Cristina Mantilla, LMHC, LLC. 5745 Main St Suite 202 New Port Richey, FL 34652
1501 S. Pinellas Ave. Suite K Tarpon Springs, FL 34689 Office 727-505-6379 / Fax 1-866-926-7270

CLIENT INF0RMATION (PLEASE PRINT)

Date: _____Name: _____(Maiden & Married)
Street: _____Apt/Bldg: _____
City: _____State: _____ Zip: _____
Cell Phone: _____OK to leave message? _____
Home Phone: _____OK to leave message? _____
Work Phone: _____ OK to leave a message? _____
E-mail: _____DOB: _____Age:_____
Social Security Number: _____ Race: _____
Driver's License Number: _____ DL State: _____

Status: Single Relationship Cohabit Married Separated Divorced Widowed
How long?_____ Name of partner:_____ Age: _____

Emergency Contact (Name/Number): _____
Emergency Contact (Name/Number):_____
Highest Education: _____
Profession:_____
Employer/School:_____
Religion/Spirituality:_____

PCP: _____Telephone Number:_____
Other Current Medical Professionals
(Psychiatrists, Psychologists, Counselors, Support Groups, etc.): Telephone Number:
_____ _____
_____ _____
_____ _____
Referral Source: _____

RELEASE OF INFORMATION:
IN ORDER TO PROCESS MY CLAIM, I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY FOR THIS PURPOSE ONLY.
I hereby assign all medical, including Major Medical benefits to which I am entitled, to the above named PROVIDER.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
THERAPIST SIGNATURE DATE

I appreciate the opportunity to help enhance the quality of your life.

INSURANCE INFORMATION:

DOES CLIENT HAVE PRIVATE INSURANCE? ___YES ___NO
IS THE CLIENT A MINOR? ___YES ___NO
DOES CLIENT HAVE MEDICAID? ___YES ___NO
DOES CLIENT HAVE MEDICARE ?___YES ___NO
IF YES, PLEASE COMPLETE SECONDARY INSURANCE INFORMATION.

PRIMARY INSURANCE:

PRIMARY INSURED NAME:_____ DOB:_____ SEX:_____
SS# OF INSURED:_____ RELATIONSHIP TO PATIENT:_____
EMPLOYER:_____ INSURANCE CO:_____
ADDRESS:_____
GROUP #:_____ POLICY #:_____
MEMBER ID #:_____

SECONDARY INSURANCE (IF APPLICABLE):

INSURED NAME:_____ DOB:_____ SEX:_____
SS# OF INSURED:_____ RELATIONSHIP TO PATIENT:_____
EMPLOYER:_____ INSURANCE CO:_____
ADDRESS:_____
GROUP #:_____ POLICY #:_____
NAME AS PROVIDED ON CARD:_____ BILL ZIPCODE_____
Valid Credit Card: Number:_____ Expiration:____/___
__ DEBIT __ CREDIT __ DISCOVER __ MASTERCARD __VISA

ALL APPOINTMENTS MUST BE CHANGED OR CANCELLED 24 HOURS IN ADVANCE TO AVOID A $40.00 CHARGE.

"I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS). I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I WILL NOTIFY YOU OF ANY CHANGES TO THIS INFORMATION. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE."

_____ _____
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I appreciate the opportunity to help enhance the quality of your life.

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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INTAKE QUESTIONNAIRE

Name: _____ Date: _____

Prior to beginning therapy with me, I request that all my clients complete this form. The questions are designed to help you clarify the changes you want to make in your life, and the expectations you have of the following counseling relationship. Please give these questions much thought.

1. State in your own words the nature of your main problems and how long they have been present:
_____
_____
_____

2. Give a brief history and development of your complaint(s) (from onset to present):
_____
_____
_____
_____

On the scale below please check the severity of your problem(s):

___mildly upsetting ___moderately severe ___extremely severe ___totally incapacitating

3. What are some of your self-defeating behaviors? That is, what do you do that seems to make things worse? (or just does not help you):
_____
_____
_____

I appreciate the opportunity to help enhance the quality of your life.

INITIAL INTAKE

Client Name: _____ DOB: _____ Age: _____

Problems with housing or daily living activities (e.g.: transportation, etc.) _____

Legal Problems: _____

Financial Problems: _____

List names of your family members growing up (parents and siblings).

