Rachel Moskowitz, M.S., LMHC
6037 Winthrop Commerce Ave. Suite #220
Riverview, Florida 33578

Client Information Form

Date: _____ Referred by:_____

Name:_____
First Middle Last

How do you prefer to be addressed (Name/Nickname):_____

Date of Birth: ____ /____ /_____ Age: _____ SSN: _____-_____-_____

Gender: [ ] Male [ ] Female Last School Grade Completed: _____

Please circle: Single Married Partnered Separated Divorced Widowed

Spouse's name:_____ Spouse's employer:_____

Spouse's Phone number:_____

Ethnicity:_____Religion:_____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone:_____can a message be left at this number?__yes __no

Work Phone:_____can a message be left at this number?__yes __no

Ext.:_____

Cell Phone:_____can a message be left at this number?__yes __no

How do you prefer to be contacted? _____

Occupation: _____ Employer: _____

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Phone: _____

Name of Insured: _____ Policy Number: _____

IF SOMEONE OTHER THAN CLIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE BELOW

Name of Guarantor: _____ SSN: _____

Address: _____

Phone: _____ Relationship to client: _____

Employer: _____ Occupation: _____

IF SOMEONE OTHER THAN CLIENT FILLED OUT THIS INTAKE PACKET:

Your name: _____ Relationship to client: _____

PERMISSION FOR RELEASE OF INFORMATION

Please note that this must be signed if you are using managed health, EAP, or any third party administrator who may require information (Please see INFORMED CONSENT)

1. I authorize Rachel Moskowitz, LLC to release any information required in the course of my treatment to:

INSURANCE: _____ Signature: _____ Date: _____

2. I authorize _____ to release any information requested by Rachel Moskowitz, LLC. Signature: _____ Date: _____

Medical/Mental Health History Self-Report

Name: _____ Date of Birth:_____

Current Primary Care Provider: _____Contact #: _____

Psychiatrist: _____ Contact #:_____

Please describe any medical issues you have been or are currently experiencing, or medical issues you believe I should know about:

_____

_____

_____

_____

_____

Have any family members had any of the following?

	YES	NO	WHO
Depression			
Bipolar disorder			
Suicide or Attempt			
Schizophrenia			
Eating Disorder			
Anxiety Disorder			
Alcohol / