Diane Colonnello, L.C.S.W., P.A.
8192 College Pkwy., Bld. B, Ste. 50
Fort Myers, Fl 33919
(239)275-9665 Fax (239)267-4438

NAME: _____
(First) (Middle) (Last)

NAME OF THE LEGAL GUARDIAN: _____
(In the case of a minor)

STREET ADDRESS/MAILING ADDRESS: _____

CITY: _____ **STATE:**____ **ZIP:**_____

HOME #:_____ **CELL#:**_____ **WORK#:**_____

DATE OF BIRTH:_____ **SOC. SEC.#:**_____

SEX: _____ **ETHNIC/RELIGIOUS B.:**_____

RELATIONSHIP STATUS: _____ **OCCUPATION:**_____

EMPLOYER NAME/ADDRESS:_____

SCHOOL NAME/ADDRESS: _____

WHAT PROBLEM(S) ARE YOU SEEKING HELP?

_____

_____

WHO REFERRED YOU? _____

WHO SHOULD BE CONTACTED IN AN EMERGENCY?

_____

HAVE YOU SEEN A MENTAL HEALTH PROVIDER BEFORE?
IF YES, PLEASE LIST THE NAMES OF EACH PROVIDER/ DATES OF SERVICE:

_____

_____

PLEASE LIST ALL CURRENT/PAST MEDICAL PROBLEMS (INCLUDE THE DATE/MD). :

LIST THE LAST ANNUAL CHECK YOU HAVE HAD?_____

PLEASE LIST ALL CURRENT MEDICATION, DOSAGE, DATES TAKEN AND PRESCRIBING MD. ALSO NOTE ANY ALTERNATIVE /OVER THE COUNTER MEDICATIONS. :

HAVE YOU EVER VISISTED AN EMERGENCY ROOM FOR CARE?_____
NAME OF THE PRIMARY INSURANCE:_____

INSURANCE ID #:_____**GROUP #:**_____

NAME OF THE POLICY HOLDER: _____

POLICY H.'S DATE OF BIRTH:_____**SOC. SEC. #:**_____

NAME OF THE SECONDARY INSURANCE:_____

INSURANCE ID #:_____**GROUP #:**_____

NAME OF THE POLICY HOLDER: _____

POLICY H.'S DATE OF BIRTH:_____**SOC. SEC. #:**_____

I hereby give permission to Diane Colonnello, LCSW to provide me with the evaluation and treatment she believes is in my best interest. This consent applies to myself, my child or the client named above. I understand that I have the right to discuss my treatment with my provider, and refuse treatment at anytime. I understand my continued participation implies voluntary consent.

My provider has the responsibility to take whatever actions she believes is necessary to ensure the safety of myself and /or others if an emergency arises. I understand the contents of my chart are confidential and information will only be released with my signed consent or under the following conditions: 1- where abuse or harmful neglect of children, the elderly, the disabled, or incompetent individuals is known or reasonably suspected 2- where an eminent threat of violence against an identified victim is disclosed 3- where an eminent threat of self harm/ suicide is revealed 4-in the case of a court order 5- where such information is necessary for the licensed clinical social worker to defend against a malpractice action bought by the

client/patient. I understand that my provider may sometimes consult other professionals regarding treatment issues (without divulging personal , identifying data) in order to strive for the best possible treatment. These professionals are bound by the same federal and state laws regarding confidentiality.

I understand that my provider will on occasion be out of town or unavailable. In case of this, she will designate another qualified psychotherapist for emergency coverage. She will make every effort to make arrangements ahead of time whenever possible, and if in case of the unexpected, the covering professional's name and number will be available by calling her office.

I understand the therapeutic relationship will end in the case that I do not show for two consecutive appointments without making arrangements.

I understand a record of service of my care will be held for 7 years. The following information is in this record: id data, test data, medication list, psychosocial history, correspondence, progress notes or summary, goals, interventions, results.

