



3723A Del Prado Blvd  
Cape Coral, FL 33904  
239-540-1155

[www.deltafamilycounseling.com](http://www.deltafamilycounseling.com)

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: Male / Female

Client Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent or Guardian Name(s): \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Okay to contact at work? Yes / No

Email address: \_\_\_\_\_ Okay to email? Yes / No

Okay to leave message: (circle approved location)      home      cell      work

Referred by: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

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**Insurance**

Company Name and Phone Number \_\_\_\_\_

Billing Address \_\_\_\_\_

Name of Insured and Relation to Patient \_\_\_\_\_

Insured's ID/Member Number \_\_\_\_\_ Group Number \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_\_ SSN of Insured \_\_\_\_\_

Address of Insured if different from patient: \_\_\_\_\_

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**Counselor Use:**

Date of first appointment: \_\_\_\_\_ Time of first appointment: \_\_\_\_\_

Financial Obligations and Policies discussed: yes / no    comments: \_\_\_\_\_

Copy of Insurance Card on File (if applicable): yes / no

Thank you sent to referral: yes / no    Date sent: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## **Delta Family Counseling, LLC Policies, General Information, and Informed Consent Agreement to Provide Psychotherapy Services**

**CONSENT:** I, \_\_\_\_\_ give my consent and approval for \_\_\_\_\_(therapist) of Delta Family Counseling, LLC, to work with me in therapy. I understand that the therapy sessions are confidential. By signing below I am stating approval of services. I understand that I am consenting to treatment and I have read this policy, general information, and informed consent agreement.

\*Please initial: \_\_\_\_\_

**CONFIDENTIALITY:** Delta Family Counseling, LLC is required to keep timely records of therapy and maintain confidentiality of all records. All information disclosed within sessions and the written records pertaining to those sessions and communication between client and therapist are confidential and may not be revealed to anyone without your (client's) written permission, except where required by law. In the event that a counselor is incapable of continuing therapy services due to illness or death, files will be accessed by a designated therapist who will keep the confidentiality of those files as expected and continue services if jointly agreed upon. Therapy files are kept for seven years or seven years after the child turns 18 years of age.

\*Please Initial: \_\_\_\_\_

**WHEN LAW REQUIRES DISCLOSURE:** The State of Florida requires that Delta Family Counseling, LLC inform you that under the following circumstances, confidentiality will be breached:

1. When there is cause to suspect a child, adolescent, or elder has been or may be abused or neglected.
2. When there is reasonable cause to believe that someone poses risk of imminent harm to themselves.
3. When there is reasonable cause to believe that someone poses risk of imminent harm to another individual.
4. When there is a valid court order compelling records or witness testimony.

\*Please Initial: \_\_\_\_\_

**LITIGATION LIMITATION:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and parenting disputes, injuries, lawsuits, etc.) neither you (client), parent/guardian, nor your attorney, nor anyone else acting on your behalf will call upon any therapist, employee, or intern of Delta Family Counseling, LLC to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If a parent or guardian is bringing his/her child to Delta Family Counseling, LLC to help during a stressful time such as court cases in the family's life, then the representatives of Delta Family Counseling, LLC work is directed toward helping the child in therapy. Therefore, the above-mentioned representatives will not participate in court proceedings because it is counterproductive to the therapy process. By establishing this policy from the beginning, each parent's rights are being protected as well as keeping the therapy room a safe, confidential place for a child. In some situations and at each counselor's discretion, the counselor may agree to parent/guardian's request to write a report about the client's progress in therapy. Both parents will receive a copy of that report. Please remember that, as stated above, Delta Family Counseling, LLC and its representatives are mandated reporters and if your child was to report abuse to a representative, then that counselor is bound to report it to the Department of Children and Families.

\*Please initial: \_\_\_\_\_

**SUPERVISION AND CONSULTATION:** If any representatives of Delta Family Counseling, LLC are serving as is a Registered Marriage and Family Therapy, Social Work, or Mental Health Counseling Intern, working towards licensure, it has been disclosed during your intake session and you are fully aware of this status. During this time, those Registered Intern representatives will be supervised by Tara Moser, LCSW, RPT-S and any other needed licensure supervisor, which will be disclosed, to ensure that you are receiving the highest quality of services. In addition, all representatives of Delta Family Counseling, LLC consult regularly with other professionals regarding clients; however, client's names or other identifying information are never mentioned. The client's identity remains completely anonymous and confidentiality is fully maintained.

