Beach Counseling & Psychological Services
Joel G. Prather, Psy.D., P.A.
Cara E. Wheeler, Psy.D Brooke McMaken, LMHC Cassie Allen, LCSW
Melissa Smith, LCSW Erin Keip-Strausbaugh, LMHC
12133 Panama City Beach Pkwy | Panama City Beach, FL 32407

Child/Adolescent Intake Form

Patient's Name:_____ Age:_____ DOB:_____

Siblings:_____ Age:_____
Siblings:_____ Age:_____
Siblings:_____ Age:_____
Siblings:_____ Age:_____

Guardian's Name: _____ Relationship:_____

Address (City, State, and Zip):_____

Guardian's Marital Status:_____ Male/Female:_____

Best Contact Number:_____ Is voicemail okay at this number? Y / N

Emergency Contact (name and phone):_____

For parents who are divorced, please describe custody arrangements:_____

_____

History of Problem

Please describe what concerns you have regarding your child/adolescent:_____

_____

_____

How long has the problem existed?_____

_____

Have there been any significant stressors in your family: losses, births, moves, trauma, divorce, or hospitalizations in the last several years? _____

_____

What symptoms are currently concerning to you? (please circle):

Sadness Depression Self-Harm Sleeping Problems Changes in Appetite

Difficulty with Concentration Anxiety Aggression Social Isolation Bed Wetting

Intense Fears Stomach Aches Headaches Academic Difficulty Defiance to Authority

Hyperactivity Impulsivity Changes in Weight

Developmental History:

Was your child born full term?_____

Was your child healthy at birth?_____

Was your child able to reach their developmental milestones at a normal rate (speaking, walking, potty training?_____

_____

Academic History:

What grade is your child /adolescent currently attending? _____

What school do they attend?_____

Has your child/adolescent ever had to repeat a grade level?_____

Does your child have an Individualized Educational Plan (IEP) at school? _____

_____

Has your child ever been suspended from school?_____

_____

Mental Health History:

Has your child/adolescent ever received any type of mental health treatment? If so, who was the provider and what services were rendered?_____

_____

Is there any family history of mental health distress? _____

_____

Please use the back of this form to tell us anything else you would like for us to know before we meet your child:

Beach Counseling & Psychological Services
Joel G. Prather, Psy.D., P.A.
Client Registration

Client's Full Name: _____
Date of Birth: _____/_____/_____ Client Social Security Number _____
Mailing Address: _____City: _____State: _____Zip: _____
Marital/Legal Status: S DP M W D Employer / School: _____ E-mail address: _____
Phones: Home: _____ Work: _____ Cell: _____

As a courtesy to you and in order to serve you better, our staff will contact you to remind you of your appointment date and time. Please only provide phone numbers you permit us to leave voicemail on.

Parent/Emergency Contact Name: _____ Phone(s): _____
Relationship: _____ Emergency Contact Address: _____

Primary Medical Ins. Co: _____Ins. Phone No. (back of card): _____
Ins. I.D. Number _____ Group Number _____
Insurance Primary Member Name: _____ Employer: _____
Subscriber D.O.B. (required): _____ Subscriber Social Security (required): _____
Subscriber Address on File w/ Ins. Co: _____
Does your insurance require pre-authorization for your visit today? (Circle One) Yes No

Please note the patient is responsible for filing claims with anything other than their primary insurance. As a courtesy we may verify whether your secondary insurance requires authorization, and make an attempt to obtain this.

If you have secondary insurance, please discuss this with our staff upon scheduling.

Medicare Beneficiaries: Are you on Medicare or a Medicare Supplement? We are not providers for Medicare and do not take Medicare supplements. If your claim is denied because of your affiliation with Medicare, you will be personally responsible for the charges. The patient with the Medicare policy will be responsible for cost in full and should notify this office of that policy, as they should request of this office a Medicare Opt-Out Form.

Missed appointments will be billed to the client, since insurance coverage does not cover missed appointments. There is a **$75 missed appointment fee, which is also applicable to cancellation made with less than 24 business hours' notice** to our office, at our discretion. Please understand that we are hold this time specifically for you.

