SOUTH MIAMI
PSYCHOLOGY GROUP
HEALTH. HOPE. HEALING.

ADULT INTAKE / HISTORY

Name: _____ Date: _____

Name you preferred to be called: _____

Age: _____ Birthdate: _____ Birthplace: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Name and number of emergency contact: _____

How did you hear about our practice? _____

Briefly state why you are seeking treatment at this time: _____

_____

What are your goals/expectations from this treatment? _____

_____

MEDICAL HISTORY

Primary care physician's name: _____ Phone #: _____

Hospitalizations, serious illnesses and/or injuries (list date (s) and describe): _____

_____

Please list any medications you are currently taking: _____

_____

RELATIONSHIP HISTORY

Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Dating ☐ Widowed

☐ Domestic Partnership/Civil Union ☐ Divorced/Permanently Separated from spouse/partner

☐ Other (Please Explain: _____)

☎ 3056622686
3056312152
www.SouthMiamiPsychologyGroup.com

3081 Salzedo Street, Suite 202
Coral Gables, FL 33134

Name of spouse/significant other: _____

Is this your first marriage: ☐ Yes ☐ No ☐ N/A Years Married/Living together: _____

Briefly describe your relationship with your spouse/significant other: _____

_____

FAMILY HISTORY

Children (if any):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Your Parent's name: _____ Age: _____ Living: ☐ Deceased: ☐

Your Parent's name: _____ Age: _____ Living: ☐ Deceased: ☐

If a parent(s) is/are deceased, how old were you when this occurred? _____

Numbers of years, parents were or have been married: _____

If divorced/separated, how old were you when parents divorced? _____

Siblings (brothers/sisters):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

DEVELOPMENTAL HISTORY

Birth Order: _____ Childhood Health: ☐ Good ☐ Fair ☐ Poor

If poor, explain: _____

If you were born in another country, how old were you when you moved to the U.S.? _____

Academic History: ☐ Excellent ☐ Average ☐ Poor

If poor, explain: _____

Highest level of education (grade/degree): _____

Religion Primarily Raised In: _____

MENTAL HEALTH HISTORY

Have you had previous psychotherapy/counseling? No ☐ Yes ☐

If yes, please list date of last contact: _____

Name of Agency/Therapist: _____

Reason for Treatment: _____

Current or Prior Diagnosis(es): _____

Have you had previous psychiatric treatment? No ☐ Yes ☐

If yes, please list date of last contact: _____

Name of treating physician: _____

Reason for Treatment: _____

Have you taken any psychiatric medications currently or in the past? No ☐ Yes ☐

If yes, please list the dates and what kind: _____

_____

Have you ever had psychological/psychoeducational testing?

No ☐ Yes ☐ If yes, date evaluation: _____

Name of Agency or Psychologist: _____

For what reasons: _____

Briefly describe results from testing including diagnoses or significant findings: _____

_____

Have you ever been hospitalized for mental health reasons? No ☐ Yes ☐

If yes, please list dates and place: _____

_____

History of any suicidal thoughts or threats: No ☐ Yes ☐

If yes, list dates: _____

Suicidal gestures or attempts: No ☐ Yes ☐

If yes, please list dates and explain: _____

_____

History of physical abuse or assault: No ☐ Yes ☐

If yes, please list dates: _____

History of sexual abuse or assault: No ☐ Yes ☐

If yes, please list dates: _____

_____

History of arrest: No ☐ Yes ☐

If yes, please explain: _____

History of incarceration: No ☐ Yes ☐

If yes, please explain: _____

_____

Have you ever received treatment for alcohol and/or drug use? No ☐ Yes ☐

If yes, please list dates and type of treatment: _____

If alcohol or drug use is current, list frequency per week: _____

MEDICAL HISTORY

Please check all the conditions that have been diagnosed as a child or adult:

☐	AIDS, ARC, HIV	☐	Hazardous substance exposure
☐	Allergies	☐	Headaches
☐	Alzheimer's Disease	☐	Heart Disease
☐	Arthritis	☐	Huntington's disease
☐	Asthma	☐	Hypertension
☐	Brain Disease/Infection	☐	Loss of Consciousness
☐	Cancer	☐	Lupus
☐	Carbon monoxide poisoning	☐	Meningitis
☐	Cerebral palsy	☐	Multiple Sclerosis
☐	Chronic Fatigue Syndrome	☐	Parkinson's Disease
☐	Concussion	☐	Stroke/TIA
☐	Dementia	☐	Thyroid Disease
☐	Diabetes	☐	Traumatic Brain Injury
☐	Encephalitis	☐	Tumor
☐	Epilepsy/seizures	☐	Other medical condition
☐	Fibromyalgia		

Do you smoke? No ☐ Yes ☐ If yes, how much? _____

Have you quit smoking? No ☐ Yes ☐ If yes, when did you stop? _____

_____

EMPLOYMENT HISTORY

Occupation: _____ Present Employer: _____

Position: _____ Length of employment: _____

Work Responsibilities: _____

Are you unable to work due to injury/illness? No ☐ Yes ☐

If yes, date last worked: _____

Please explain injury/illness: _____

_____

_____

Please rate the amount of stress you are currently experiencing:

SOUTH MIAMI PSYCHOLOGY GROUP HEALTH. HOPE. HEALING.	Little or None			In the Middle			Extreme	
At Home	1	2	3	4	5	6	7	N/A
At Work	1	2	3	4	5	6	7	N/A
With Family	1	2	3	4	5	6	7	N/A
With Friends	1	2	3	4	5	6	7	N/A
In General	1	2	3	4	5	6	7	N/A

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CONSENT FOR TREATMENT-ADULT

I give my consent to receive psychological services for me and/or my dependent at the office of **South Miami Psychology Group**.