\*Please initial: \_\_\_\_\_

**YOUR RIGHTS:** As a client, you have the right to terminate treatment at any time and request appropriate referrals from Delta Family Counseling, LLC. If at any time you want another professional's opinion or wish to consult with another therapist, your assigned Delta Family Counseling, LLC counselor will assist you in finding someone qualified. If your written consent has been obtained, the counselor will provide the new therapist with the essential information needed. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Delta Family Counseling, LLC assesses that releasing such information might be harmful in any way. In such a case, Delta Family Counseling, LLC will provide the records to an appropriate and legitimate mental health professional of your choice.

\*Please Initial: \_\_\_\_\_

**TERMINATION:** During the first couple of sessions, your Delta Family Counseling, LLC counselor will be assessing if they can be of benefit to you. If following the assessment the counselor feels that another provider would be a more appropriate match, that counselor will give you a number of referrals for you to contact that specialize in your area of concern. If at any point during therapy, your counselor assesses that they are not effective in helping you reach your therapeutic goals, they are obligated to discuss it with you and if appropriate, to terminate treatment and refer you elsewhere for appropriate services. If you request it and authorize it in writing, your Delta Family Counseling, LLC will talk to the psychotherapist of your choice in order to help with the transition. You have the right to terminate therapy at any time.

\*Please initial: \_\_\_\_\_

**PAYMENTS:** Clients are expected to pay by cash, check, or credit card (Visa, MasterCard, Discover, or American Express) at the rate of \_\_\_\_\_ per 50-minute session at the time of service unless other arrangements have been made. Telephone conversations, emails, site visits, school observations, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. may be charged at the same rate as indicated and agreed upon. If you are receiving Victim's Compensation or any other insurance benefit to help pay for your sessions, please be aware that you are fully responsible for any charges not covered by those benefits, which include but are not limited to, services provided after the exhaustion of benefits, or missed appointments. Please notify your assigned counselor if any problem arises during the course of therapy regarding your ability to make timely payments.

\*Please initial: \_\_\_\_\_

**APPOINTMENTS & CANCELLATIONS:** Appointments are reserved specifically for you, therefore a 24-hour cancellation notice is required if you are unable to attend a scheduled appointment. In the event that an appointment is not canceled with 24- hour advance notice, you will be charged in FULL for the appointment. Until the charge has been paid, you will not be able to schedule any future appointments. If you cancel within the 24 hours prior to your appointment or fail to attend two consecutive appointments or cancel/no-show an irresponsible number of appointments, Delta Family Counseling, LLC may terminate your case due to noncompliance with treatment. If you arrive more than 10 minutes late for an appointment, you will be responsible for payment in full and your session will be rescheduled for a later time. Sessions will not begin more than 10 minutes after the scheduled time. Any appointments that are missed without 24 hour notice and traditionally would be paid for through an insurance benefit or Victim's Compensation are the full responsibility of the client and/or parent/guardian.

\*Please initial: \_\_\_\_\_

**INSURANCE:** I hereby authorize payment of medical benefits to **Delta Family Counseling, LLC**. I hereby accept responsibility for payment for any service(s) provided to me or my child that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by insurance, if Delta Family Counseling, LLC does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time service is rendered.

\*Please initial: \_\_\_\_\_

In case of emergency with therapist, you authorize a representative of Delta Family Counseling to notify you of any appointment changes that may occur. This may include another counselor or administrative person within Delta Family Counseling, LLC. If you need to contact any counselor at Delta Family Counseling, LLC, counselors cannot be available at all times. Office hours are by appointment only and a counselor is generally in the office Monday through Saturday. All telephone calls are returned within 24 hours, with the exception of Sundays and holidays. A message can always be left on confidential, office voicemail and your call will be returned. Email is only an appropriate mode of communication for non-therapeutic issues (i.e. appointment re-scheduling, etc.), however should NEVER be used for emergencies or time-sensitive issues. Email responses will be returned as soon as possible, generally within 48 hours of receipt. In the event of an emergency that is a threat to life or health, please dial 911 or contact the local crisis line, Lee Mental Health at 239-275-4242.

