Dr. Carmine Pecoraro, Psy.D. & Associates, PA
10021 Water Works Lane, Riverview, FL 33578
2708 Alt 19 N., Suite 507 Room #13 Palm Harbor, FL 33305
7747 Mitchell Blvd, Suite B, Trinity, FL 34655
1650 NE 26th Street, Suite 206, FT Lauderdale, FL 33305
Astateofmindcounseling.com
Email to: Intake@Drcarminep.com
OFFICE: (954) 463-2723 or (727) 543-7678 FAX: (954) 463-1687

DATE: _____ **HOME PHONE:** _____ May we use this as a contact number? ____

CELL PHONE: _____ May we use this as a contact number? ____

BUSINESS PHONE: _____ May we use this as a contact number? ____

E-MAIL: _____ May we use this to contact you? _____

1. **CLIENT INFORMATION** (IF MINOR USE MINOR'S INFORMATION)

NAME: _____ SOC. SEC. #: _____
LAST NAME FIRST NAME INITIAL

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ May we contact you at this address? _____

SEX: ( )F ( )M AGE: _____ BIRTHDATE:_____ ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED

CLIENTEMPLOYED BY: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____
Street Address City State Zip

WHOM MAY WE THANK FOR REFERRING YOU: _____ May we contact them? _____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED: _____ PHONE: _____

2. RESPONSIBLE PARTIES INFORMATION:

PERSON RESPONSIBLE FOR ACCOUNT: _____
LAST NAME FIRST NAME INITIAL

RELATIONSHIP TO CLIENT: _____ BIRTHDATE: _____ SOC. SEC. #: _____

ADDRESS IF DIFFERENT FROM PATIENT: _____
STREET ADDRESS CITY STATE ZIP

3. INSURANCE INFORMATION

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO CLIENT: _____

BIRTHDATE OF POLICY HOLDER: _____ POLICY HOLDER'S EMPLOYER: _____

INSURANCE COMPANY: _____ POLLICY HOLDERS SOC. SEC. #: _____

POLICY NUMBER: _____ GROUP NUMBER:_____ IS THERE A SECONDARY INSURANCE: ( ) Y ( ) N

I, THE UNDERSIGNED CERTIFYTHAT I (OR MY DEPENDENT) HAS THE ABOVE MENTIONED INSURANCE COVERAGE.

I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE WHENEVER ANY INFORMATION ON THIS FORM CHANGES.

I AGREE TO PRESENT THIS OFFICE WITH A PICTURE ID CARD (DRIVER'S LICENSE, MILTARY ID, STATE ID) AND IF APPLICABLE MY INSURANCE CARD. I UNDERSTAND THAT THIS OFFICE WILL MAKE A COPY OF MY ID AND INSURANCE CARD TO KEEP ON FILE.

_____ _____ _____
SIGNATURE OF RESPONSIBLE PARTY **RELATIONSHIP** **DATE**

_____ _____
PRINT RESPONSIBLE PARTIES NAME **Signature of Client if differ from responsible party.**

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CLIENT RIGHTS

All individuals who apply for services, regardless of sex, race, age, color, creed, financial status or national origin are assured that their lawful rights as clients shall be guaranteed and protected.

1. To be provided a copy of our office's Privacy Notice.

2. To be treated with respect and dignity.

3. To privacy for interview/counseling sessions.

4. To confidentiality

Exceptions:

(a) The court may request information about clients and/or treatment without client consent.
(b) By law, all suspected cases of child abuse/neglect must be reported.
(c) By law, all suspected cases of elderly abuse/neglect must be reported.
(d) By law, "Whenever a patient has declared an intention to harm other persons, such declaration may be disclosed.
(e) If client fails to make good on a bounced check within a reasonable amount of time, some confidentiality information may be released so that the State Attorney's office can collect on the outstanding debt.
(f) If client fails to pay the balance of his account in full within a reasonable amount of time, some confidential information may be released so that collections of the fees may be pursued.

5. To refuse treatment.

6. To be informed of the client grievance procedure upon request.

7. To receive full information regarding treatment process.

Additional information and explanation of the above rights has been given in the Notice of Privacy and is available upon request. Our office welcomes any questions or concerns.

I hereby acknowledge the receipt of this Clients Rights Statement.

_____ _____ _____

Signature of Client **Print Client Name** **Date**

Further Legal Acknowledgements: In consideration for the therapeutic services provided, neither I nor may an attorney issue any subpoena or in any way direct the attendance of the therapist to appear for deposition, hearing, trial or matter of any nature as it may relate, in anyway, to the client, client's family, or anyone who may be affected by the services or opinions rendered on behalf of the client. I expressly authorize the therapist to disregard any required appearances except those issued under lawful authority of a judge of competent jurisdiction.

