GLENDA BEACH, MS, LMFT, PA

3980 Tampa Rd., Suite 205
Oldsmar, FL. 34677

REGISTRATION FORM

The purpose of this questionnaire is to provide me with information that can be helpful in the course of your therapy. Information you provide will be held in confidence.

Client Name(s)_____Sex_____ _____
Address_____City_____State___ Zip_____
Address:_____ City_____State___Zip_____
O.K to send correspondence? Yes___ No___
HomePhone:_____ O.K. To Call? Yes___ No__O.K. to leave message? Yes_ No_
Home Phone:_____O.K. To Call? Yes___No__O.K. to leave message? Yes_ No_
Cell Phone:_____ O.K. To Call? Yes__No___O.K. to leave message? Yes_No_
Cell phone:_____ O.K. To Call? Yes_ No__ O.K. to leave message? Yes_No_
Client DOB: _____SS#:_____Cell #:_____
Client DOB:_____ SS#_____Cell#:_____

Employed By:_____Occupation:_____Income:_____
Employed By:_____Occupation:_____Income:_____
O.K. to call you at work? Yes___ No___ Leave a message? Yes___ No___
Work Phone # _____ Work Phone # _____
Who To Notify in Case of Emergency_____
Relationship_____ Phone #_____

Presenting issues:
Interpersonal_____ Marital_____ Substance/Alcohol Abuse_____
Job Related_____ Parent/Child_____ Mental Health_____

History of Problem:
New_____ 6 mos. + _____ 12 mos. + _____
2 years_____ 5 yrs. _____ 6 yrs. _____

How strongly do you want treatment for your issues? (Circle one)
Very much Much Moderately Could do without treatment

Family/Marital Status and Living Arrangement:

Single_____ Separated_____ Cohabit _____
Married_____ Divorced_____ Widowed _____ How long?_____

Name and age of spouse/partner: _____
Number of children _____ Ages of children _____

Others living in household: _____

Suicide risk? Yes_____ No_____Homicide Risk? Yes_____ No_____
Please explain_____

Whom have you previously consulted about your present issue(s)?_____
_____

Any psychiatric hospitalizations? (Please list hospital name and give your age at that time)

_____

List psychotherapists with whom you have consulted in the past:_____
_____

List prescribed medications that you are now taking:_____
_____

Who is/are your family physician(s)?_____

Does any member of your family (or nuclear family) suffer from problems with drugs, alcohol , epilepsy, or anything which could be considered a serious emotional problem?
(list family member and problem)_____
_____

Substance abuse history (yourself)_____

Consequences of use:
Marital_____Family_____Health_____Social_____ Work_____
Legal/DUI_____ Financial_____ Other_____
Explain:_____
_____
Has there been a history of any abuse (physical, emotional, verbal, or sexual) in your family? _____
_____

Other Disorders/Problems:
Nicotine_____ Eating_____ Sex_____ Gambling_____ Spending_____

Working_____ Other _____

Explain_____
UNKEPT APPOINTMENTS NOT CANCELED WITHIN 24 HOURS ARE MY RESPONSIBILITY AT FULL FEE ($).
Signed:_____Date:_____

GLENDA BEACH, LMFT, PA

3980 Tampa Rd., Oldsmar, FL. 3467
(727)-787-0646 or fax (727)474-5503

CONSENT TO TREATMENT

_____agree to meet with Glenda Beach for psychotherapy.

(Name of Clients)
The client's agree to a fee of $_____per session to be paid at each session.

Our signatures affirm that the aforementioned therapist has disclosed to us in simple, non-technical language the nature of the therapy, including the material risks and benefits, alternatives available to us and the risks of no treatment. This disclosure was understood by us and enabled us to make an informed consent to this treatment. We understand that we may revoke this consent at any time without penalty.

Glenda Beach does not assure availability at all times and the practice is not geared to the provision of emergency services. In case of psychiatric emergency and Glenda Beach is not readily available to assist us in making arrangements, I / we agree to call 911 or go to the nearest emergency room. Our signatures affirm that we understand and agree to these emergency procedures.

I / we also understand that we will be responsible for the payment at the above rate for failed sessions or for sessions canceled less than 24 hours prior to the appointment. We agree to pay for counseling services at the time they are rendered.

If your insurance company refuses to pay for any services rendered, I/we understand that payment is the responsibility of the client.

For clients that request a standing appointment, if three appointments are missed, that appointment time will be offered to those on the waiting list.

_____
Email Address

Client Signatures:

_____ _____

_____ _____

_____ _____

FINANCE POLICY

I am committed to providing you with the best possible care, and I will be pleased to discuss my professional fees with you at any time. Your clear understanding of my Financial Policy is important to our professional relationship. Please ask if you have any questions about the fees, Financial Policy or your responsibility.

PAYMENT FOR all CO-PAYS OR FULL PAYMENT IF NOT USING INS. IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, CREDIT CARDS.

COUNSELING - Now and then questions or emergencies arise of a counseling nature that can be handled quickly and more briefly over the phone. The charges for this time follow the sliding scale fee level.

FEES FOR SPECIAL SERVICES – Fees for special services are set at $90.00 per hour. This fee applies to the following:

- Preparation of any reports, forms, or other administrative requests.

- If I participate in a legal case, regardless of which party's attorney calls or subpoenas me, fee includes, but is not limited to testimony, time for travel, waiting in the courtroom, telephone conferences, depositions, review of notes. In addition, you are responsible for any fees that I incur by my attorney.

REGARDING INSURANCE - If you have insurance, I will be happy to fill out insurance forms. However, by signing this agreement, you agree that you are responsible for the timely payment of your account whether your insurance reimburses or denies payment.

MISSED APPOINTMENTS - Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal counseling session. (not just co-pay) Please help us serve you better by keeping scheduled appointments.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

_____ _____

(Responsible Party Signature) (Date)

_____ _____

(Witness)