Meridian Counseling Center

38052 Meridian Avenue/ PO Box 2398, Dade City, FL 33526
Phone (352) 518-5232 / Fax (352) 518-9458

Client's Name: ______________________________ Date of Birth: _____/_____/_____ Today's Date________________________

Address: ___________________________________City: _________________________ State: _______ Zip Code: _____________

Phone Number:_________________ Place of Employment:______________________ Occupation: _________________________

Spouse, Partner, or Parent's Name: _______________________________ Occupation___________________________________

Relationship Status: ○ Single ○ Partnered ○ Married ○Separated ○ Divorced ○ Widowed

If you are Partnered or Married, how long have you been in the relationship? ___________________________________

If you are married; this is your ○1st ○2nd ○3rd or more and your spouse's _○1st ○2nd ○3rd or more marriage

Please list those persons in your home

Name	Age	Relationship to You

Please list siblings/children living outside home:

Have you ever been diagnosed with a mental disorder? ○ Yes ○No Doctor's name:_____________________________________

If yes what was the diagnosis? ____

Have you been hospitalized for psychiatric problems? ○ Yes ○ No. If yes; how many times? ________________________________

When was the last time? ____________________________ Where? ____

Have you attempted suicide in the past? ○ Yes ○ No. If yes; when was the last time? ______________________________________

Do you physically hurt yourself? ○ Yes ○ No. If yes; when was the last time? ____

Do you have thoughts of seriously harming yourself or others now? ○ Yes ○ No

What level of education have you completed? _________ grade ○ GED ○ High School ○College ○ Post Graduate

Referral Source: Please indicate how you heard of Meridian Counseling Center.

○Insurance Company (only if referral source)________________________________ ○ Newspaper/Phone Book ○Brochure

○Clergy/Friend (name)______________________________________ ○ Agency/Organization ○ EAP ○ Internet/Website

○ Physician/Psychiatrist: Dr.___________________________________

List Medications, Supplements, Vitamins, and purpose for taking them: If you have a printed list we can make a copy of it.

Medication	Dose	Reason for Prescription	Prescribing MD

Supplements	Dose	Reason for Taking	Source

Allergies: ____

Reason for visit: ____

Client's Name: ____

Please circle any that apply to you

Sadness	Irritable	Hopeless	Loss of interest
Loss of appetite	Overeating	Suicidal thoughts	Worry
Unable to relax	Overwhelmed	Panic	Nightmares
Cannot get to sleep	Frequent waking	Drug abuse	Cannot return to sleep
Alcohol abuse	Feel inferior	Shyness	Jealousy
Temper problem	Feel used	Feel pushed around	Guilt/Shame
Confusion	Failing at work	Difficulty with spouse	Difficulty with parents
Difficulty with children	Difficulty with coworkers	Failing in school	Trouble concentrating
Distracted	Slow thoughts/speech	Rapid thoughts/speech	Stomach aches
Fatigue	Muscle tension	Trembling	Nausea
Chronic pain	Chronic disease	Sexual performance	Sexual deviance
Forced vomiting	Erratic behavior	Impulsive behavior	Obsessive thoughts
Hear voices	Hallucinations	Grief	Headaches
	Memory loss	Lonely	

Other:____

____

Client's Name: ____ Date of Birth: _____/_____/_____

PLEASE CHECK PLACES IN WHICH YOU MAY BE REACHED BY PHONE. Include phone numbers and how you would like us to identify ourselves when phoning you.

___ HOME	________________	____	___ Yes ___ No
	Phone number	How should we identify ourselves?	May we say the clinic name?
___ WORK	________________	____	___ Yes ___ No
	Phone number	How should we identify ourselves?	May we say the clinic name?
___ CELL	________________	____	___ Yes ___ No
	Phone number	How should we identify ourselves?	May we say the clinic name?

EMAIL ADDRESS ____

(only used for necessary communication)

Parental Status of a Minor Child

If you are bringing a minor child for counseling; what is your parental status? ○ Sole Custody ○ Joint Custody ○ Other

May the minor child's other parent/ legal guardian access records? ○ Yes ○ No

Name of person(s) that may access records: ____

Record requests must be made in person and with appropriate identification.

EMERGENCY CONTACT: Name: ____

Relationship to Client: ____

(_____)_________________ ____ ___ Yes ___ No

Phone number How should we identify ourselves? May we say the clinic name?

