Comprehensive Assessment Center
Psychological Evaluations, Consultations, and Interventions

6625 Miami Lakes Drive, Suite 328 ❖ Miami Lakes, FL 33014 ❖ Tel: 305-779-8565 ❖Fax: 305-779-8564

Name: _____ Date: _____

Address: _____

City: _____ Sate: _____ Zip Code: _____

Home Phone: _(___)_____ Business Phone: _(___)_____

Pager Phone: _(___)_____ Cellular Phone: _(___)_____

The best number to reach you? _(___)_____ May we leave a message? Yes __ No _____

Social Security Number: _____ Date of Birth _____ Age: ____ Gender: ____

How did you hear about our practice?_____

May we thank your referral source? Yes____ No _____

If yes, referral address: _____

Place of Birth: _____ Marital Status: (Married) (Single) (Divorced) (Widowed) (Cohabitating)

Employer: _____ Occupation: _____

Name of Spouse/Partner: _____ Occupation: _____

Have you informed your spouse/Partner that you are attending counseling? Yes ____ No _____

Is this your first time in therapy? Yes __No ___ Do you wish for me to notify your PCP? Yes__ No__

Presenting Problem(s):
Briefly state what prompted you to seek therapeutic services now? Identify current precipitants and historical information.

Developmental History

To the best of your recollection, how would you describe your early childhood experiences?
Stable ___ Unstable ___ Please explain:_____
_____
_____

Identify your primary care giver and describer your relationship? _____
_____
_____

As a child, did you suffer from any form of abuse? Physical ___Sexual ____ Neglect _____
If yes, please explain:_____
_____
_____

Childhood Health: _____ Excellent _____ Good _____Poor If poor, please explain ____
_____
_____

If you migrated from another country, please identify your country of origin and how old you were you when you came to the United States?_____

Academics: Excellent ____ Average ____ Poor ____ If poor, why? _____

Highest academic grade?_____ Religion primarily raised in? _____

Family History

Mother: _____ Living ____ Deceased ____ Age ____

Address: _____ Occupation(s): _____

Father: _____ Living ____ Deceased ____ Age _____

Address: _____ Occupation(s): _____

Number of years parents are/were married? _____ If divorced, how old were you? _____
Other people who live in your home?

Name	Age	Grade/Occupation	Relation

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Work History

Name of your last employer? _____ Position Held: _____

Briefly describe your responsibilities:
_____
_____
_____
_____

How long were you employed? ____ Years _____ Months _____ Days

Terms of termination: ____ Quit ____ Fired ____ Laid Off ____ Retired

Briefly explain the circumstances for the termination:
_____
_____
_____
_____

What has been the longest employment position held? ____ Years ____ Months ____ Days

Name of the agency: _____ Position Held:_____

Briefly describe your responsibilities:_____
_____
_____
_____

Medical History

Height ____ Weight ____ Please list any medical conditions and/or injuries; and dates incurred_____
_____
_____

Major operations and dates _____

Hospitalization(s) No ____Yes ____ If yes, list dates and reason_____
_____
Allergies?_____

Present Medications: _____
_____

Date of last Physical: _____ Results: _____

Do you engage in physical activity? Yes __ No __ Explain_____
_____
_____

Mental Health History

Previous outpatient psychotherapy? No__ Yes __ If yes, list dates (s) _____
Name of previous clinician: _____

Previous psychiatric treatment? Yes__ No __ If yes, list date(s) _____

What type of service did you receive? Inpatient __ Outpatient __

If inpatient, were you hospitalized? Yes __ No __ Are you currently under the supervision of a psychiatrist? Yes __ No __

If yes, please provide the name, contact information and psychotropic medications.