Assignment & Release: I, the undersigned, certify that I, or my dependent, have insurance coverage with _____ and assign directly to the psychotherapist Joel G. Prather, Psy.D, PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the psychotherapist to release all information necessary to secure the payment of benefits, and I authorize the use of this signature on all insurance submissions.

X _____ _____

Signature of Client or Personal Representative Responsible for Payment Date

I certify that the information on this sheet is correct and hereby authorize Joel G. Prather, Psy.D., P.A. to provide therapy or other services deemed necessary for the client above.

Beach Counseling & Psychological Services
Joel G. Prather, Psy.D., P.A.
Credit Card on File

REQUIRED

MUST sign and acknowledge:

There are situations in which **your insurance company may bill us back your visit**. If that is the case, YOU ARE RESPONSIBLE FOR THAT PAYMENT. In order for us to provide adequate and uninterrupted service to you, **you MUST have a credit card on file**. If the insurance company charges back your claim for any reason, YOUR CARD WILL BE CHARGED the remainder of the fee for your visit. Please understand that the insurance may take 90 days or more to bill back your claim. **If we are charged back, WE WILL CHARGE YOUR CARD without prior notice.**

If balances delinquent more than 60 days are not paid, the balance will be charged in full to this credit card. This is an alternative to sending delinquent accounts to collections. All returned checks will be immediately charged to the credit card, plus a $25.00 returned check fee. Missed and late cancellation charges will be charged immediately. Please provide your credit card information below for our record:

Please Circle Credit Card Type: MasterCard / Visa (We do not accept Discover or American Express)

Credit Card Number: _____-_____-_____-_____ Exp. Date: _____

Name on Card: _____
Billing Address (include zip): _____ Sec. Code (3 digits): _____
***Cardholder acknowledges contact with vendor and agrees to authorize payments for any unpaid balances as explained above. ***

X _____ _____

Signature of Client or Personal Representative Responsible for Payment Date

Beach Counseling & Psychological Services
Joel G. Prather, Psy.D., P.A.
Additional (Correspondence) Fees

REQUIRED

There will be **additional fees for services not reimbursed by your insurance**. Such services may be included, but not limited to: **letters to third parties, referral services out of the normal services offered**, and other special requests.

These **services will be billed at the rate of $100 per hour, prorated, $25 minimum per service**. These rates are subject to change without notice.

X _____ _____

Signature of Client or Personal Representative Responsible for Payment Date

Beach Counseling & Psychological Services
Joel G. Prather, Psy.D., P.A.
Policies & Procedures
Client-Therapist Agreement

REQUIRED

Initials, Review, and Signature are Required, Please.

☐ **Sessions**: All sessions are by appointment only. Due to the nature of a full week's schedule, it is best to secure your appointments one to two weeks ahead to ensure a suitable time. We highly recommend recurring appointments and plans to return weekly for six to eight weeks as part of your therapy program. The office will make all attempts to secure last-minute appointments, but when non-emergent these may not be available. In order to be fair to all patients, appointments are secured on a first-come, first-serve basis. According to insurance reimbursement, each individual, couple or family session is forty-five (45) or sixty (60) minutes, followed by session documentation and other procedures. Every effort will be made to schedule a regular weekly time that you can plan into your schedule, and to start each session on time. Due to ethical standards and equality for each patient in regards to schedule appointment times it is important to make every effort to adhere to your appointment time and recognize that concerns brought up at your appointment's end should be explored at your next session.

☐ **Cancellation/Missed Appointments**: Your appointment time is reserved specifically for you. If you are unable to keep an appointment, please give at least 24 hours' notice. Without adequate notification, $75 will be charged for all missed appointments. Credit card kept on file will be billed for no show/no call and less than 24 hour appointment cancellations. Illness or sudden emergency will be taken into consideration. Continuous cancellations or missed appointments will result in termination of services and/or referral to other mental health professional in the community. If you are late your time will end at the regularly scheduled time and your session will be shortened.

☐ **Fees & Alternative Billing**: Individuals who do not have insurance and cannot afford to pay the customary self-pay rate may qualify for a discounted rate based on income and ability to pay. A discounted rate is available but requires proof of income as at or below current poverty level.