\*Please initial: \_\_\_\_\_

I have read the above Agreement and Policies and General Information carefully. I understand them and agree to comply with them. I consent to treatment.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date

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**NOTICE OF PRIVACY PRACTICES**  
**for**  
**Delta Family Counseling, LLC**

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED  
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW THIS NOTICE CAREFULLY.**  
THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US.

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**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide for you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to the use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in affect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so in writing.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will NOT use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law, such as a subpoena or in regards to "Duty to Warn".

**Duty to Warn:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, or letters) with your authorization.

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## CLIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health and Human Services.

Contact Officer: Office Manager

Telephone: 239-540-1155

Fax: 1-866-397-5664

Address: 3723 A Del Prado Boulevard, Cape Coral, Florida 33904



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## Receipt and Acknowledgment of Privacy Practices Notice

Client Name: \_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_

Date of Birth (identified client): \_\_\_\_\_

I hereby acknowledge that I have received a copy of Delta Family Counseling, LLC. Notice of Privacy Practices and had the opportunity to ask questions and discuss the privacy rights described therein. I understand that if I have further questions regarding the Notice or my privacy rights, I can contact my therapist at her telephone number.

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Signature of Client

Date

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Signature of Parent, Guardian, or Personal Representative

Date

---

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

Client refused to acknowledge receipt:

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Signature of Staff Member

Date



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## Client Rights and Informed Consent – Guideline

- I have chosen to receive treatment services and understand I may terminate therapy at any time, unless ordered by the court.
- I understand there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.
- I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my problems.
- I understand that records and information collected about me will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.
- I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.
- I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.
- I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
- I understand that I may be contacted by my health plan to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.
- I have read and had explained to me the **Basic Rights of Individuals** including:
  - The right to be informed of the various steps and activities involved in receiving services.
  - The right to share in the formation of the plan of care/treatment plan.
  - The right to confidentiality under federal and state laws relating to the receipt of services.
  - The right to humane care and protection from harm, abuse, or neglect without regard to race, color, religion, gender, sexual orientation, age, disability, or cultural background.
  - The right to make an informed decision whether to accept or refuse treatment.
  - The right to contact and consult with counsel at my expense.
  - The right to select practitioners of my choice at my expense.

I understand that my therapist, health plan representatives, and my primary care physician may exchange any and all information pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

\_\_\_\_\_  
Signature of Patient/Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian/Conservator or  
Authorized Representative, if required

\_\_\_\_\_  
Date



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## Consent For Primary Care Physician (PCP) Contact

At Delta Family Counseling, LLC we strive to provide the most comprehensive treatment to you and/or your child. Based on this, we are asking that you allow us to notify your PCP that you or your child are now involved in mental health counseling and/or psychiatric services. In this way there is a continuum of care between practitioners who are committed to the care and well-being of you or your child.

We will initially send the attached letter with a copy of the Release of Information that you sign. At any time that there is a need for communication between practitioners we will do so. The other practitioner will be able to do the same. You may also request this at any point in your treatment.

Should you change or add providers we ask that you notify staff working with you so that we can update this information.

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Please complete the following information in addition to the attached release of information.

Name of Primary Care Physician: \_\_\_\_\_

Telephone Number: (     ) \_\_\_\_\_ ext: \_\_\_\_\_.

Secondary Physician: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ ext: \_\_\_\_\_.

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I, or the child I am parent/guardian to, currently do not have a PCP and understand that it has been recommended that I obtain one. Should I need assistance with this I will be referred to the Physicians referral program in my area. Once obtained I will notify the clinician and/or TCM/CM assigned to my case so that the above process can be completed.

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Client or Parent Guardian Signature

\_\_\_\_\_ Date

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I choose not to have my PCP or any other MD involved with my care be notified of my or my child's involvement in MH and/or psychiatric services. I understand that should I be prescribed medication or there be a significant event that warrants medical consultation this issue will be again be discussed with me. If it is felt that failure for Delta Family Counseling, LLC to be able to consult with the MD(s) who are providing medical treatment to me or the child I am parent/guardian to may result in harm to me I understand that Delta Family Counseling, LLC reserves the right to then end my treatment with an appropriate referral for services elsewhere made.

---

Client or Parent/Guardian Signature

\_\_\_\_\_ Date

(4/12/10)

# SOCIAL HISTORY

**Directions: Please complete to the best of your ability and bring with you to your first session.**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

1. **Chief Complaint** — Please explain your present concerns and what you think is causing the problem:

2. **Onset** — When did you first notice the concern/problem? What else was happening at that time that might be important?

