpose of clinical consultation.

You should be aware that First Step Counseling Center staff may be required to disclose client information, even without consent, in the following situations:

- When doing so is necessary to protect the client or someone else from imminent physical and/or life- threatening harm.
- When a client lacks the capacity or refuses to care for him/herself and such lack of self-care presents substantial threat to his or her well-being.
- When the abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected. Examples of abuse, neglect, or exploitation include, but are not limited to, violence towards a minor, a minor witnessing violence or being in the presence of violence, drug use in front of or while caring for a minor, or financial exploitation of an elder adult. Examples also include incidents of past abuse, including those described above, if the alleged perpetrator of abuse is currently in a caretaker capacity with any minor or is still present in the home of a minor.
- When a client is involved in a legal proceeding and there is a court order for the release of the client's records.
- When a release is otherwise required by law (e.g., Patriot Act)

(continued below)

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Consent (2 of 2)

Parental Consent and Treatment Agreement for a Child or Adolescent (continued)

Benefits and risk: Counseling is an active and cooperative effort involving both the patient and the counselor. Counseling may result in better emotional and mental health and positive changes in behaviors and coping ability. However, through the normal process of counseling and discussing your child's personal concerns, your child may experience greater emotional distress at times. Your child also may find that the positive changes that (s)he makes may result in changes in the relationships in her/his life (e.g., gaining relationships, becoming closer in relationships, losing relationships, or relationships feeling more distant). If you or your child has any concerns about your child's progress or the results of her/his counseling, we encourage you or your child to discuss them with her/his counselor at any time.

Patient responsibilities: Patients are expected to behave in a respectful manner. Failure to do so may also result in termination of services.

Parental informed consent for child's counseling services at First Step Counseling Center

I am the parent or legal guardian of _____

Minor Child's Name

I have full, partial, or rotating custody of the above child/adolescent. I have received a copy of the First Step Counseling Center Parental Consent for counseling form. I have read and fully understand the information contained in this form. I hereby give my permission to Susan Capitano, MS. LMHC to engage in counseling/ psychotherapy with my daughter/son.

_____

Child's Name (Print) Child's Date of Birth

_____

Name of Parent/Legal Guardian (Print) Date

_____

Parent/Legal Guardian's Signature Date

_____

Susan Capitano, 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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FirstStep CounselingCenter

Life History Questionnaire: For Child/Adolescent (1 of 6)

The purpose of this questionnaire is to obtain an understanding of your life experience and background. Then we can begin to develop a comprehensive treatment program suited to your specific needs. Please return this questionnaire when completed, or at your scheduled appointment.

Name:_____ Gender: M / F Date of Birth: _____

Place of Birth:_____ How did you hear about us?_____

Chief Complaint: _____

Presenting Problems: (check all that apply)

Very unhappy ____
Irritable ____
Temper Outbursts ____
Withdrawn____
Daydreaming____
Fearful ____
Clumsy ____
Trouble with the law ____
Bed wetting ____
Overactive ____
Slow ____
Short attention span ____
Distractible____
Lacks initiative ____
Undependable____
Peer conflict ____
Phobic____
Running away ____
Self-mutilating____
Head banging ____
Shy____
Rocking____
Strange behavior ____
Strange thoughts ____
Soiled pants ____
Eating problems ____
Sleeping problems ____
Drug use ____
Sickly____
Alcohol use ____
Suicide talk ____

In regards to the presenting problems, please offer a short explanation:

_____

_____

_____

_____

In regards to the presenting problems, how long have they been ongoing (number of weeks, months, years)?

_____

What made you seek help at this time?

_____

Any previous mental health counseling? If yes, please explain:

_____

_____

Problems perceived to be (circle one):

very serious / serious / not serious

What changes would you like to see in you/your child and family?

_____

_____

_____

_____

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Life History Questionnaire: For Child/Adolescent (2 of 6)

Psychological History-Mother

Mother-relationship to child (circle one): natural parent / step-parent / relative / adoptive parent

Occupation:_____Education:_____

Religion:_____Birthplace:_____Birth date:_____

Explain marital history, including number of marriages, divorces and separations:

_____

_____

Psychological History-Father

Father-relationship to child (circle one): natural parent / step-parent / relative / adoptive parent

Occupation:_____Education:_____

Religion:_____Birthplace:_____Birth date:_____

Explain marital history, including number of marriages, divorces and separations:

