STAR POINT COUNSELING CENTER
207 Morgan St., Brandon, Florida 33510
419 W. Platt St., Tampa, Florida 33606

If you have questions or concerns about anything feel free to call or text Sam DiFranco, Founder/ Executive Business Director on his personal cell number at 813-260-8892. Thank you

TODAY'S DATE

NAME OF PERSON BEING SEEN Date of Birth

NAME OF SPOUSE, if couples counseling Date of Birth

ADDRESS

CITY ZIP CODE

IN SCHOOL IF UNDER 18, NAME OF PARENT GUARDIAN

SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ IN SCHOOL ☐

DATE OF BIRTH GENDER

HOW DID YOU HEAR ABOUT US

PLACE OF EMPLOYMENT

PRIMARY CONTACT PHONE NUMBER IS IT OK TO LEAVE A MESSAGE ☐

SECONDARY PHONE NUMBER IS IT OK TO LEAVE A MESSAGE ☐

EMERGENCY PHONE NUMBER NAME

E-MAIL

INSURANCE COMPANY

POLICY NUMBER

NAME OF MAIN POLICY HOLDER

POLICY HOLDERS ADDRESS CITY ZIP

POLICY HOLDERS DATE OF BIRTH

RELATIONSHIP TO YOU: SELF ☐ SPOUSE/PARTNER ☐ CHILD ☐ OTHER ☐

PATIENT OR AUTHORIZED PERSONS SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits, and government benefits, to Star Point Counseling Center. I authorize Star Point Counseling Center to see myself and/or my child. I authorize consent to be seen by a therapist at Star Point Counseling Center, and by typing my name authorize that I am electronically signing this form

SIGNATURE DATE

SIGNATURE OF SPOUSE, if couples counseling DATE

Parent or Guardian signature, if under 18 years DATE

OFFICE POLICY REGARDING MISSED APPOINTMENTS:

UNLIKE MEDICAL DOCTOR'S WE RESERVE THE HOUR JUST FOR YOU TO SEE THE THERAPIST. IF YOU CANCEL OR DO NOT SHOW UP FOR YOUR APPOINTMENT THEN THE THERAPIST DOES NOT SEE ANY OTHER CLIENTS UNTIL THE NEXT HOUR AND IT DOES NOT ALLOW SOMEONE ELSE TO SEE THE THERAPIST. LET US KNOW AS SOON AS POSSIBLE IF YOU CAN NOT MAKE YOUR SCHEDULED APPOINTMENT, SO WE CAN SCHEDULE ANOTHER CLIENT IN YOUR RESERVED TIME SLOT. **IF YOU CANCEL OR RESCHEDULE YOUR APPOINTMENT LESS THAN 36 HOURS BEFORE YOUR APPOINTMENT YOU WILL BE CHARGED A $50 CANCELLATION FEE.** IF YOU DO NOT CALL OR SHOW UP FOR YOUR APPOINTMENT WE WILL NEED TO COLLECT THE $50 FEE BEFORE WE CAN SET YOUR NEXT APPOINTMENT. I UNDERSTAND AND AGREE TO THIS POLICY

SIGNATURE DATE

REASON FOR COMING HERE TODAY/ PRESENT SYMPTOMS (MARK ALL THAT APPLY)

- ☐ RELATIONSHIP PROBLEMS
- ☐ COUPLES COUNSELING
- ☐ FAMILY/PARENTING
- ☐ STRESS/ANXIETY
- ☐ SUBSTANCE ABUSE/ALCOHOL
- ☐ HELP WITH EMPLOYMENT
- ☐ COURT ORDERED
- ☐ GRIEF & LOSS
- ☐ SEPARATION/DIVORCE
- ☐ TROUBLED TEENS
- ☐ DOMESTIC VIOLENCE
- ☐ DEPRESSED
- ☐ CRYING A LOT, MOODY
- ☐ EXCESSIVE EXERCISE
- ☐ CAN'T SLEEP/SLEEPING TOO MUCH
- ☐ CAN'T EAT/EATING TO MUCH
- ☐ LOSING OR GAINING WEIGHT
- ☐ VOMITING ON PURPOSE
- ☐ LOSS OF SEXUAL INTEREST
- ☐ MANIC, OVERLY HAPPY CAUSING TROUBLE
- ☐ RACING THOUGHTS
- ☐ EXCESSIVE SPENDING
- ☐ HYPERACTIVE
- ☐ FEELING ANXIOUS
- ☐ FELLING PANIC
- ☐ SWEATING/SHAKING/LIKE A HEART ATTACK
- ☐ NIGHTMARES
- ☐ HISTORY OF SEVERE TRAUMA
- ☐ FEARFUL, STARTLE EASILY
- ☐ FLASHBACKS
- ☐ TROUBLE LEAVING HOUSE
- ☐ AVOIDANCE DUE TO FEAR OF PANIC
- ☐ REPETITIVE, UNWANTED THOUGHTS
- ☐ REPETITIVE BEHAVIOR
- ☐ OBSESSIVE BEHAVIOR
- ☐ HEARING VOICES
- ☐ SEEING THINGS OTHERS CAN'T
- ☐ DISORGANIZED THOUGHTS
- ☐ DELUSIONAL THINKING
- ☐ CUTTING, BURNING, SELF MUTILATION
- ☐ FEELING OF EMPTINESS
- ☐ FEAR OF BEING ALONE
- ☐ SUICIDAL THOUGHTS
- ☐ SEVERE CHILDHOOD ABUSE
- ☐ SEXUAL ABUSE
- ☐ ALCOHOLISM/ HEAVY DRINKING
- ☐ ILLEGAL DRUGS, WHAT KIND
- ☐ BACKACHES
- ☐ HEADACHES
- ☐ STOMACHACHES
- ☐ OFTEN TIRED, ACHY
- ☐ ILLEGAL ACTIONS, ARRESTS
- ☐ PAST COUNSELING/HOSPITALIZATION