3. **Referral** — How were you referred here (school, court, etc.)? What have you already tried in order to solve the problem?

4. **Family Composition**

- Biological parents \_\_\_\_\_
- Dates married/separated/divorced \_\_\_\_\_
- Parental relationship: Strained / Fair / Strong \_\_\_\_\_
- Custody / Visitation \_\_\_\_\_
- Parent / Guardian Occupations \_\_\_\_\_
- Siblings: DOB / Schools \_\_\_\_\_

5. **Significant Others** — Are there other individuals who play a large role in your life?

6. Are there any immediate family members that reside outside of the home? Yes / No  
If yes, who and where do they live \_\_\_\_\_

7. Please describe your personality, attitudes, values, etc. To whom are you most similar, and in what way(s)?

8. Injuries/Illnesses/Hospitalizations:

<u>Date</u>	<u>Location</u>	<u>Reason</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. Please list your current physician, including address, phone number, and date of most recent wellness exam \_\_\_\_\_

\_\_\_\_\_

10. Please list any current medical problems, including allergies you have? \_\_\_\_\_

\_\_\_\_\_

11. What medications are you currently taking and for what condition? By whom were the medications prescribed? \_\_\_\_\_

\_\_\_\_\_

12. Have you had any previous psychiatric/psychological evaluations/treatments, including counseling? Yes / No If yes,

<u>Dates</u>	<u>Treating Professional</u>	<u>Reason</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. How would you rate your temperamental qualities?

	Less than average	Average	More than average
Activity level	_____	_____	_____

Affection	_____	_____	_____
Persistence	_____	_____	_____
Moodiness	_____	_____	_____
Intensity of emotional response	_____	_____	_____

**14. Family Medical and Psychiatric History**

	<u>Maternal Relatives</u>	<u>Paternal Relatives</u>
Alcoholism	_____	_____
Drug abuse	_____	_____
Mental illness (specify)	_____	_____
Psychiatric hospitalizations	_____	_____
Mental retardation	_____	_____
Learning disabilities	_____	_____
Hyperactivity	_____	_____
Suicide or attempts	_____	_____
Other medical illnesses (specify)	_____	_____

15. Have you *or any member of your family* been a victim or perpetrator of physical, sexual, emotional, or substance abuse or neglect?      Yes / No      If yes, please explain

\_\_\_\_\_

\_\_\_\_\_

16. What are your hobbies and interests? (Boy/Girl Scouts, sports, reading, etc.) How much time per week does your child spend in each?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

17. Have you been diagnosed with any learning delays? Yes / No

If yes, what type? \_\_\_\_\_

33. Have you noted any problems in these areas? If yes, please explain.

Depression? Yes / No \_\_\_\_\_

Anger? Yes / No \_\_\_\_\_

Grief? Yes / No \_\_\_\_\_

Anxiety? Yes / No \_\_\_\_\_

Regressed behaviors (acting like a younger-aged child)?

Yes / No \_\_\_\_\_

Social skills? Yes / No \_\_\_\_\_

Detachment? Yes / No \_\_\_\_\_

34. Please share any additional information about your you that may be relevant (frequent moves, death of family member/pet, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

35. What are your family's spiritual or religious beliefs? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date



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## Pre-Authorized Mental Health Care Payment Form

I, \_\_\_\_\_, authorize Tara Moser, LCSW, RPT-S of Delta Family

Counseling, LLC to keep my signature on file and charge my credit card account for:

- \*Charges for appointments attended (fees for services rendered)
- \*Charges for missed appointments (including those canceled within 24 hrs)
- \*Balances for charges not paid within 90 days

For services provided by:

- Tara Moser, LCSW, RPT-S
- Julie Corbin, IMFT
- Robin Smith-Velazquez, LCSW

I understand that I may revoke this agreement at any time by a written request.

Client name: \_\_\_\_\_

Cardholder name: \_\_\_\_\_

Cardholder billing address: \_\_\_\_\_

- Visa
- MasterCard
- Discover
- American express

Account number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

Signature: \_\_\_\_\_

Email address (optional): \_\_\_\_\_

Tara Moser, LCSW, RPT-S agrees to charge only for reasons stated above at the agreed upon rates as committed to in policy letter.