



GENERAL PATIENT INFORMATION

Date: _____ How did you hear about us? _____

Full Name: Mr. Mrs. Ms. Miss Dr. _____

Nick Name: _____ Name You Prefer: _____

Age: _____ Date of Birth: _____ Sex: Male Female

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: Yes No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: Yes No

Home Phone: (_____) _____ May We Leave a Message Here: Yes No

Mobile Phone: (_____) _____ May We Leave a Message Here: Yes No

Work Phone: (_____) _____ May We Leave a Message Here: Yes No

Email Address: _____ May We Send Email Here: Yes No

I would like to be added to ASPEN Psychology & Counseling Newsletter to receive free articles, tips and resources: Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary: \$0 to \$10,000 \$20,001 to \$40,000 \$50,001 to \$60,000 \$80,001 to \$100,000
 \$10,001 to \$20,000 \$40,001 to \$50,000 \$60,001 to \$80,000 More than \$100,000

EDUCATION INFORMATION

Last Year of School Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

Are You Currently in School: Yes No. If Yes, What School: _____

What was your major/minor/area of concentration? _____

Did you experience any learning problem in school? None Little Some Substantial Always/Constant Struggle

How satisfied are you with your academic progress so far? Very satisfied Satisfied Very Dissatisfied

What barriers, if any, are impeding your academic progress? _____



CULTURAL BACKGROUND

Race: White Black Hispanic Asian Other: _____

How much do you identify with your ethnic heritage? Not At All A Little Somewhat Moderately Strongly

Does your family speak a language other than English at home? Not At All Very Little Sometimes Frequently Always

Were you and both of your biological parents born in the U.S.? Yes No Unsure

If no, who was foreign-born, from what country, and what was the approximate age of immigration to the U.S.?

RELIGIOUS BACKGROUND

Please describe your religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of?

Church attendance? If so, what is the name? _____

Do You Have a Personal Support System: Yes No. If Yes, Who: _____

RELATIONAL INFORMATION

Current Relational Status: Single Dating Engaged Married Separated Divorced Widowed

Are You Content with Your Current Status: Yes No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: White Black Hispanic Asian Other: _____ Partner's Sex: Male Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: Yes No Unsure Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): Alone Spouse Children Parent(s) Sibling(s)
 Boyfriend Girlfriend Roommate Other: _____



CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Natural, Adopted, Step)</i>	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: Yes No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: Yes No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Mom, Dad, Sibling, Step)</i>	Occupation	Describe Him/Her

Please check any past, present, or impending problems/issues in your family:

- | | | |
|---|--|---|
| <input type="checkbox"/> Deaths | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Financial crisis/unemployment | <input type="checkbox"/> Frequent relocations | <input type="checkbox"/> Legal Problems |
| <input type="checkbox"/> Debilitating injuries/disabilities | <input type="checkbox"/> Attempted/completed suicide | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Serious chronic illness | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Marital affairs/infidelity | other _____ | |

Please specify family member(s), which problem/issue, and approximate years of occurrence.

In general, how happy or adjusted were you growing up? Poor Unsatisfactory Average Substantial Completely

How much is your immediate family a source of emotional support for you? None Little Somewhat Substantial Always

How much conflict in values do you currently experience with your parents? None Little Sometimes Substantial Always

Who in your family do you currently feel closest to? _____

Most distant from? _____ In most conflict with? _____



MEDICAL & SOCIAL INFORMATION

How is your physical health at present? [] Poor [] Fair [] Satisfactory [] Good [] Excellent

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are You Currently Receiving Medical Treatment: [] Yes [] No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (Use Back if Necessary): _____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ [] Improves [] Prevents [] Controls: _____

Medication: _____ Dosage: _____ [] Improves [] Prevents [] Controls: _____

Are You Taking these Medication(s) According to Your Doctor's Recommendations: [] Yes [] No

If No, Briefly Explain: _____

Are you having any problems with your sleep habits? [] Yes [] No

If yes, please check all applicable: [] Sleeping Too Little [] Sleeping Too Much [] Poor Quality Sleep

[] Disturbing Dreams [] Other _____

How many times per week do you exercise? _____ For how long? _____

Are you having any difficulty with appetite or eating habits? [] Yes [] No

If yes, please check all applicable: [] Eating Less [] Eating More [] Binge Eating

