Joel I. Kimmel, Ph.D., P.A. & Associates

• Clinical Psychology • Marriage and Family Counseling • Corporate Psychology

5551 N. University Drive, Suite 102
Coral Springs, Florida 33067
Tel: [954] 755-2885
Fax: [954] 344-6007
www.KimmelPsychology.com

INTAKE AND HISTORY FORM

(Confidential Information)

Patient's Name _____Birth Date _____

Responsible Party (if patient is a minor) _____

Insured's Name (if other than patient) _____

SS# of insured: _____Insured's Birth Date: _____

Street Address _____

City, State, Zip _____

Phone: Home ( ) _____Work ( ) _____Cell ( ) _____

May we text you a reminder of your appointment? _____ Yes _____ No
(Note: Phone company charges may apply for texting).

Marital Status: Single ___Married ___Separated ___Divorced ___Widowed___

Currently Employed? _____ Yes _____No Patient's Occupation: _____

Patient's Employer: _____

Employer Address: _____City, State, Zip _____

Email address: _____

Are you interested in receiving our monthly newsletter via email? _____ Yes _____ No

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CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

As a condition of providing treatment to you, a therapist from Joel I. Kimmel, Ph. D. P.A. and Associates may request your consent to use and disclose protected health information about you to carry out treatment, payment, and health care operations.

You may revoke this consent at any time by notifying Joel I. Kimmel, Ph.D. P.A. and Associates, ***in writing***, except to the extent that the provider has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that Joel I. Kimmel, Ph.D. P.A. and Associates may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent.

Joel I. Kimmel, Ph.D. P.A. and Associates have reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice.

You have the right to request that Joel I. Kimmel, Ph.D. P.A. and Associates restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Joel I. Kimmel, Ph.D. P.A. and Associates is not required, however, to agree to such requested restrictions. If, however, Joel I. Kimmel, Ph. D. P.A. and Associates agree to the requested restriction, they will honor the request and it will be binding.

I hereby consent to the use and disclosure by Joel. I. Kimmel Ph.D. P.A. and Associates, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

Signature:_____

Signature of Personal Representative of
Patient:_____

Representative's Authority to Act on Behalf of
Patient:_____

Date:_____

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INSURANCE BILLING POLICY AND FINANCIAL RESPONSIBILITY

Our fees generally fall within the reimbursement guidelines for psychotherapy in this area. However, there is no guarantee that your insurance company will cover the entire fee. You may have an insurance policy that has payment limitations, makes payments based on a set fee schedule, or makes payments on approved visits through managed care. The insurance you have is a contract between you and your insurance carrier; you should be aware of your policy and its limitations.

As a courtesy, we will contact your insurance company to verify benefits. You are responsible for payment of all deductible, co-payment and coinsurance amounts. If your insurance company does not pay in accordance with our telephone verification, you will be responsible for payment in full. Please be aware that we file your insurance claim as a courtesy to you. You are responsible for keeping track of all of your therapy sessions including those with other providers, and how many visits your insurance coverage allows per calendar year combined. Should your benefits be exhausted for the year, you will be responsible for any unpaid services and for future visits until benefits resume.

In circumstances where benefits are exhausted through your insurance company, or if there is no longer insurance coverage in effect, it is your responsibility to notify your therapist in order to establish the total fee that is your responsibility for ongoing visits.

It is your responsibility to keep your appointments as scheduled. Failure to keep an appointment and/or failure to notify the office of an appointment cancellation at least 24 hours prior to the appointment will incur a **$50.00** fee on your account. Please discuss any concerns about a cancellation fee with our office staff.

Checks returned from your bank for any reason will incur a **$45.00** fee on your account. The payment of the original check amount and the $45.00 fee must be made by cash or credit card only.

In the event that outstanding balances on my account remain unpaid and I fail to arrange a payment plan, I understand that collection procedures will begin. I will be responsible for any interest accrued and the costs of collection, including attorney's fees.