Dr. _____ Telephone: _____ Medications: _____
_____
_____
_____

Is there a family history of mental illness? Yes __ No __ If yes, please explain:
_____

In a case of an emergency, whom may we contact? _____
_____

Substance Use

Have you ever smoked? _____ If yes, what age did you start to smoke? _____

Do you currently smoke? Yes __ No _If yes, how many cigarettes do you smoke daily? _____

Current Frequency: daily _____ weekly _____ monthly ____

Reasons for smoking: socially __ recreational __ addicted __ do not use ___ Have you ever tried to stop smoking? Yes __No __ If yes, on your own or with medication? _____
Were you successful? Yes __ No___ Please explain _____
Please list any medical conditions due to smoking _____
_____
_____

Alcohol Use

Have you ever used alcohol? Yes __ No __ If yes, what age did you start to drink? _____

Do you currently drink? If yes, how many drinks per day do you have? _____

Current Frequency: daily ___ weekly ___ monthly ____

Reasons for drinking: socially __ recreational __ addicted __ do not use ___ Have you ever tried to stop drinking? Yes __ No __ If yes, on your own or with help? _____

Have you needed treatment for your drinking? Yes __ No __ If yes, list dates and where?
_____
_____
_____

Drug Use

Have you ever used drugs? Yes __ No __ If yes, list dates and what type?_____
_____
_____
_____
Do you currently use drugs? Yes __ No __ If yes, what is your drug of choice?_____

Age you started to use drugs _____ Current Frequency: daily ___ weekly ___ monthly ____

Reasons for drug use: socially __ recreational __ addicted __ do not use ___ Have you ever tried to stop using? Yes __ No __ If yes, on your own or with help? _____

Have you needed treatment for your drug use? Yes __ No __ If yes, list dates and where?
_____
_____
_____

Suicide Assessment

History of suicidal thoughts: No _____ Yes _____ If yes, date(s): _____

History of suicidal threats: No ____ Yes _____ If yes, date(s) _____

Suicidal Gesture and/or Attempts: No ____ Yes ____ If yes, list dates and explain:
_____
_____
_____

Violence and Aggression

History of suicidal thoughts: Yes __ No ____ If yes, date(s) _____

History of homicidal thoughts: Yes __ No ____ If yes, date(s) _____

History of sexual assault: Yes __ No __ If yes, date(s) _____

History of self-injury: Yes __ No__ If yes, list dates and explain how _____

Destruction of property, but no injury: Yes___ No___ If yes, date(s) and explain _____
_____
_____
_____

History of animal cruelty: Yes__ No ___ History of bed wetting: Yes__ No___ If yes, how often & until what age? _____

Blind rage: Yes__ No __ If yes, date(s) and explain _____

History of arrest: Yes__ No__ If yes, date(s) and explain _____

History of incarceration: Yes__ No___ If yes, date(s) and explain _____

Consent for Treatment

I voluntarily agree to and give consent for treatment at Comprehensive Assessment Center.

Signature: _____ Date: _____

Print Name:_____

Patient Payment Responsibility

I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or family members. I understand that I am responsible to meet my insurance deductible and co-payments, in addition to payment for any services of treatment not covered by my insurance carrier. In the event that my insurance carrier refuses to make payment against my claim for services, I accept responsibility for prompt payment for any treatment and services rendered to myself and/or my family. Additionally, if I receive any insurance payments directly from my insurance carrier for services performed, I will immediately (no later than 5 days) pay over such payments to Comprehensive Assessment Center, Inc.

When I reserve an appointment exclusively for me and/or my family members, I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled

appointment. In the event that I do not provide 24 hours advance notice, I am financially responsible to pay an incurred fee of $70.00 for the reserved appointment.

Upon prior discussion and agreement, I understand that charges will be added to my account for other professional services rendered (telephone contacts, court time, etc.).

Signature: _____ Date: _____

Signature on File

Kindly accept a photocopy of this authorization as if it were an original executed authorization. I authorize the release of any payment and medical information necessary to process my, or my family member's claim and related claims.

Signature: _____ Date: _____

Assignment of Benefits Agreement

I hereby authorize payment directly to Comprehensive Assessment Center, Inc. for Psychological Services of the insurance benefits otherwise payable to me for all professional services.