Signature:_____**Date:**_____

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CONSENT FOR SERVICES/TREATMENT

Client's Name: _____Date of Birth:_____

I, the undersigned a client of Dr. Carmine J. Pecoraro, Psy.D.& Associates, PA,

I, the Undersigned, a (Parent of a minor, Guardian, Guardian advocate) of the above named client

Who is a client of this office and the subject of this authorization, hereby authorize the professional staff of the above stated agency to administer mental health and/or substance abuse services/treatment, which may include psychotherapy, chemotherapy, psychoeducational services and/or emergency evaluations, EXCEPT Electoconvulsive treatment.

I have been informed that this consent can be revoked orally or in writing prior to or during the treatment period. I acknowledge that there have been no guarantees or assurances made to me as to the results of services/treatments rendered by Dr. Carmine J. Pecoraro, Psy.D & Associates, PA and/or their employees.

I am aware that I am financially responsible for any costs incurred as the result of services/treatment rendered by this office and such costs may be adjusted based on my gross family income.

I have read and fully understand the above Consent for Services/Treatment.

_____
Date of Consent

_____ _____
***Client Signature** **Print Client's Name**

_____ _____
Parent of Minor/Guardian/Guardian Advocate Signature **Print Name**

_____ _____ _____
Witness Signature **Print Witness Name** **Position**

- **The client shall always be asked to sign this authorization form. In addition, a parent of a minor, guardian or guardian advocate may be asked to give consent.**

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CREDIT CARD AUTHORIZATION

I authorize Dr. Carmine J. Pecoraro, Psy.D. & Associates, PA to charge my credit card for cancellations of appointments not honoring the 24-hour cancellation policy as well as missed services and I guarantee any services rendered with my credit card, including renewed cards.

_____ _____
Authorized Signature Date

_____
Print Signature

Type of Card:

American Express
Mastercard
Visa

_____
Card Number

_____
Expiration Date

_____
Security Code

_____
Name as it appears on the card

Address where Bills are sent.

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INFORMED CONSENTS

Client Name: _____ **Date of Birth: _____Today's Date_____**

Information Authorization (Primary Care Physician): I authorize _____ or decline _____ authorization of the release of information to the primary care physician for the purpose of coordinating care .

Name of PCP: _____ Phone: _____

Signature: _____ Date: _____

Information Authorization (other doctor): I authorize _____ or decline _____ authorization of the release of information to the primary care physician for the purpose of coordinating care.

Name of other Doctor: _____ Phone: _____

Type of Doctor: _____ Reason for coordinating care: _____.

Signature: _____ Date: _____

Information Authorization (In the case of an emergency): I authorize _____ or decline _____ authorization of the release of information to my _____(relationship) for the purpose of coordinating care.

Relationship: _____ Name: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Address: _____

Signature: _____ Date: _____

Information Authorization (Thank you for referral): I authorize _____ or decline _____ authorization of the release of my name to _____ for the purpose thanking them for the referral.

Name of Referral Source: _____ City and State: _____

Signature: _____ Date: _____

_____	_____	_____	_____
Witness Signature	Print Witness Signature	Witness Title	Date

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Notice of Privacy

THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE OF THIS NOTICE

Our Office is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This Notice describes your legal rights, advises you of our privacy practices, and lets you know how our office is permitted to use and disclose PHI about you.

This Notice is covered under HIPAA (Health Insurance Portability & Accountability Act). Any state law that is more stringent than the HIPAA rules and regulations has priority.

We are required to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. If we do so, we will post a new Notice in our waiting area. You may request a copy of the new notice from our Secretary or our Privacy Officer, ___ Dr. Carmine Pecoraro, Psy.D., CAP by calling (954) 463-2723 or (727) 543-7678

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED MENTAL HEALTH INFORMATION

We use and disclose PHI for a variety of reasons. For most uses/disclosures, we must obtain your consent. However, the law provides that we are permitted to make some uses/disclosures without your consent. The following offers more description and examples of our potential uses/disclosure of your PHI.

Uses And Disclosures Requiring Your Consent:

- **For treatment:** We may disclose your PHI to other mental health care practitioners who are involved in providing your mental health care. For example, a referral to a mental health practitioner for assessment and/or long-term treatment would require a signed consent form from you for us to release and/or receive PHI about you to appropriately coordinate your care.