☐ **Payments**: All fees and co-pays must be paid at the time of services via cash (exact or near-exact cash should be paid; this office keeps minimal cash for change on the premises), cashier's check, or credit card. Checks are acceptable if no other form of payment is available. If checks are returned there is a fee.

☐ **Confidentiality**: I am legally, ethically, and morally required to keep all information strictly confidential. As confidentiality is necessary to facilitate the therapeutic process, it is important that you understand the following legal exceptions to confidentiality: (1) If you disclose that you intend to harm yourself, someone else, or damage property, I must take steps to prevent you from harming yourself and/or inform the intended victim of the possible danger. (2) Reporting any reasonable suspicion of child abuse is required by Florida State Law, FS 415.504, to the Florida Abuse Hotline at 1-800-96-ABUSE. (3) If you utilize third party payments, information you have authorized to be available can be released by the use of a Release of Information form. (4) Clients must sign a Release of Information Form for the therapist to release or receive information, records, or other information from others regarding your case.

☐ **Emergencies and After Hours**: In case of emergency if patient is unable to reach the office, regardless of time of day, the patient should dial "911" on their telephone or call Emerald Coast Behavioral Hospital at: (850) 763-0017 and/or visit the facility at: **1940 Harrison Avenue, Panama City, FL 32405**. If the patient does admit themselves to Emerald Coast Behavioral Hospital, a Release of Information with your clinician's name is requested to be put on file with the facility in order to allow proper managed care and communications. All efforts will be made to schedule the patient within twenty-four business hours for urgent but non-emergent issues. If there is an emergent issue during hours of operation the patient will either be scheduled to attend session that same day with your provider, or scheduled a phone appointment with them IF an available appointment does exist.

I certify that I have reviewed and agreed to the above:

X _____ _____

Signature of Client or Personal Representative Responsible for Payment Date

Beach Counseling & Psychological Services
Joel G. Prather, Psy.D., P.A.
Release of Information

OPTIONAL (Required for Communication with Physician, Attorney, School, or Family Member for Patients Over the Age of 18.)

<u>SEND / REQUEST</u> RECORDS (Circle One or Discuss with your Clinician)

Client's Name _____Date of Birth: _____

Between: Beach Counseling & Psychological Services and

_____
(Agency, physician, other (list)

Phone, Fax, and Mailing Address of this Agency: _____

Nature of information to be released (Please mark or initial):

_____ YES _____ NO Verbal IN ORDER TO DISCUSS DIAGNOSTICS, TREATMENT MODALITIES, ETC WITH ANY PARTY YOU PERMIT ABOVE-PHYSICIAN, ATTORNEY, FAMILY MEMBER

_____ YES _____ NO To obtain reports from releasing agency so the therapist can use this information for diagnosis and treatment.

_____ YES _____ NO To allow therapist to send reports to the above named agency. REQUIRED IN ORDER TO RELEASE RECORDS TO YOUR PHYSICIAN.

_____ YES _____ NO Other:_____ IF ADDITIONAL DETAILS/LIMITATIONS OF PERMISSION ARE REQUESTED, PLEASE DESCRIBE HERE

I hereby consent to the use or disclosure of my protected health information as specified above. I understand that this consent is voluntary and I may refuse to sign it. I understand that I may revoke this consent at any time by giving written communication to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the consent prior to the revocation. Other limitations on my right to revoke this consent may be found in my provider's Notice of Privacy Practices. I understand that if the recipient is not a health care provider or a health plan, the information disclosed under this consent may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this consent, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this consent, except: (1) if the consent is the very reason for seeking health care (e.g., a pre-employment physical), that the health care may be denied, or (2) if the consent is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur: (1) if the consent is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it, and (2) if the consent is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage that I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to consent to disclosure of certain psychotherapy notes.

Expiration:

Unless sooner revoked by me, this authorization expires:

_____ YES _____ NO ONE (1) YEAR AFTER MY FINAL THERAPY SESSION WITH THE ABOVE NAMED THERAPIST.

_____ Other Time Limitation (Please specify) _____

_____ _____

Client Signature & Date Witness Signature & Date