MEDICAL PROBLEMS, LIST ALL

PRESENTLY TAKING MEDICATION, LIST ALL

OTHER CONCERNS

CHILD/CHILDREN PROBLEMS, PLEASE EXPLAIN

PAYMENT:

- ☐ I WILL PAY THE FEE IN FULL
- ☐ INSURANCE IS PAYING AND I WILL BE RESPONSIBLE FOR ANY DEDUCTIBLES OR CO PAYMENTS
- ☐ I AM REQUESTING A SLIDING SCALE PROOF OF INCOME IS REQUIRED (PAY STUB, CHILD SUPPORT ETC)

WE WILL OFFER YOU A SLIDING SCALE FEE FOR CLIENTS THAT HAVE A HIGH DEDUCTIBLE OR THOSE THAT DO NOT HAVE INSURANCE. WE BASE THE FEE ON YOUR ENTIRE HOUSEHOLD INCOME, SO WE NEED PROOF OF INCOME FROM EVERYONE IN THE HOUSEHOLD, INCLUDING CHILD SUPPORT, UNEMPLOYMENT, SSI, SS ETC….

IF YOU DO NOT HAVE INCOME THEN YOU WILL HAVE TO SUBMIT A STATEMENT SAYING YOU DO NOT HAVE ANY HOUSEHOLD INCOME. OUR SLIDING SCALE FEE IS AS FOLLOWS: OUR NORMAL FEE IS $120 PER SESSION

$0 TO $25,000 IS $60 PER SESSION (REGISTERED MENTAL HEALTH COUNSELOR INTERN)
$25,000 TO $50,000 IS $75 PER SESSION (REGISTERED MENTAL HEALTH COUNSELOR INTERN)
$0 TO $55,000 IS $90 PER SESSION (LMHC, LCSW or LMFT)
OVER $55,000 IS $120 PER SESSION (LMHC, LCSW or LMFT)

I AUTHORIZE STAR POINT COUNSELING CENTER TO BILL MY INSURANCE COMPANY. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CHECK WITH MY INSURANCE COMPANY ON BENEFIT DETAIL. I ALSO UNDERSTAND THAT IF MY INSURANCE COMPANY DENIES ANY CLAIMS I WILL BE RESPONSIBLE FOR PAYMENT IN FULL, UP TO THE ALLOWED AMOUNT OF THE INSURANCE COMPANY. IF MY INSURANCE COMPANY REJECTS ANY PAYMENT I HAVE THE OPTION OF THE SLIDING SCALE.

SIGNATURE _____ DATE _____

I HAVE RECEIVED AND UNDERSTAND THE CONFIDENTIALITY NOTICE ON THE FOLLOWING PAGES

SIGNATURE _____ DATE _____

CLIENT COPY TO KEEP CLIENT COPY CONFIDENTIALITY NOTICE:

Contents of all therapy sessions 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. Noted exceptions Are as follows:

DUTY TO WARN AND PROTECT

When a client discloses intentions or a plan to harm another person, the mental health Professional is required to warn the intended victim and report this information to legal Authorities. In cases in which 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 family of the client.

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 mental health professional is required to report this information to the appropriate social service and/or legal authorities.

PARENTAL EXPOSURE TO CONTROLLED SUBSTANCE

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

MINORS/GUARDIANSHIP

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

INSURANCE PROVIDERS (WHEN APPLICABLE)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that 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.

If you would like us to release information we will have you fill out and sign a Consent To Release form.

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