the Coastal Center

Last Name:_____

Patient Information – Please Complete All Pages

Last Name:_____ First:_____ MI:_____

Age:_____ Date of Birth:_____ Gender: ___ Male ___ Female

Street Address:_____

City:_____ State:_____ Zip Code:_____

OK to send mail?___ Yes ___ No If not, please provide alternate address:

_____

Email Address:_____

Home:_____ OK to leave a message? ___ Yes ___ No

Cell:_____ OK to leave a voice/ text msg? ___ Yes ___ No

Work:_____ OK to leave a message? ___ Yes ___ No

Referral Source (how you heard about us):_____

Emergency Contact Information

Emergency contact name:_____

Relationship to you:_____

Address:_____

Phone:_____ Cell/Work Phone:_____

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Medical History

Please answer the following questions using:

1 – Failing 2 – Poor 3 – Average 4 – Good 5 – Excellent

How would you rate your physical health: ____

How would you rate your mental health: ____

Please list your current symptoms (reason you are here) and circle those you find most bothersome

_____

_____

_____

Are you currently under the care of a doctor or other medical professional?

___ Yes ___ No

Primary Care Physician Name: _____

Primary Care Physician Phone Number: _____

Specialist Physician Name:_____

Specialist Phone Number: _____

Please list any prescription medications you are currently taking:

_____

Please list any over the counter medications, including vitamins or herbal supplements you are currently taking:

_____

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Have you ever thought of hurting yourself or others? ___Yes ___No

Have you ever made a plan to hurt yourself or others? ___Yes ___No

Have you ever purposefully hurt yourself or others? ___Yes ___No

Relationship Information

Are you currently in a relationship? ___ Yes ___ No

If yes, please list status:_____

Name of Person:_____

Length of time you have known each other: _____

Length of time you have been together: _____

Do you currently live together? ___ Yes ___ No

Number of marriages: _____ Number of divorces: _____

If widowed age at death of spouse:_____ Do you have children? ___Yes ___No

If yes please list:

_____

Education Information

Number of years of education completed:_____

Degree(s) achieved (check all that apply):

___ High School ___ Associates Degree ___ Bachelor's Degree

___ Masters Degree ___ Doctorate Degree ___ Other:_____

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Employment Information

Are you currently employed? ___ Yes ___ No

If yes, please list position title, employer, type of work and length of employment:

_____

_____

_____

If you are not currently working, how long have you been unemployed?

_____

What type of jobs have you typically held:

_____

_____

Legal Information

Are you currently involved in divorce or child custody proceedings? ___ Yes ___ No

If yes, please explain:

_____

_____

_____

the Coastal Center

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Client Agreement

Confidentiality

Everything that you discuss with our staff at The Coastal Center will be kept confidential. Exceptions include, but are not limited to, situations that 1) you are in danger of harming yourself or someone else, 2) you report abuse or neglect of a child, elder or disabled person in your care, 3) if we are asked to appear in court on your behalf or on behalf of another party, or if your records are subpoenaed for legal purposes, 4) if you give us written permission to share information with a family member, another therapist or a physician on your behalf. We utilize consultations when needed.

Scheduling and Fees

Sessions for families will be scheduled for 50-60 minutes and individual sessions will be 40-50 minutes. If you are unable to arrive on time, we will end at the scheduled time. Twenty-four-hour notice of cancellation is expected to avoid a charge for your scheduled session. Insurance companies cannot be billed for cancellations.

Initial evaluation: $125 per intake
Individual and Family Therapy: $120 per session
Documentation Fees for letters and reports: $80 per hour
Other Services Including Phone Calls, Letters, Reports and Collateral Work: $80 per hour

Insurance Benefits

If we have a contract with your health insurance provider, we will bill them and accept payment according to that contract. If we do not have an agreement with your insurer, you must pay at the time of your visit and seek reimbursement from your insurer. We will help you to keep track of how many sessions you have used. In all cases you are ultimately responsible for knowing this information and paying for services. Please bring your insurance card to your first appointment so we can make a copy of it.

Name of Subscriber:_____ DOB:_____
Address (if different):_____

Insurance Company: _____

Emergency Coverage

Although we do our best to respond promptly, we are not always immediately available in emergencies. In such an instance, it is your responsibility to seek appropriate attention at a local emergency room.

Agreement

I have read the above and agree to participate in treatment with these policies.

Signature:_____ Date:_____

the Coastal Center

Last Name:_____

HIPPA Authorization for Use or Disclosure of Health Information

Patient Name:_____ DOB:_____/_____/_____

Cell Phone:_____ Home Phone:_____

I authorize the Coastal Center to leave messages with medical information on:

___ My cell phone ___ My home phone (check one or both)

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office. My revocation will be effective once received by (The Coastal Center for Developing Minds).
2. The information provided under the release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules.
3. My authorized representative will be required to provide legal documents to prove their authority to sign on my behalf and may be required to provide proof of identity.
4. A copy of this authorization may be used with the same effectiveness as the original.

This authorization shall supersede any prior written authorization I have made regarding the use, release and disclosure of my medical information. This authorization will expire 2 years from the date it is signed.

Patient or Guardian Signature:_____ Date:_____

Name:_____ Relationship:_____