Primary Insurance Company: ____

Primary Policy Holder's Name: ____

Policy Holder's DOB: _____/_____/_____

Client is Primary Insured's: ○ Self ○ Husband ○ Wife ○ Child ○ Parent ○ Other

Employer Insurance Plan: ○ Yes ○ No

ONLY IF YOU HAVE A SECOND INSURANCE WILL YOU FILL THIS SECTION OUT.

Secondary Insurance Company: ______________________________Phone: _____________________________________

ID Number: ______________________________________ Group Name or #: ___________________________________

Policy Holder's Name: ____Policy Holder's DOB: _____/_____/_____

Policy Holder's Address: ____

Relationship to Guarantor: ○ Self ○ Husband ○ Wife ○ Child ○ Parent ○ Other

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Consent for Treatment

I hereby give my consent for Emily Gilbert, LCSW/Trauma Treatment of Pasco, PLLC/DBA/ Meridian Counseling Center at Your Family Walk-in Clinic to provide Traditional Cognitive Behavioral Therapies and/or Counseling as needed for **non-emergency** therapeutic intervention appropriate to the designated client(s).Every client is treated with the highest standard of ethical and professional treatment typical to effective therapies. Although there is an expectation of benefit, there are no guarantees. Outcomes are dependent on my cooperation, effort, and my ability to incorporate change into my life. I have the right to terminate the therapeutic relationship at any time that I desire without fault, and with the understanding that I am responsible for payment of all outstanding charges. I understand my records may be released to current or future doctors or therapists in this practice.

Financial Agreement

I agree to participate in services provided at Meridian Counseling Center. Although I am not bound to complete services, in good faith, I agree to participate in sessions and keep scheduled appointments. I am aware that although exact time may vary, most sessions will be approximately 55 minutes and the fee per session is $180.00. I understand that payment is due upon services rendered. **Where insurance is applicable, co-payment must be made at the time of service rendered** and designated insurance company will be billed through Meridian Counseling Center.

Appointment Agreement

We understand your time is valuable, and therefore make it a priority to inform you of any changes in your appointment time with Emily Gilbert, LCSW/Trauma Treatment of Pasco, PLLC/DBA/Meridian Counseling Center. In the same respect we would like for you to be aware that when you schedule an appointment that time is reserved solely for you. Because of this we ask that you extend the same courtesy to us that we extend to you by giving ***at least 24 business hours' notice of any appointment that you will not be able to attend*****.** Please understand that by canceling your appointment with sufficient notice you make it possible for us to efficiently meet the needs of other clients. Also, be aware that a fee is charged for late cancellations and for failure to show up for your appointment, and that these fees are **your responsibility** not your insurance company's. **We send appointment reminders as a courtesy, they are NOT a requirement. You will be charged accordingly if you forget your appointment**. Fees are as follows: **$100 for a late cancellation and $150 for a no-show**. While you have the right to terminate your therapeutic relationship at any time without fault, you remain responsible for any outstanding balance you should have with Meridian Counseling Center. By signing below you are agreeing that you have read and understand the above contract guidelines. If you have any questions, please ask before signing the agreement to ensure there are no miscommunications.

Insurance Agreement

I hereby give consent to Emily Gilbert, LCSW/Trauma Treatment oF Pasco, PLLC/DBA/Meridian Counseling Center located at Your Family Walk-in Clinic to provide whatever treatment deemed necessary to the above patient. **I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy** and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all court costs, attorney's fees, and a collection expense of no more than 30% of the referred balance. I hereby request payment of authorized insurance benefits for me to be paid directly to Meridian Counseling Center for any services furnished me by Emily Gilbert, LCSW located at Meridian Counseling Center. I authorize Emily Gilbert, LCSW and Meridian Counseling Center to release to my insurance carrier and its agents any information concerning health care, advice, treatment, or supplies provided to me, needed to determine these benefits payable for related services. I understand this is a lifetime authorization. I agree to pay copay fees at time of service.

Limits of Confidentiality

I have received a copy of the LIMITS OF CONFIDENTIALITY; I agree to the limits of confidentiality and understand their meanings and ramifications.

____ ______________________________________
Signature of Responsible Party Date

____
Print Name

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Limits of Confidentiality

The contents of counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases where the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the client's family.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a healthcare professional must be reported by other healthcare professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release clients' records when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.

Insurance companies and other third-party payers are given information that they request regarding services to clients. The information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. This information includes (a) testing results, (b) information given to the mental health professional not in the presence of the other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.