[] Restricting Calories [] Significant weight change (in the past two months)

Do you regular use alcohol? [] Yes [] No

In a typical month, how often do you have 4 or more drinks in a 24 hr. period? _____

Have you ever tried to cut down on the amount of alcohol you consume? [] Yes [] No

Has anyone close to you ever been annoyed by your drinking? [] Yes [] No

Do you consider your alcohol consumption to be a problem? [] Yes [] No [] Unsure

How often do you engage in recreational drug use? [] Daily [] Weekly [] Monthly [] Rarely [] Never

Do you consider this drug use to be a problem? [] Yes [] No [] Unsure

Have you ever experienced legal problems? [] Yes [] No Nature of problem: _____

Do you have any problem or worries about sexual functioning? [] Yes [] No

If yes, check all applicable: [] Performance Problem [] Sexual Impulsiveness [] Lack of Desire

[] Difficulty Maintaining Arousal [] Worry about STD(s) [] Other _____

Besides family members, approximately, how many people can you really count on currently for friendship or emotional support? _____

How do you spend your leisure time? _____



PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

- Headaches..... Past Present
Visual Trouble..... Past Present
Weakness..... Past Present
Difficulty Breathing.. Past Present
Change in Appetite. Past Present
Hearing Voices..... Past Present
Dizziness..... Past Present
Sleep Trouble..... Past Present
Tension..... Past Present
Intestinal Trouble.... Past Present
Tiredness..... Past Present
Seeing Things..... Past Present
Stomach Trouble.... Past Present
Trouble Relaxing.... Past Present
Rapid Heart Rate... Past Present
Hearing Noises..... Past Present
Pain..... Past Present
Other..... Past Present

Your Height: Your Weight: How has Your Weight Change in the Last 2-3 Months:

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

- Stress..... Past Present
Panic..... Past Present
Guilt..... Past Present
Recent Death..... Past Present
Inferiority Feelings.. Past Present
Shyness..... Past Present
Marriage..... Past Present
Emotional Abuse.... Past Present
Temper..... Past Present
Bad Dreams..... Past Present
Unwanted Thoughts Past Present
Impulsive Behavior. Past Present
Sexual Problems.... Past Present
Legal Matters..... Past Present
Drug Use..... Past Present
Career Choices..... Past Present
Children..... Past Present
Recent Loss..... Past Present
Nervousness..... Past Present
Unhappiness..... Past Present
Apathy..... Past Present
Grief..... Past Present
Defective Feelings.. Past Present
Fears..... Past Present
Communication..... Past Present
Verbal Abuse..... Past Present
Anger..... Past Present
Concentration..... Past Present
Memory..... Past Present
Self-Control..... Past Present
Pregnancy..... Past Present
Trauma..... Past Present
Alcohol Use..... Past Present
Ambition..... Past Present
Being a Parent..... Past Present
Disaster..... Past Present
Anxiety..... Past Present
Depression..... Past Present
Terminal Illness..... Past Present
Hopelessness..... Past Present
Loneliness..... Past Present
Friends..... Past Present
Physical Abuse..... Past Present
Sexual Abuse..... Past Present
Aggressiveness..... Past Present
Racing Thoughts.... Past Present
Loss of Control..... Past Present
Compulsivity..... Past Present
Abortion..... Past Present
Eating Problems.... Past Present
Trouble with Job.... Past Present
Making Decisions... Past Present
Finances..... Past Present
Smoke Cigarettes... Past Present

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1 = Very Little Distress; 10 = Extreme Distress):



Are you currently receiving psychiatric services, professional counseling or therapy elsewhere? Yes No

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back If Necessary):

Therapist: Location: Dates: Reason:
Therapist: Location: Dates: Reason:

Are You Currently Experiencing Any Suicidal Thoughts: Yes No Have You Experienced Them in the Past: Yes No

Have You Ever Attempted Suicide: Yes No. If Yes, When and How:

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: Yes No

If Yes, When and Who:

Have you ever intentionally inflicted harm upon yourself? Yes No

How often? Daily Weekly Monthly Rarely Nature of harm:



Have you ever intentionally hurt someone else? Yes No Nature of harm: _____

Have you ever experienced any form of traumatic experiences? Yes No When? _____

Nature of experience: _____

Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?