- **For mental health care operations:** We may use/disclose your PHI in the course of operating our Program. For example, we may use your PHI in evaluating the quality of services provided, creating reports that do not individually identify you, or disclose your PHI to our accountant or attorney for audit purposes.

- **For Payment:** We may use/disclose your PHI in the course of collecting outstanding payment from you. For example, If failure for paying on a bad check in a timely manor, we may employ the State Attorney's office to collect on the outstanding debt. Or if failure to pay on your account in a timely manor, we may employ an attorney or collection agency to collect any outstanding debt.

Exceptions: Although your consent is usually required for the use/disclosure of your PHI for the activities described above, the law allows us to use/disclose your PHI without your consent in certain situations. For example, we may disclose your PHI if needed for emergency treatment if it is not reasonably possible to obtain your consent prior to the disclosure and we think that you would give consent if able. Also if we are required by law to provide your treatment, we may use/disclosure your PHI for treatment and operations without obtaining your prior consent.

Uses And Disclosures Requiring **Authorization:** For uses and disclosures beyond treatment and operations purposes we are required to have your written authorization (signed permission), unless the use or disclosure falls within one of the exceptions described below. Like consents, authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

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Uses and Disclosures Requiring **Authorization By A Minor:** The law provides that we may not use/disclose a minors PHI to the parent/legal guardian without a consent or authorization in the following circumstances.

- **When required by law:** We may not disclose a minors PHI to the a parent/legal guardian when a law requires that we keep confidentiality about:
- Substance Abuse/Chemical Dependency
- Pregnancy
- Abortion

Uses And Disclosures **Not Requiring Consent Or Authorization:** The law provides that we may use/disclose your PHI without consent or authorization in the following circumstances:

- **When required by law:** We may disclose PHI when a law requires that we report information about:
- Suspected abuse
- Neglect or domestic violence
- Suspected criminal activity
- In response to a court order

We must also disclose PHI to authorities who monitor compliance with these privacy requirements.

- **For health oversight activities:** We may disclose PHI for audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) to oversee the health care system.

- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm. Fore example, a plan to commit suicide or a homicidal act.

- **For specific government functions:** We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

Uses And Disclosures Requiring You To Have An **Opportunity To Object:** In the following situations, we may disclose your PHI if we inform you about the disclosure in advance and you do not object. However, if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

- **To families, friends or others involved in your care:** We may share with these people information directly related to your family's friends or other person's involvement in your care. We may also share PHI with these people to notify them about your location or general condition. For example, parents of a minor have certain rights to PHI. Also, we may have to locate family members to inform them of the location of a client who was hospitalized after being diagnosed as severely depressed.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION. You have the following rights relating to your protected mental health information:

- **To request restrictions on uses/disclosures:** You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

- **To choose how we contact you:** You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.

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- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is (1) amended and complete; (2) not created by us and/or not part of our records; or (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will amend the PHI and so inform you, and tell others that need to know about the amendment in the PHI.

- **To find out what disclosures have been made:** You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made. If you would like to receive an accounting, you may send us a letter requesting an accounting or contact our Privacy Officer. The accounting will not include several types of disclosures, including disclosures for treatment or disclosures for which you gave consent. It will also not include disclosures made prior to April 14, 2003. However, from that day forward, disclosures must be documented and retained for a period of 6 years. We will respond to your written request for such a list within 60 days of receiving it. There will be no charge for up to one such list each year/ (12) month period. There may be a charge for more frequent requests.

- **To receive this notice:** You have a right to receive a paper copy of this Notice and/or electronic copy by email upon request.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a complaint either with us or with the federal government. We will not take any action against you or change our treatment of you in any way if you file a complaint. You may file a written complaint with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street SW, Atlanta, GA 30303-8909.

CONTACT PERSON FOR INFORMATION OR TO SUBMIT A COMPLAINT AND QUESTIONS

If you have questions about this Notice or any complaints about our privacy practices, please contact:
Dr. Carmine J. Pecoraro, Psy.D., CAP
P O Box 834
Palm Harbor, FL 34682

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Dr Carmine Pecoraro, Psy.D. & Associates, PA Notice of Privacy Practices effective 04/14/2003.

Name (please print): _____

Signature: _____Date:_____

(FOR CHILD BELOW OR PERSON WITH LEGAL GUARDIAN)

Name (please print): _____

Relationship to Patient: ( ) Parent ( ) Legal Guardian

Signature: _____ Date: _____

(OFFICE USSE ONLY)

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective [date] given to individual on _____ (date)

0 In Person 0 Mailing 0 Email 0 Other _____

Reason individual or parent/legal guardian did not sign this form:

0 Did not want to
0 Did not respond after more than one attempt
0 Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

0 In person conversation _____
0 Telephone contact _____
0 Mailing _____
0 Email _____
0 Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

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Family Medical Leave Paperwork, Short/Long Term Disability Paperwork or Summaries for Social Security Disability
Policies and Procedures.

