



Patient Name: _____ Date: _____

Parent/Guardian Information

Parent/ Guardian Name: _____ Relationship to Patient _____
Address: _____ City _____ Zip _____
Home Phone: _____ Business Phone: _____ Cell Phone: _____
Email Address: _____ Place of Employment _____
Occupation: _____
Marital Status: Single Engaged Married How Long _____? Divorced How Long _____? Widowed How Long _____?
Name of Person or Establishment who referred you _____
In case of emergency contact: _____ Relationship _____
Phone _____

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

I hereby give Marta Kelly Rocha, MA, LMHC permission to provide counseling services for the patient mentioned above: Signature of parent or legal guardian:

Signature: _____ Date: _____

Patient's DOB: _____ Age: _____ School _____ Grade: _____

Has patient received counseling from a Pastor, Psychiatrist, or other counselor? [] Yes or [] No

If yes, who: _____ When: _____

What was the previous chief complaint or diagnosis: _____

Has anyone in your family been treated for a mental disorder? [] Yes or [] No

If yes, Who & What were they treated for? _____

Physician's Name: _____ Date of last physical exam: _____

Significant past medical conditions and years _____

Current medical conditions (include any known allergies or dietary concerns) _____

Medications/dosage patient is currently taking and for what reason: _____

Briefly describe major reasons for coming to counseling and what you hope to accomplish: _____

Severity of Problem: [] Crisis [] Severe [] Moderate [] Mild

I would like to be added to Marta Kelly Rocha's newsletter to receive free articles, tips and resources: [] Yes [] No



Child/Adolescent Comprehensive Psychosocial Assessment						Staff Notes
Family Information:						<hr/> <hr/> <hr/>
Family	Name	Age	Educ.	Occupation	At Home	
Dad						
Mom						
Stepdad						
Stepmom						
Bro/Sis						
“ ”						
“ ”						
Other						
Has your child ever lived with anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who? _____						
Is your child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how old was your child? _____						
A. Your Child's Development:						
Please list the approximate age at which your child:						
	Age		Problems			
Walked	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Talked	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Toilet Trained	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Puberty/1 st Menstruation	_____	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Sexually Active	_____	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
B. Family History:						
Has anyone in your immediate family ever had any of the following problems?						
1. Epilepsy or Diabetes?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
2. Significant Medical Problems?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
3. Mental Illness Requiring Hospitalization?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
4. Counseling For Emotional Problems?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
5. Current or past use of alcohol/drugs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
6. Suicidal Behavior?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		



C. Your Child's Behavior:

- 1. Does your child get along well with others?
2. Does your child follow instructions?
3. Is your child appropriate with pets?
4. Does your child have self-control?
5. Has your child ever set a fire?
6. Does your child cry easily?
7. Has your child ever used alcohol or other drugs?
8. Has your child ever experienced problems with the law?
9. Has your child ever talked about, threatened or tried to harm himself or herself?
10. Has your child ever threatened to or harmed others?
11. Has your child ever used tobacco products?

D. Your Child's Education:

- 1. What school is your child attending?
2. In what grade is your child?
3. Has your child attended a special education program?
4. Has your child repeated, skipped or had any interruptions in his/her education?
5. How many days has he/she missed this year?

E. Activities, Interests and Strengths:

- 1. What does your child do in his/her spare time?
2. What does your child do well?

F. Spiritual:

Please describe your child's religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of as we meet with him/her?

G. Health

Staff Notes

Multiple horizontal lines for staff notes.



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Has your child experienced any of the following: If Yes, When?

Soiling or lack of bowel control? Yes No _____

Urinary problems? Yes No _____

Seizures or Convulsions? Yes No _____

Eye/Ear Problems? Yes No _____

Complications from high fever? Yes No _____

Persistent Headaches? Yes No _____

Persistent Stomach Aches/Nausea Or Vomiting? Yes No _____

Sleeping Problems? Yes No _____

Physical, Sexual or Emotional Abuse? Yes No _____

Poor Appetite? Yes No _____

Significant Weight Loss or Gain? Yes No _____

Frequent Colds/Respiratory Yes No _____

Rocking, Head Banging? Yes No _____

Coma or Unconsciousness Yes No _____

Blank lines for handwritten responses.



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Serious Injury Resulting From Accidents? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____	_____ _____
Parent or Guardian's Signature _____	Date _____

Please do not write in space below. For office use only

Issues	Descriptions	Measurable Objectives	Interventions

Diagnostic Impressions:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF: _____ Highest GAF: _____



Authorization of Release

I, _____, hereby authorize Marta Kelly Rocha, MA, LMHC, 7450 Dr. Phillips Blvd., Suite 303, Orlando, Florida 32819 to:

_____ Release To _____ Release from _____ Exchange Written and/or Oral Communication

_____ Psychiatric _____ Medical
_____ Psychological _____ Counseling

From the records of: _____ Name of Client _____ Date of Birth

To: _____

For the purpose of: [] Outpatient Counseling [] Coordination with schools [] Send Thank You Card for Referral
[] Coordination with MD/Psychologist/OT Therapist/Therapist

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire on _____

Client, Parent, Guardian _____ Date

Witness _____ 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 licensed with the State of Florida 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 disable 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, LMHC 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. 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>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 Licensed Mental Health Counselor, MH11811</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: _____