STEVEN P. PERA, PSY.D., P.A.
Licensed Psychologist / FL #PY0005142

21301 Powerline Road, Suite 302
Boca Raton, Florida 33433

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

_____ Social Security #: _____

Insurance: _____ ID# _____ Cell Phone: _____

Group #_____ Home Phone: _____

BACKGROUND INFORMATION

Please review the following list for symptoms that you may have experienced in recent days or weeks and check all that apply:

☐ Crying Spells	☐ Change in sleep	☐ Family Problems
☐ Angry Outbursts	☐ Change in appetite	☐ Relationship Problems
☐ Increased Nervousness	☐ Eating Changes	☐ Social Problems
☐ Confusion	☐ Headaches	☐ Work Problems
☐ Trouble concentrating	☐ Other physical complaints	☐ Suicidal
☐ Feel out of control	☐ Change in sexual activity	☐ Homicidal
☐ Loss of trust in others	☐ Financial problems	☐ Panic Attacks
☐ Lonely	☐ Drastic Weight Change	☐ Forgetfulness
☐ Violent Feelings	☐ Seeing Things	☐ Increased Drug use
☐ Sadness	☐ Hearing Things	☐ Increased alcohol use

☐ Other (please specify): _____

Have you previously received counseling or psychological services? ☐ No ☐ Yes

When? _____

With whom ? _____

Outcome? _____

Do you have any medical conditions? _____

Primary Care Physician: _____ Phone #: _____

Are you currently on any medications? ☐ No ☐ Yes (please specify) Known allergies? _____

_____

Prescribing physician: _____ Phone # : _____

Briefly describe the reason for which you are coming today: _____

_____

EMERGENCY CONTACT:

Name: _____ Phone Number: _____

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CONSENT FOR TREATMENT

Client: _____ Date of Birth: _____

This contract explains the conditions that you, as the client, have agreed upon when obtaining services through Steven P. Pera, Psy.D., P.A. . Some of these rights and obligations are imposed by Florida law while others are established herein by contractual agreement. Any concerns regarding the matters stated herein should be discussed prior to initiation of treatment. Your signature at the end signifies your consent in its entirety.

CONFIDENTIALITY

The confidentiality of information and records pertaining to your treatment will be held in accordance with state laws. All communication between the client and Steven P. Pera, Psy.D., P.A. will be treated as strictly confidential; the client controls whether or not confidential information may be disclosed. By law, however, confidential information may be provided without client/guardian consent under limited circumstances. Steven P. Pera, Psy.D., P.A. may provide confidential information in the following circumstances:

1. The client waived confidentiality as indicated on a Steven P. Pera, Psy.D., P.A. Release of Information form;
2. There is reason to believe that the client poses a risk of imminent danger to self or others;
3. There is cause to suspect that a minor or elder has been or may be abused;
4. A court order is enforced to release records;
5. The client raises mental status or competency in a legal proceeding; and,
6. The client brings suit against the therapist or practice.

CHILD AND ADOLESCENT

In the case where identified client is a minor, authorization is granted by a legal guardian for the provision of diagnostic and therapeutic services by Steven P. Pera, Psy.D., P.A. . Further, the involvement of the significant individuals in a child's life is frequently necessary for positive change. The guardian(s) agree to participate in treatment and assist in getting other significant individuals in the child's life to participate as well.

FAMILY, GROUP AND COUPLE THERAPY

Unless otherwise specified, when multiple individuals with a common bond or relationship are seen in therapy, the "client" is the relationship that bonds the individuals together (i.e., the marriage is the marital therapy). Steven P. Pera, Psy.D., P.A. does not take responsibility in any instance where confidentiality may be breached by one of the participants. Further, individual therapy for any one of the participants is available by referral.

ACCESSIBILITY

Your therapist tries to be available to clients by telephone for any emergencies that may arise. In the event of a life threatening emergency, please call 911. Steven P. Pera, Psy.D., P.A. is equipped with a voice messaging system so that each therapist is accessible at all hours to assist with crises situations. Telephone consultations/sessions are billed in 15 minute increments based on a rate of $100 per hour.