_____

_____

What is the child's religious upbringing? _____

Is the child adopted? Yes / No If yes, list adoption source:_____

Living Arrangements

Number of moves in child's life (list dates and places): _____

_____

_____

Was the child ever placed, boarded, or lived away from the family? Yes / No If yes, please explain:

_____

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Life History Questionnaire: For Child/Adolescent (3 of 6)

What are the major family stressors at the present time, if any? _____

_____

Brothers and/or Sisters (indicate if step): (indicate if step-brothers and sisters)

Name Age Sex Any Mental Health or substance abuse problems

1._____

2._____

3._____

4._____

5._____

List all extended family members and their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems:

_____

Others living in the home (and their relationship):

_____

Are there any family members with chronic or severe medical problems? If yes, please indicate relative and illness.

_____

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Life History Questionnaire: For Child/Adolescent (4 of 6)

Child Health History

Illness/Diagnosis/Symptom (circle all that apply and list age and details in space provided):

High fevers _____
Pneumonia _____
Flu _____
Dental Problem _____
Weight Problems _____
Allergies _____
Unconsciousness _____
Stomach Problems _____
Concussions _____
Encephalitis _____
Skin Problems _____
Accident Prone _____
Meningitis _____
Asthma _____
Anemia _____
Convulsions _____
Headaches _____
Head Injury _____
Fainting _____
Blood Pressure _____
Dizziness _____
Sinus Problems _____
Tonsils Out _____
Heart Problems _____
Visions Problems _____
Hyperactivity _____
Hearing Prob _____
Ear Aches _____
Other health problems: _____

Has the child ever been hospitalized? Yes / No If yes, at what age and for what reason?

_____

Child's Physician/Pediatrician: _____ Phone: _____

List any allergies: _____

Has the child ever taken, or is he/she presently taking prescribed medications? If yes, please explain.

_____

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Life History Questionnaire: For Child/Adolescent (5 of 6)

Development History

In regards to the child I am seeing, was the pregnancy expected and planned for? Yes / No

In regards to the child I am seeing, was the pregnancy/child wanted/desired? Yes / No

In regards to the child I am seeing, was the pregnancy a normal pregnancy or were there complications?
Normal Pregnancy: Yes / No Complications:_____

Were there complications during the child birth? Yes / No
Complications:_____

Did mother use or abuse alcohol or drugs during pregnancy? Yes / No
If yes, list all substances abused:_____

Newborn Period

In regards to the child I am seeing, please circle any of the below issues the issues the child had as a newborn:

irritability / vomiting / difficulty breathing / difficulty sleeping / convulsions / twitching / colic

Developmental Milestones

Were milestones met at appropriate ages: Yes / No
If no, explain:_____

Early Social Development

What role does the child assume while playing with siblings and peers (circle all that apply):
(the child mainly likes individual play) / (the child participates in group play) / (the child is competitive)
(the child is cooperative during play) / (the child assumes a leadership role) / (the child generally follower)

Describe any special habits, fears, or idiosyncrasies of the child:_____
_____

Educational History

The child attends the following school:_____; the child is in_____grade.

Types of classes the child is enrolled in: mainstream / learning disability / emotionally handicapped

Favorite subject:_____Least favorite subject:_____

Did child skip a grade? Yes / No; If yes, what grade was skipped:_____

Has the child had to repeat a grade? Yes / No; If yes, what grade was repeated:_____

Does child attend school on a regular basis? Yes / No; Does child appear motivated for school? Yes / No

Has the child ever been suspended or expelled? Yes / No; If yes, for what:_____

Any school issues I should be aware of, but not mentioned above:_____

Highest grade on last report card:_____Lowest grade on last report card:_____

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Life History Questionnaire: For Child/Adolescent (6 of 6)

Social/Athletic/Criminal History

Does child participate in extracurricular activities? Yes / No; If no, explain: _____

How many friends does the child have (circle one): a lot / a few / none

What are child's educational aspirations (circle one)
(wants to quit school) / (wants to graduate high school) / (wants to attend college)

List child's special interests, hobbies, skills:_____

_____

Has the child ever been involved with the legal system? Yes / No; If yes, explain:

_____

_____

Has child every used any drugs or alcohol? Yes / No; If yes, please explain types of drugs and whether or not the drug use is ongoing:

_____

_____

Has child ever been employed? Yes / No; If yes, where, how long and why the separation of employment:

_____

_____

_____

Any additional comments I should be aware of that is not expressed in the life history questionnaire:

_____

X_____ X_____

Signature of parent of guardian / Date **Signature of client if age 14 or older / Date**

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