Frequently A Few Times Once Never Unsure

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling (*i.e. What Are Your Issues, Problems?*): _____

Why Have You Decided to Come for Counseling Now: _____

What Do You Hope to Gain or Change by Coming for Counseling: _____

How Long Do You Believe Counseling Should Last: _____

TERMS OF SERVICE

I hereby give Marta Kelly Rocha, MA, LMHC permission to provide counseling services for the patient mentioned above:

Signed: _____ Date: _____



Financial Policy

Payment Policy:

We are committed to providing you with the best possible care. Payment for services is due at the time of service. We accept cash, checks, Master Card, and Visa.

Our fees:

- Individual, Family and Marriage Sessions are _____ per hour (therapy sessions are 50 minutes).
- Groups are \$48.00 per session.
- Counselor Services: Treatment Summary Requests, Professional Letters, and Phone/Conference calls will be billed, if requested, at the individual therapeutic rate for a minimum of 30 minutes.
 - Emails will be charged in 15-minute increments at the individual therapeutic rate (15 minute minimum).
- Administrative Services: Letters from the administrative office, insurance forms, authorization requests and/or calls to your insurance company will be billed at \$15 per 15 minutes (15 minute minimum).
- Court Appearances and Depositions are \$280 per hour & minimum \$1000 retainer.
- Returned checks are subject to a \$30 fee.
- A cancellation fee is charged for appointments that are no show or canceled without a 24 hours advance notice unless there is an emergency or illness. The no-show fee is equivalent to your normal session fee.

Policy on Insurance Reimbursement:

If you have medical Insurance that provides coverage for mental health counseling, we want to help you receive your maximum allowable benefits, however, it is your responsibility to pay for services at the time of service and then work with your insurance company for any reimbursement.

We will be happy to help you process your insurance claim form for your reimbursement. A completed insurance form must accompany any such request at each visit. You are responsible for mailing it to the insurance company and tracking your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, called "Usual, Customary and Reasonable" (UCR).
Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.
5. I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

If you have any questions about our financial policy please do not hesitate to ask us. We are here to help you.

Signature _____ Date _____



Informed Consent & Release of Liability

Name: (please print): _____

I understand the following:

1. Counseling services are provided by Marta Kelly Rocha, MA, LMHC who has earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and who has been registered with the State of Florida as a Licensed Mental Health Counselor.
2. Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
3. Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
4. This counselor is not providing an emergency service; therefore, at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance. We do not provide an on-call service at this time.
5. Regular attendance will produce maximum results, but I am free to discontinue treatment at any time. A final closure/summary session is highly recommended to get the greatest benefits.
6. I understand that my counseling records & conversations with the counselor are kept confidential, except where disclosure is required by law (i.e. abuse of a child, elderly or disabled person; potential harm or threat to self or others and specific information subpoenaed by a court of law.)
7. I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

My signature below indicated that I grant informed consent for Marta Kelly Rocha, MA to provide counseling services to myself and or minor members of my family.

Signature: _____ Date: _____



Notice of Privacy Practices

This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

<p>The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.</p> <p>Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.</p> <ul style="list-style-type: none"> • <i>Treatment</i> means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc. • <i>Payment</i> means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services. • <i>Health Care Operations</i> include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc. <p>In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by</p>	<p>law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.</p> <p>Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.</p> <p>You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:</p> <ul style="list-style-type: none"> • The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. • The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations. • The right to request an amendment to your PROTECTED HEALTH INFORMATION. 	<p>outside of treatment, payment and health care operations.</p> <ul style="list-style-type: none"> • The right to obtain a paper copy of this notice for us upon request. <p>We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.</p> <p>We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.</p> <p>You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.</p> <p>For more information about our Privacy Practices, please contact: The Privacy Officer Marta Rocha, MA, LMHC 7450 Dr. Phillips Blvd., Suite 315 Orlando, Florida 32819 407-453-3305</p> <p>For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 877.696.6775 (toll-free)</p>
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Acknowledgement of Receipt: Privacy Practice Notice

I, _____ have received a copy of Marta Kelly Rocha, MA, LMHC Notice of Privacy Practices.

Street Address: _____

City: _____ State: _____ Zip: _____

Client
Signed: _____ Date: _____

Parent/Guardian
Signed: _____ Date: _____

Witnessed
Signed: _____ Date: _____