I understand that Dr. Carmine Pecoraro, Psy.D. and Associates, PA has the following Policies and Procedures for Family Medical Leave Act (FMLA), Short Term/Long Term Disability and Social Security Disability paperwork.

1. I must be an existing client, who has been seen at least four times. My Evaluation and first treatment plan must have been completed.

2. I understand that Dr. Carmine Pecoraro, Psy.D. and Associates has the rights to refuse to complete any paperwork for the Family Medical Leave Act (FMLA), Short and Long Term Disability.

3. The paperwork must be into Dr. Carmine Pecoraro, Psy.D. and Associates, PA, at least, a week before it is due. I understand that the office needs time to complete the paperwork.

4. I understand that there is a fee to complete the paperwork. The fee is my responsibility to pay. It cannot be charged to insurance, and the disability company will not pay the fee.

5. I understand that not all disability paperwork can be completed by this office because some require a Medical Doctor (MD) to complete the paperwork.

6. I understand that full disclosure of my medical records is needed for Dr. Carmine Pecoraro, Psy.D. and Associates, PA to comply with the requests from the companies handling your Leave or Disability claims. These companies may request records that can help your case. At which time, our office will provide based on your authorization. When giving full consent, you are permitting our office to release information about Mental Health, Substance Abuse, HIV status.

7. I understand that Dr. Carmine Pecoraro, Psy.D. and Associates, PA will send my records to Short/Long Term Disability or Social Security Disability, once a release of information with a request for records is received.

At this time,
I am ( ) applying for/or on _____

I am ( ) thinking about applying for _____

I am ( ) not/and do not intend to file for any type of FMLA or disability.

_____ _____ _____
Client Signature Print Client Name Date

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APPOINTMENT POLICES, FEES AND AGREEMENTS

1. All **appointments** are scheduled at the front office or by telephone. In **Urgent situations**, the earliest available appointment will be offered. If you must cancel an appointment, a 24 hour notice is **REQUIRED** unless there is a **MUTUALLY** agreed upon situation. If such cancellation is not made the charge for a **missed session is $200.00**.

2. **Our office does not have an answering service.** We apologize for any inconvenience that this may cause you. We will do our best after hours to collect messages; however, we are unable to guarantee immediate returns of emergency telephone calls, until the next business day. Therefore, **in the case of an emergency, please go to the nearest hospital or call 911.**

3. The fees for services are: $200.00 for initial interview and assessment, $200.00 per 45-50 minute for the following sessions. School appearances, psychological testing, reports, letters, court reports, court appearances, and additional services have different fees and those will be discussed and agreed upon prior to the service.

4. **My insurance company is entitled** to any medical or other **information necessary to process my insurance claims. Signature on File** is to be used on all my insurance submissions. **My doctor or doctor's secretary may act as my agent in helping me obtain payment from my insurance company**. **The insurance payment is to go directly to my doctor**. The insurance co-payment is due at the time of service. **I authorize use of this form on all my insurance submissions**. **I permit a copy of this authorization to be used in place of the original.**

5. Clients without insurance are expected to pay in full at the time of the service, unless other arrangements are made with this office.

6. If your insurance payment is not received within 60 days, or if the amount paid by your insurance is less than expected, you will be responsible for the total amount remaining.

7. For services rendered to a minor dependent, the **PARENT WHO SIGNS THIS FORM** is the one responsible for the balance.

8. **There is a $30.00 fee for any returned checks**. If failure for paying on a bad check in a timely manor, I give my consent for this office to employ the State Attorney's Office to collect on the outstanding debt. I understand to bounce a check and not make the outstanding check good in a timely manor is a crime, and this office does prosecute to the fullest extent by law.

9. **In failure of paying my account** in a timely manor, **I give my consent for this office to employ another agency** (i.e., attorney, or collection agency) to collect any outstanding debt. I understand that I will be responsible for any additional costs. I understand that all necessary records will be released to the retained agency.

If you have any questions regarding the above agreement, please feel free to speak with your therapist.

I have read, understood and agreed to the following terms for services:

_____ _____ _____
Print Name Social Security Number Date of Birth

_____ _____
Signature Date

_____ _____ _____
Minor's Date of Birth Minor's Name Minor's Signature