Signature: _____ Date: _____

Missed Appointments/No Show/No Cancellation Policy

Comprehensive Assessment Center, Inc. is a group of dedicated professionals whose mission is to ensure that each of our clients reach their maximum potential. In an effort to attain your therapeutic goals, we ask that you commit to your scheduled appointments. Should you be unable to attend, we ask you notify the office a minimum of 24 hour before your scheduled visit. This policy is necessary to ensure the smooth and adequate functioning of the office.

Should you fail to notify the office within the **24 hours** of your scheduled appointment, you will be responsible for a $50.00 cancellation fee. This amount is not your full fee, but a minimum charge the office has set for missed, no show or no cancellation appointments. We cannot bill your insurance company or missed appointments so you will be responsible for this payment.

I _____ hereby authorize "Comprehensive Assessment Center, Inc" to charge my credit card account in the amount of $50.00 in the event that I do not call to cancel my appointment within 24 hours in advance of my scheduled appointment or without prior notice.

CARD INFORMATION:

Credit Card Number

_____

Expiration Date: ____/____ VID Code: _____

BILLING ADDRESS

Street: _____

City: _____ State: _____

Zip Code: _____ -_____

Country: (if not US) _____

Telephone: _____-_____-_____

As the credit card holder, I hereby authorize this transaction.

Cardholder's Signature _____ Date: _____/ _____/ _____

HIPAA Notice of Privacy Practices

When I examine, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions. A complete detailed report can be found on our website and in our offices. By signing this form you are agreeing to let me use your information here and send it to others. **If you do not sign this consent form agreeing to what is in the Notice of Privacy Practices, I cannot treat you.** In the future I may change how I use and share your information and so may change the Notice of Privacy Practices. If I do change it, you can get a copy by calling me at 305-779-8565. After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Confidentiality

The information you share with me, both written (i.e., intake paperwork) and verbally, is part of your Protected Health Information (PHI) and is considered confidential. I will not release your information to anyone, including your family and healthcare providers, without a written consent. If you are a minor, it is the legal right of your parents to have access to the information that we discuss in our sessions. I will discuss with each minor client and their parent/guardian the expectations of exchange of information between parent/child, therapist/child, and the therapist/parent for their particular situation. It is important that you understand the legal limitations to confidentiality which include, but are not limited to:

1. When individuals express intent to harm themselves or others, the therapist may be required to break confidentiality to assure the health and safety of all concerned.
2. Therapist are mandated by law to report to the appropriate state authorities information documenting child and/or elder abuse or neglect.
3. When a judge orders that information be disclosed, I cannot guarantee that an appeal will be upheld, but I will do everything in my power not to disclose your confidential information.
4. The PATRIOT Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.
5. I will release protected health information when you authorize me to do so by signing a Consent for Release of Information. Your confidential files will be routinely be accessed only by me (your therapist) and/or Dr. Tania Diaz. Administrative assistants will only access the portions of your file pertinent to administration, such as your contact information and payment history, not your medical records or notes.

Waive right to subpoena:

In order to protect you and the information you and/or your child(ren) provide to me during our sessions, I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your child(ren) provide during session is considered privileged. If you anticipate the need for a therapist's involvement in court activity, I will be happy to refer you to someone who is more suited to meet your needs. The undersigned client has read, discussed and understands this agreement and stated policies.

_____ _____

Print Name Signature

Notice of Agreement Not to Participate in Legal Forums

This form is an agreement between you, _____, and the acting clinician at Comprehensive Assessment Center, Inc. When I use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When I examine, diagnose, treat, or refer you, I will be providing services that relate to your psychological assessment and or treatment. I will not be serving as your representative in any legal matters that may arise nor will I appear in court to represent you or your guardian. The findings of the assessment and or treatment may be provided, independent of my appearance in court.

By signing this form you are agreeing to the above mentioned Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in the Notice of Agreement Not to Participate in Legal Forums, I cannot treat you.

_____ ____/____/_____

Signature of client or his/her personal representative **Date**

_____ _____

Printed name of client or personal representative **Relationship to client**

_____

Signature of authorized representative of this practice **Date**