

Breakthroughs: Counseling & Recovery

(904) 419-6102

NEW PATIENT INFORMATION

Welcome to our Office!

Cindy Falor, LMHC, CAP Tony Fiser, LCSW, CAP* Luann Edwards, MA, LMFT*
Susan McCulloch, MSW, LCSW* Bob Buscemi, M.Ed, LMHC* Ron Cipriano, MS, CAP*
Gene Bilbray, M. Ed, LMHC* Anthony Britton, MS, CAP* Linda Gamble, LMHC**

Patient Name (Please Print)	SSN	Marital Status	Sex	DOB	Age
		S M W D Sep	M F		
Street Address	City/State	Zip Code	Home Phone #		
Patient Employer or School Name (if minor)	Occupation	Years Employed	Work Phone#		
Spouse or Parent's Name (if minor)	Occupation	Years Employed	Work Phone #		

Person Responsible for Payment	Street Address	City/State	Zip Code
Phone #	DOB	SSN	

Primary Insurance Name
Employee Assistance Program (EAP) Name

Referred By:	Street Address	City/State/Zip
Phone #	May We Thank Them?	Comments

All the information above is deemed correct to the best of my knowledge

Signature of the Patient or Parent/Guardian

Date

**Breakthroughs Counseling & Recovery, Inc.
3810-3 Williamsburg Park Blvd
Jacksonville, Florida 32257**

CONFIDENTIAL INTAKE (Client to Complete)

Client Name: _____ Date: _____

Person completing this form: _____ Relationship to Client: _____

Previous mental health treatment? () No () Yes

Therapist name, dates, & outcomes: _____

Client statement of presenting problem: _____

Family statement of presenting problem: _____

Please list all Medications you are currently taking, dosage prescribed and doctor who prescribed it.

Please circle all symptoms:

Fatigue	Paranoia	Easily Agitated
Sleep disturbance	Violent	Extreme Sadness
Irritability	Homicidal	Loss of interest in Daily Activities
Obsessive Behavior	Rebellious	Decreased Concentration
Memory Loss	Mood Swings	Excessive Guilt
Stealing	Hallucinations	Delusions
Feeling of Worthlessness	Suicidal	Loss of Sexual Desire
Isolation	Panic/Anxiety	Defiant
Lying	Anger	Flashbacks
Alcohol Abuse	Drug use	Other _____

Who Suggested that you come today (circle all that apply)

My own decision	Family or Partner
Employer	Doctor or other health care professional
Court or Social Services	Employee Assistance Program (EAP)
Other _____	

SIGNATURE PAGE

(Initial) I hereby authorize _____ (therapist's name) and his/her authorized representative to release any information necessary to process my insurance claim, acquired in the course of my treatment; to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. I claim any insurance benefits due me for services rendered by _____ (therapist's name) and authorize any direct my carrier to issue payment check(s) directly to _____ (therapist name). Should I receive reimbursement check(s) from my carrier as a result of out of network benefits, I agree to bring in check(s) and explanation of benefits (EOB) to Breakthroughs Counseling to apply payment toward my account. Regardless of my insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred, and I agree to pay such fees in full.

(Initial) The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe, may incur full liability for professional charges, as a result of non- payment by any carrier.

(Initial) I understand that payment is due at time of service, unless other arrangements have been made in advance.

(Initial) **NO SHOW/LATE CANCELLATION FEE:** This charge is the patient's responsibility and will not be billed to the insurance company. I agree that I am responsible for the \$45.00 charge if less than 24 hour notice is given for a cancellation.

(Initial) I understand that communication between behavioral health providers and my primary care physician is important to help ensure that I receive comprehensive and quality health care. Therefore, I understand that if necessary, my primary care physician listed may be contacted in order to maintain continuity of care.

Physicians Name: _____

Address: _____

Telephone #: _____

(Initial) I have read and received a copy of the HIPPA and Florida Health Privacy Standards; as well as facility grievance procedure with "important phone numbers".

(Initial) For Clients Receiving Substance Abuse Treatment Only:
I have read and received a copy of HIV/AIDS information and understand that I will receive further HIV education if I am in the substance abuse treatment program.

Patient or Parent/Guardian Signature

Date

Witness

Date