The nature of those services has been explained to me. I understand that all information, including verbal communications and written material, is treated with confidentiality.

Confidential information will not be released to anyone without the written permission of the client.

As provided by law, confidentiality may be breached for protective purposes when the client is imminently a danger to her/himself, to others, or in cases of suspected child abuse or neglect.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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FINANCIAL POLICY

PLEASE READ CAREFULLY

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____/_____/_____

PARENT/GUARDIAN'S NAME (IF PATIENT IS A CHILD)**:** _____

Please write your initials next to each line, indicating that you've read and understood each policy.

_____ **Patient Financial Policies**

Self-Pay Patients and/or Out-of-Network Patients:

- It is your responsibility to provide payment prior to entering your session.

In-Network Insurance Patients:

- We bill the insurance carrier for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles, are due prior to your appointments. Additionally, if you receive any insurance payments directly from your insurance carrier for services performed, you are responsible to pay such payments to *South Miami Psychology Group*. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

_____ **Signatures on File and Assignment of Benefits Agreement**

- Patient authorizes the release of any medical information necessary to process their insurance claim.

_____ **Methods of Payment Currently Accepted**

- Cash; Credit / Debit Cards; Personal Checks (A $25 Not Sufficient Funds (NSF) charge will apply for returned checks).

AT THE PATIENT'S DISCRETION, A CREDIT/DEBIT CARD MAY BE LEFT ON FILE TO BE CHARGED AFTER EACH APPOINTMENT. IF YOU CHOOSE TO DO SO, PLEASE COMPLETE THE FOLLOWING INFORMATION.

*****WE ACCEPT VISA, MASTER CARD, DISCOVER & AMERICAN EXPRESS*****

CARD HOLDER'S NAME (*AS PRINTED ON CARD*) _____

CARD NUMBER _____

EXPIRATION DATE (*MM/YYYY*) _____

BILLING ADDRESS _____ **ZIP CODE** _____
(ASSOCIATED WITH THE CARD)

*I authorize **South Miami Psychology Group** to charge my credit card for the amount owed after each psychotherapy / testing session.*

CARDHOLDER'S SIGNATURE: _____ **DATE:** _____

_____ Cancellation Policy:

- Because my time has been reserved exclusively for me and/or my family members, I understand that I am required to provide **at least 24 hours** advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment. **There is a $75.00 cancellation fee per appointment reserved regardless of insurance.** If you have a credit card on file, the credit card will be charged for your cancellation fee unless otherwise specified. Exceptions may be considered for emergency situations.

Additional Fees For Services That Are Not Covered By Insurances

Upon prior discussion and agreement, I understand that charges will be added to account for additional services rendered **not** billable to insurance carriers such as:

- Telephone contacts exceeding 15 minutes.
- Preparation of letters or reports.
- Preparation and review of medical records.
- Court time (portal to portal) including preparation, travel, and wait time.
- Additional meetings with other family members and/or professionals.
- Scoring of material, interpretation and report writing.
- Excessive email correspondence.

If not paid according to the above terms, the patient understands that our office may report to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of the debt.

I have read, understood, and agreed to the above financial policy for payment of professional fees.

SIGNATURE: _____ **DATE:** _____

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HIPAA Privacy Notice and New Patient Consent to the Use and Disclosure of Health Information

At ***South Miami Psychology Group***, we are committed to treating and using health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights are they relate to your Protected Health Information. This notice became effective June 1, 2005, and applies to all Protected Health Information as defined by Federal Regulations. Each time you visit ***South Miami Psychology Group***, a record of your visit is made. This medical record typically contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information serves as:

- Basis for planning care and treatment.
- Means of communicating among the many health professionals who contribute to your care.
- Legal document describing the care you receive.
- Means by which you or a third party payer (ie., insurance) can verify that services billed were actually provided.
- Source of information for public health officials charged with improving the health of the state and the Nation, as required by law (ie., reporting child abuse and neglect or reporting domestic violence).
- Basis for disclosing your child's health information to a law enforcement official, for purposes such as identifying or locating an individual, in complying with a court order or subpoena, etc.
- Source for public safety. We may disclose your child's health information to appropriate persons in order to prevent or lessen a serious threat to health or safety of a particular person, or the general public.
- Tool in educating health professionals, source of data for medical research, and tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Although your health record is the physical property of ***South Miami Psychology Group***, the information belongs to you. You have the right to:

- Review the Consent before signing it.
- Object to the use of your health information for directory purposes.
- Request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or health care operations.
- Request a restriction on certain uses and disclosures of your information, as provided by 45 CFR 164.522.

South Miami Psychology Group is required to:

- Maintain the privacy of your health information.
- Provide you with a copy of this Notice as to your legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if we are unable to agree to a request restriction.
- Accommodate reasonable requests you may have to communicate health information by alternate means or at alternative locations.

We reserve the right to change our practice and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice, provided those changes affect your health information, to you at the address you have supplied us, or if agreed, via email. We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization, according to the procedures included in the Authorization.

I, _____ ***(print name of patient)*** understand the content of this Notice. Further, I permit a copy of this acknowledgement to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefit apply. I understand that as a part of ***South Miami Psychology Group***'s treatment, payment, or healthcare operations, it might become necessary to disclose my protected health information to another entity (ie., insurance, emergency, etc…) and I consent to such disclosures for these permitted uses, including via fax and e-mail only to appropriate parties.

I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice.

Name of patient: _____ **Date:** _____

Patient Signature: _____

If refused, reason for refusal: _____

Restrictions noted: _____

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