

Christy McNamara, MSW, ISW5269

2150 Park Avenue North, Winter Park, FL 32789 (407) 645-2545 Fax (407) 539-2447

(Please Print Clearly — Use Back Of Sheets If You Need More Room)

Contact and Billing Information

Name _____ Today's Date _____

Social Security# _____ D.O.B. _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Okay to call? Yes No

Work Phone _____ Okay to call? Yes No

Cell Phone _____ Okay to call? Yes No

Who referred you? _____

May we thank this person? Yes No

Please list any previous counseling (name and date)

Current Household Information

Indicate who lives at the above address and include yourself. Write a couple of key words to describe those persons listed below. (Quiet, Angry, Sad, etc.)

Name	Relation	Age	Key Words
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Have you been in a committed relationship or marriage previously?

Yes No

If yes, how many times? _____

Parents And Siblings Information

List the family members with whom you were raised. If someone is deceased put the date they died under "age". Again, write a couple of key words.

Name	Relation	Age	Key Words
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Medical Information

Has a physician ever told you that you had any of the following (please indicate "NO, YES or SUSPECTED" and if yes, when it first occurred)?

Hepatitis NO SUSPECTED YES

Nephritis NO SUSPECTED YES

Tuberculosis NO SUSPECTED YES

Bronchitis NO SUSPECTED YES

Pneumonia NO SUSPECTED YES

Pleurisy NO SUSPECTED YES

Sinusitis NO SUSPECTED YES

Asthma, Hay Fever NO SUSPECTED YES

Malaria NO SUSPECTED YES

Rheumatic Fever NO SUSPECTED YES

Chorea (St. Vitus Dance) NO SUSPECTED YES

Venereal Disease NO SUSPECTED YES

Cancer (specify site/type) NO SUSPECTED YES

Coronary Heart Disease NO SUSPECTED YES

Phlebitis (inflamed vein) NO SUSPECTED YES

Peptic Ulcer (specify site) NO SUSPECTED YES

Gall Bladder disease NO SUSPECTED YES

Colitis NO SUSPECTED YES

Anemia NO SUSPECTED YES

Rheumatoid Arthritis NO SUSPECTED YES

Gout NO SUSPECTED YES

Diabetes NO SUSPECTED YES

Thyroid Disease (specify) NO SUSPECTED YES

Skin disease (specify) NO SUSPECTED YES

Epilepsy NO SUSPECTED YES

Nervous or Mental Disorder NO SUSPECTED YES

Drug Allergies NO SUSPECTED YES

Fractured bones/serious injuries NO SUSPECTED YES

Any other serious conditions for which you required treatment? NO SUSPECTED YES

Current Physician _____

Date of Last Medical Exam _____

What medical problems or conditions do you currently have?

What medication(s) are you taking?

Key Information

Have you ever-attempted suicide? Yes No

Are you currently suicidal? Yes No

Have you ever been psychiatrically hospitalized? _____ Yes No

Do you use illicit drugs? Yes No

How much alcohol do you drink a week? _____

Have you ever been in trouble for threatening or harming others?

Yes No

What problems bring you in for services and how long have you had them?

What changes do you plan on making in therapy?

Regarding yourself:

In relation to others:

In relation to work:

Consent For Treatment

I, the undersigned, have voluntarily applied for and agree to participate in counseling and/or psychotherapy services. Please indicate your understanding and acknowledgement of the foregoing information by signing below.

Patient/Parent/Guardian Name _____
Signature _____ Date _____

Rights, Professional Fees and Responsibilities of Patient for Office of Christy McNamara, MSW, ISW5269

IMPORTANT: Please read carefully and initial or sign where indicated

Rights

As a patient, you have the right to receive available services individualized to your specific needs and provided in the least restrictive manner. You have the right to seek information about and to approve of therapeutic practices. With limited exceptions, information discussed and recorded is confidential. You will be asked to provide written consent if information is to be released to third parties. The exceptions to this written consent and strict maintenance of confidentiality include: 1) information that is shared on a need to know basis during clinical supervision of the therapist's work; 2) imminent physical danger to self or others; 3) child abuse; 4) information legitimately ordered by a court of law; and 5) information required by your insurance company in order to process a claim made by you. We are committed to providing you with the best possible care. Please ask if you have any questions about our fees, policies, or your responsibility.

PLEASE INITIAL _____

Appointments And Cancellations

YOU MUST GIVE AT LEAST 24 HOURS NOTICE IF YOU NEED TO CANCEL AN APPOINTMENT.

YOU WILL BE CHARGED IN FULL FOR THE APPOINTMENT--EVEN IF YOU DO NOT ATTEND—IF LESS THAN 24-HOUR NOTICE IS GIVEN.

Appointments can be scheduled as my hours become available. Traditionally, an "hour" is considered to be approximately 45 minutes. The length and frequency of therapy sessions depend on many factors and you may discuss this during your initial session.

PLEASE INITIAL _____

Professional Fees And Insurance

Responsible Party

You are responsible for the fees that you incur with Christy McNamara and NOT your insurance company or other third party. Thus, if your insurance company fails to pay in whole or in part for whatever reason within the time limits described below, you must pay any remaining balance. You are also always responsible for any co-payment and deductible. Parents/guardians are responsible for payment of a minor. If you fail to pay on your account, we have a right to turn your account over to a collection agency or attorney for collection.

If this account is assigned to an outside collection agency, an additional fee of 40% of the total amount owed will be added. PLEASE INITIAL _____

Payment Due and Insurance

Payment is due in full at the time of service. NO insurance is accepted for your first visit, unless we have a contract with your insurance company. There is a \$30.00 charge for checks returned for insufficient funds. As a courtesy, we may accept your insurance and file your insurance claim if you discuss this with your therapist and get approval. HOWEVER, if your insurance company fails to pay for any reason any portion of the claim within 60 days after we send the claim, you must pay any remaining balance.

PLEASE INITIAL _____

I have read the above statement of "RIGHTS, PROFESSIONAL FEES AND RESPONSIBILITIES OF PATIENT" for the Office of Christy McNamara, MSW, ISW5269. I understand its contents and conditions, give my consent to such, and agree to be bound by them.

Patient/Parent/Guardian Name _____

Signature _____ Date _____

Witness Name _____

Signature _____ Date _____

Insurance Information

Insurance Company Name

Insurance Company Phone

Insurance Company Address

Street City State Zip _____

Policy/contract # _____

Employer

Subscriber's Name _____ SS# _____

Patient's Name _____ D.O.B. _____

Authorization To Release Information

I authorize the release of any information to my insurance carrier by telephone, letter, or fax, for the purpose of validating and determining benefits payable.

Patient/Parent/Guardian Name _____

Signature _____ Date _____

**Christy McNamara, MSW
Psychotherapy**

2150 Park Avenue North
Winter Park, Florida 32789

407-645-2545
407-539-2447 (Fax)

**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received, and have been given an opportunity to read, a copy of Christy McNamara's, Notice of Privacy Practices. I understand that if I have any questions regarding the Notice, or my privacy rights, I may contact Christy McNamara at 407-645-2545.

Signature of Patient/Client

Date

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.)

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member

Date