Claims are automatically filed electronically with my insurance company or companies, unless I indicate I prefer to file my own claims or make a self pay arrangement. Co payments / coinsurance/deductibles/payments are expected on the date service is rendered. Statements regarding accounts will be sent if there is an outstanding balance. I understand I may request a statement of my account. Delinquent accounts will be handled on an individual basis, which could potentially result in collections agency fees which will be added to my outstanding balance.

I hereby give permission to Diane Colonnello, LCSW, PA to bill my insurance company (ies) and to provide said company (ies) with clinical information that is pertinent and necessary to the processing of the claims. I understand that a billing service and/ or electronic billing may be employed. I understand I am responsible for notifying Diane Colonnello of my insurance authorization number for services and if services are not authorized or not covered by my insurance company, I will be responsible for the payment.

My signature below indicated that I have read and understood the statement above and have had an opportunity to discuss the above information with my provider, upon my request.

_____ _____

(Client Signature) **(Date)**

_____ _____

(Legal Guardian Signature) **(Date)**

_____ _____

(Witness Signature) **(Date)**

CLIENT-THERAPIST CONTRACT

CLIENT NAME: _____

THERAPIST NAME: **DIANE COLONNELLO**

As a client, I understand that my responsibilities are as follows:

-Attend all scheduled sessions

-Give at least 24 hours notice of my inability to keep an appointment

-make fee payments in a timely manner

-Honestly share my thoughts and feelings, including my feelings about the therapist

-Present information regarding my past and current circumstances truthfully

-Take responsibility for my actions and decisions

-Express my feelings verbally not through actions

-Refrain from inflicting harm to myself and/ or others

-Participate in at least one session regarding ending the client-therapist relationship

-Contact the crisis line at 275-4242 or go to the emergency room, if a need arises

As a therapist, my responsibilities are as follows:

-Provide the type of therapy which I believe will be in your best interest, although I can not guarantee results

-Provide honest feedback regarding observations about any behaviors, thoughts or feelings which may be an obstacle to your happiness and self-fulfillment

-Support your attempts to solve your problems, but not make decisions for you

-Refer you to other professionals if problems a rise which I believe are beyond my scope of knowledge and training

-Protect your confidentiality by disclosing information only to those parties to whom you designate in writing by signing a Consent to Release Information with the exceptions outlined in the Notice of Privacy Practices

-Make myself available in an emergency, when ever possible

Client Signature: _____ **DATE:** _____

Therapist Signature: _____ **DATE:** _____

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24 HOUR CANCELLATION/ NO SHOW POLICY

I understand psychotherapy involves a commitment that requires time, emotional energy, and financial commitment. I know that time has been set aside by my therapist for my appointment. Therefore, it is important for me to contact the therapist to let her know if I will not be able to come in during that time. Likewise my therapist will contact me in the event that an appointment must be cancelled/ rescheduled for her own reasons.

It is a policy that clients are responsible for attending **all** scheduled sessions. If a client is unable to attend a session, the client must notify the therapist within the 24 hours prior to that appointment time.

If an emergency or unusual circumstance occurs that prevents the client from notifying the therapist, the therapist will handle this on a case by case basis.

As the client, I understand that if I do not comply with the above policy, **I will be billed 50% of the customary fee as outlined below.** For a missed appointment and will be responsible for the payment. I also understand that the insurance company or any other third payor will not be billed. This policy will be administered within the guidelines of my insurance policy.

CUSTOMARY FEE SCHEDULE

Initial Evaluation	$ 180
Individual Psychotherapy	$ 130
Individual Psychotherapy 25 min.	$ 80
Individual Psychotherapy 85 min.	$ 190
Marital/Family Psychotherapy	$ 130
Group Psychotherapy	$ 50

Client Signature: _____ DATE: _____

Witness Signature: _____ DATE : _____

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

CLIENT NAME: _____

DOB: _____

I hereby acknowledge that I have reviewed and have been given an opportunity to read a copy of Diane Colonnello, LCSW, PA Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Diane Colonnello.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____