_____ _____

Print patient's name Date

_____

Patient's signature (parent if minor)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our office except when the release is required by law or regulation.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgement of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: _____

Signature of Personal Representative of Patient: _____

Description of Representative's Authority to Act on behalf of patient: _____

Date: _____

CLIENT STATEMENT OF UNDERSTANDING

I understand that confidentiality of records and information about me will be held in accordance with state laws regarding confidentiality. I understand that by law confidential information may be provided under the following circumstances:

1. If I give written permission requesting release of information.
2. If a court orders the release of my records.
3. If I raise my mental status or competency in a legal proceeding.
4. If there is reason to believe that I may be a danger to myself or to others.
5. If there is evidence or reason to suspect child abuse or neglect of a child or an incompetent or disabled person.

I have read and understand the above.

Date: _____ Signature: _____

SIGNATURE ON FILE

I authorize the release of any payment and medical information necessary to process my or my family member's claim and related claims. Please accept a photocopy of this authorization as if it were an original authorization. My signature below acts as a signature on file.

Date: _____ Signature: _____

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of insurance benefits to Joel I. Kimmel, Ph.D., P.A. & Associates for professional services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Date: _____ Signature: _____

CHILDHOOD HISTORY

Name: _____Date: _____DOB:_____ Age: _____

Presenting problem:_____

_____

EARLY CHILDHOOD INFORMATION

Birth: Normal? _____ Weight: _____ Length:_____

Unusual events at birth:_____

_____

Adoption? At what age?_____Circumstances:_____

_____

Growing up: Normal? _____ Problems? _____

_____

Parents: Married_____ Alive? _____ Quality of their relationship: _____

_____

Siblings: _____Quality of Relationship? _____

_____

Do any siblings have disabilities or developmental problems? _____

_____

Describe Childhood: _____

_____

Describe Adolescence: _____

_____

Any Issues or Traumatic Events? _____

_____

Describe Father's Personality and relationship to him: _____

_____

Describe Mother's Personality and relationship to her:_____

_____

Other significant information: _____

_____

_____

_____

SCHOOL HISTORY

Type of Student/Typical Grades: _____

_____

Any identified learning problems? _____

_____

Any difficulties doing/with homework? _____

_____

_____

Any suspensions/expulsions? _____When? _____ Why?_____

_____

Previous Schools Attended and Teacher Reports:_____

_____

_____

_____

_____

Describe Current School/Activities/Honors: _____

_____

_____

Describe Any Behavior Problems: _____

_____

_____

Other Information: _____

_____

_____

WORK HISTORY

Current Job: _____

Prior Jobs: _____

_____

PREVIOUS PSYCHOLOGICAL TESTING

When?_____ By Whom?_____

Results:_____

_____

_____

_____

MEDICAL HISTORY

Hospitalizations: _____

_____

_____

Unusual Illnesses: _____

_____

Medications and prescribed by: _____

_____

_____

Previous medications:_____

Previous psychotherapy: When? _____ With whom? _____

_____

_____

Is there any family history of mental illness? _____ Whom?_____

_____

Eating problems? _____

_____

Sleeping problems? _____

_____

Suicide attempts? _____ How many times? _____ When? _____

What happened/methods used? _____

_____

_____

Any current suicidal thoughts? _____

Any self-mutilating/cutting behaviors?_____

_____

ALCOHOL/DRUG HISTORY

Age of First Alcohol Use: _____ Current use: _____

_____

Drugs used and age started: _____

_____

_____

_____

Current alcohol/drug use: _____

_____

_____

Is there abuse of prescription drugs? _____ Which? _____

_____

Other information: _____

_____

_____

SOCIAL LIFE

Are there friends and how many? _____

What are the social activities with friends? _____

_____

Excessive texting?_____ Excessive videogaming?_____Excessive computer time?____

Has there been any community service? _____ What?_____

_____

Have there ever been any arrests? _____

_____

Are there any legal problems? _____

_____

_____

Are there any financial problems? _____

_____

What are spare time activities? _____

_____

Other information: _____

_____

PERCEPTIONS

Describe how you see your child: _____

_____

How do they handle stress? _____

_____

What makes them feel angry? _____

_____

What makes them feel nervous? _____

_____

What makes them feel sad? _____

_____

What makes them feel happy? _____

_____

What do they worry about? _____

_____

Other information/Additional comments: _____

_____

_____

_____

_____