

Susan Corbett, LCSW, BCD

4067A South Tamiami Trail, Sarasota, FL 34231 (941) 926-8080 FAX: (888) 664-2547

INFORMATION SHEET

(Please PRINT all information)

Date: _____ Home Tel. _____ Work Tel. _____ E-mail _____

Name: (Print) _____ Social Sec. # _____

Insurance Company ID #: _____

Address: _____ City/State/Zip _____

Date of Birth _____ Age _____ Sex: _____ Marital Status: S ___ M ___ D ___ Partner _____

Occupation: _____ Employer (Print) _____

Insurance Information

EAP Name: _____ **Telephone** _____

Insurance Co. Name: _____ **Telephone** _____

Claims Address _____

City: _____ State: _____ Zip _____

Account # _____ Group # _____

Authorization Number _____ Co-Pay Amt. _____

Insured Name (*if different*) _____ Relation to patient _____

Insurance Co. Name: _____ **Telephone** _____

Claims Address _____

City: _____ State: _____ Zip _____

Account # _____ Group # _____

Authorization Number _____ Co-Pay Amt. _____

Employer _____

Home Address: _____ City/State Zip _____

Soc. Sec.# _____

Date of Birth : _____ Age: _____ Sex : _____ Telephone: _____

ASSIGNMENT AND DISCLOSURE

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits payable to provider indicated on the claim. **I understand that I am financially responsible for any balance not covered by my insurance carrier. Co-Pays are due at time of service.** A copy of my signature is as valid as the original.

CANCELLATION: We set aside a specific time for you. If you should cancel, every effort will be made to re-schedule during that same calendar week. *Otherwise, the full fee will be charged.*

If you wish further information about your legal privacy rights, you may receive a written copy of your privacy rights, upon request. The privacy rights are also posted in the waiting room.

Signature of Insured

Date

Last Name _____

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Briefly describe your reason for contacting me now: _____

_____ How long has this been a problem? _____

Has this affected your: (Mark with X all that apply):

MOOD: ANXIETY___ SADNESS___ ABILITY TO CONTROL ANGER___ CONCENTRATION___

MARRIAGE/PARTNER/FAMILY___ CHILD REARING___ EATING/SLEEPING HABITS ___

JOB/SCHOOL/PERFORMANCE___ FINANCIAL SITUATION___ LEGAL SITUATION___

Have you had prior therapy? _____ Reason_____ How long? _____

Any Current Drug/Alcohol use? _____ If so, do you feel it might be a problem?_____

If you have children, what are their names and ages? _____

We are legally required to ask you the following:

Do you ever feel like hurting yourself, have suicidal impulses, or feel like causing physical harm to others? _____

Current **medical** problems: _____

What medications, if any, are you taking? _____

What do you hope to accomplish here? _____

Confidentiality - All communication between patient and therapist is **confidential**.

Patient however may complete a Medical Release in writing and reason for request.

This directs and allows therapist to share information with specifically identified Third Party or Parties.

Patient shall provide Therapist with third party contact information. Third party could be the Patient's spouse or other family members, lawyer(s), Physician(s), or other health professionals, guardians and other person(s) specifically identified by Patient. Patient allows Third party to receive Date(s) of Service, Diagnosis, Treatment Summary, and/or Treatment Recommendations

Patient agrees that in no circumstance will therapist be required to testify in a court of law, nor act as an expert witness, nor will therapist be deposed. Therapist notes on Patient are privileged and are only admissible in Court via a specific Court Order. Patient also agrees that if his/her situation becomes litigious, therapist will continue treatment with the understanding that in no circumstance will therapist be involved in any way with such litigation or pre-litigation.

Patient agrees to pay therapist out of pocket a reasonable per hour rate for therapist to review records and complete requested documentation. In addition, Patient understands that these charges are NOT reimbursable by insurance companies.

I understand and consent to the above declarations:

Signature of Patient

Date