REASONABLE EXPECTATIONS

Your therapist will execute his professional knowledge and skills in every effort to assist in obtaining the client's specific objectives. In some instances, clients may experience a slight decline prior to experiencing improvement. As therapeutic services are individual in nature, Steven P. Pera, Psy.D., P.A. can make no guarantees to the outcome of services.

I acknowledge that I have reviewed and understand the terms of the contract and do hereby consent to treatment under these terms. I have received Steven P. Pera, Psy.D., P.A.'s Notice of Privacy Practices. In case of a minor client, I acknowledge that I am the legal custodian and can legally consent to treatment, should legal custody change following the onset of treatment, I agree to notify Steven P. Pera, Psy.D., P.A. immediately.

Client signature: _____ Date: _____

Guardian signature: _____ Date: _____

Witness: _____ Date: _____

STEVEN P. PERA, PSY.D., P.A.
Licensed Psychologist / FL #PY0005142
Telephone (561)852-2525

21301 Powerline Road, Suite 302
Boca Raton, Florida 33433
Fax (954)314-7826

FINANCIAL POLICY AND AGREEMENT

Client: _____ Date of Birth:_____

Our office policy is to charge usual and customary fees for therapeutic and psycho-educational services provided. The client, or responsible party (if client is a minor) is ultimately responsible for the fee at the time that services are rendered. This fee may be adjusted in the following circumstances:

1. A special rate has been negotiated with a third-party payor (i.e., insurance company, HMO, PPO);
2. * No or very limited insurance coverage exist; or
3. *Existing coverage has been exhausted.

*In these cases, a rate is negotiated on a "sliding scale" based on verifiable financial hardship.

While our office will assist in determining the limits of insurance coverage, the client or responsible party is required to guarantee payment for services utilized. In the event that collection procedures become necessary, the client is responsible for interest accrued and the costs of collection, including attorney's and court fees.

If the client or responsible party has reserved an appointment and chooses for any reason not to utilize that time, twenty-four (24) hours notice is required. This allows our office sufficient time to offer the time slot to another client who may be awaiting an opening. If inadequate notice is given or a client misses an appointment that he or she has reserved, the client or responsible party will be charged a fee of $50.00 for the reserved appointment.

Having discussed your financial situation and terms, we both agree to the terms above and the following fee arrangements (choose one):

_____ Insurance plus co-payment of $ _____ per session.* (Initials) _____

_____ Private pay fee of $ _____ per session. (Initials) _____

Signature: _____ *Date:* _____

Witness : _____ *Date:* _____

*SIGNATURE ON FILE:

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

Signature: _____ *Date:* _____

*ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment of insurance benefits to "The Company" for professional services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Signature: _____ *Date:* _____

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Coordination of Care with Primary Care Physician

Authorization to Disclose Information:
I understand that my records are protected under the applicable state laws governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it . This release will automatically expire twelve (12) months from the date signed.

I, _____, hereby authorize Dr. Steven Pera

to release any applicable information to my Primary Care Physician:

Name: _____ Phone/Fax: _____

Address: _____

not to release information to my Primary Care Physician.

_____ _____
PATIENT OR GUARDIAN SIGNATURE *PRINTED NAME*

_____
DATE

Clinician's Comments for Primary Care Physician:
Your patient has been seen for psychotherapeutic evaluation and/or treatment by the clinician noted above. In an effort to coordinate our care, please take a moment to review the following information pertaining to our mutual patient. Please contact our office for any additional information or to discuss these remarks in further detail.

DATE OF INITIAL APPOINTMENT: _____

DIAGNOSIS IMPRESSION: _____

TREATMENT RECOMMENDATIONS:
Psychotherapy/Counseling Medication Evaluation Psychological Testing

ADDITIONAL REMARKS:

_____

_____

_____

_____

_____

_____