Name	Relationship	Age	Current Type of Relationship (close, not speaking, etc.)	City/State

Please answer the following statements how you feel: Strongly Disagree=SD, Disagree=D, Neutral=N, Agree=A, or Strongly Agree=SA

(*The following items concern how you feel about your life in general*)

1. I am satisfied with my life: _____
2. I feel good about myself: _____
3. I am happy with the way I look: _____
4. I have a good relationship with my family: _____
5. I have supportive friends: _____
6. My health is good: _____
7. I experience little physical pain: _____
8. I have adequate physical strength: _____
9. I enjoy my leisure time: _____
10. I am happy with my job/work: _____

I appreciate the opportunity to help enhance the quality of your life.

Please answer the following statements how you feel: Strongly Disagree=SD, Disagree=D, Neutral=N, Agree=A, or Strongly Agree=SA

(*The following items concern feelings you may have had during the last month*)

1. I have a feeling of hopelessness about the future: _____
2. I feel worthless: _____
3. I feel blue: _____
4. I feel weak in parts of my body: _____
5. My heart pounds and races: _____
6. I have to avoid certain things, places, or situations because the frighten me: _____
7. I feel that people, in general, are unfriendly and dislike me: _____
8. I have urges to beat, injure, or harm someone: _____
9. I feel that I am watched or talked about by others: _____

(*The following items describe difficult or stressful situations you may have experienced during the last month*)

1. I have recently had a physical fight with someone: _____
2. I have recently tried to harm myself or had a plan to do so: _____
3. I have recently become upset or angry: _____
4. I have recently broken things or destroyed property: _____
5. I am able to get around in the community on my own: _____
6. I can get help when I need it: _____
7. I take care of my home and living space: _____
8. I am functioning well at my work/school: _____

I appreciate the opportunity to help enhance the quality of your life.

MEDICAL HISTORY

Client: _____ Age: _____ Sex:_____

Family Physician: _____ Date of last physical: _____
Previous Hospitalizations:
Where (hospital/city) When How Long Reason
_____ _____ _____ _____
_____ _____ _____ _____

Rx	Prescribed By	For	Dose	Times Taken per day	Outcome

Any known allergies: _____
Please list any previous Psychological/Psychiatric treatment, or counseling:

_____

_____

Females: Any discontinued pregnancies? _____ How many? _____
Full term pregnancies? _____ How many? _____
Has anyone in your family (parents, brothers, sisters, cousins, aunts, uncles) had any of the following?
Please check all that apply:
_____ Kidney Disease _____ Tuberculosis
_____ Heart Disease _____ Mental Illness
_____ Cancer _____ Drug/Alcohol Abuse
_____ Tumors _____ Epilepsy
_____ Diabetes _____ Nervous Disorders

I appreciate the opportunity to help enhance the quality of your life.

Please check any of the following of which you had in the past, or are now experiencing:

PROBLEM	PAST	PRESENT	PROBLEM	PAST	PRESENT
Blurred Vision	_____	_____	Chest Pain	_____	_____
Double Vision	_____	_____	Blackouts	_____	_____
Severe Headaches	_____	_____	Seizures	_____	_____
Dizzy Spells	_____	_____	Hepatitis	_____	_____
Head Injury	_____	_____	Allergies	_____	_____
Vomited Blood	_____	_____	Pneumonia	_____	_____
Back Pain	_____	_____	Diabetes	_____	_____
Hearing Loss	_____	_____	Sleeping More	_____	_____
Mood Swings	_____	_____	Sleeping Less	_____	_____
Compulsions	_____	_____	Confusion	_____	_____
Excessive Blood Loss	_____	_____	Extreme Sadness	_____	_____
Loss of Consciousness	_____	_____	Stomach Pains	_____	_____
Jaundice	_____	_____			

PROBLEM	PAST	PRESENT
Shortness of Breath	_____	_____
Blood in Bowel Movement	_____	_____
Heart Attacks	_____	_____
Tuberculosis	_____	_____
Smoker's Cough	_____	_____
Kidney/Urinary Infection	_____	_____
Blood in Urine	_____	_____
Menstrual Difficulties	_____	_____
Swollen Ankles	_____	_____
Bruise Easily	_____	_____
Weakness in Arms/Legs	_____	_____
Venereal Disease	_____	_____
Reactions to Medications	_____	_____
Blood Transfusions	_____	_____
Broken Bones	_____	_____
Sinus or Frequent Colds	_____	_____
Weight Loss	_____	_____
Weight Gain	_____	_____

I appreciate the opportunity to help enhance the quality of your life.

Please check any of the following of which you had in the past, or are now experiencing:

PROBLEM	**PAST**	**PRESENT**
Appetite Changes	_____	_____
Drug/Alcohol Abuse	_____	_____
Irritability	_____	_____
Excessive Worries	_____	_____
Crying Spells	_____	_____
Fears or Phobias	_____	_____
Hallucinations	_____	_____
Difficulty Concentrating	_____	_____
Frequent Loss of Temper	_____	_____
Extreme Nervousness	_____	_____
Frequent Job Changes	_____	_____
Bedwetting past age 6	_____	_____
Fingernail Biting	_____	_____
Blaming Others Often	_____	_____
Lack of Self-Confidence	_____	_____
Low Self-Esteem	_____	_____
Indecisiveness	_____	_____
Sexual Problems	_____	_____
Extreme Loneliness	_____	_____
Frequent Accidents	_____	_____

_____ _____
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_____ _____
THERAPIST SIGNATURE DATE

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CLIENT ORIENTATION

Program Rules :

1. Cristina Mantilla, LLC will provide outpatient counseling, evaluation, information and/or referral.
2. No drug or alcohol screening or "search and seizure" methods will be employed.
3. Client is expected to pay for services when services are rendered. If for any reason payment of services is received back from clients' financial institution (e.g. NSF fee from bank) there will be a $40.00 fee collected prior to next appointment.
4. Clients must not be under the influence of alcohol or illegal substances at the time of the scheduled session. Should the client be under the influence of substances other than prescribed medication the session will be cancelled by the counselor and the client will be expected to pay for the session at the usual, agreed upon, fee.
5. Except in cases of emergency, **cancellations must be made 24 hours in advance**; failure to give 24 hour notice will be considered a "no show" and billed a **$40.00 fee**.

Program Procedures :

1. Client's rights to confidentiality will be observed at all times, with the following exceptions:
• In cases of probable imminent danger to self or others.
• In cases of child abuse, including sexual abuse.
• Communicable diseases must be reported by the counselor to the appropriate county health department.
or
• When you, the client, request that we release information. Information is only shared with other entities (i.e.: doctors, insurance companies, etc.) when you request it by signing an Authorization to Release Information form. In accordance with HIPPA privacy regulations, any information shared will reveal only the basic minimum information necessary.
2. We reserve the right to release only a Treatment Summary instead of detailed case notes.
3. A minimum requirement of 72 hours is needed for medical records, once a written request is received.
4. The undersigned will neither individually nor jointly involve the therapist or Cristina Mantilla, LLC (and it's staff) in any litigation. The undersigned will neither request nor require that Cristina Mantilla, LLC or the therapist provide testimony in court. The reason for this is so that treatment is not compromised, the therapeutic relationship with the family is maintained, and a child can experience his or her play therapist in a clear, consistent, therapeutic role and not as an assessor or detective. If the services of a mental health professional are desired for court purpose, the services of a person outside of Cristina Mantilla, LLC must be enlisted.

Counseling Recordings/Artwork: The use of video recording or photography is sometimes necessary in therapy. Any type of recording is used to provide feedback to you, the client, or for therapist training purposes. Your confidentiality is protected and recordings are erased after each session unless your permission is given for another use. In the case of video or audio recording, you would be informed ahead of time and your written permission would be needed. The use of photography typically involves pictures of children's play structures (i.e.: sand trays, block building, etc.) or pictures of the children with our therapy pet. Children are offered copies of the pictures and this often helps them extend the therapy program to home and school. Artwork is sometimes used for training purposes, but the child's identity is protected. If you have any questions about this, please ask your therapist.

After Hours Emergencies: In the event of a behavioral health emergency, contact 911, National Suicide Prevention Line at: 1-800-273-TALK or go to the nearest crisis center.

I appreciate the opportunity to help enhance the quality of your life.

Payment of Fees for Service:
1. We accept cash, check, Visa, or insurance reimbursement.
2. If a check is returned for insufficient funds, you will be required to pay any bank service charges in addition to the check amount.
3. All co-pays and private pay fees are due at the time counseling services are provided.

Acknowledgement/Consent:

I authorize the Release of Medical information necessary for my insurance company to process my claim. I also authorize the payment of benefits to Cristina Mantilla, LLC.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

I certify all information on the counseling intake forms is true and correct to the best of my knowledge. I will notify Cristina Mantilla of any changes to my insurance information, address, telephone numbers, and any other relevant changes.

By signing this form I am acknowledging receipt of a copy of this paper and in agreement with the Orientation terms and conditions as provided by Cristina Mantilla, LLC.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
THERAPIST SIGNATURE DATE

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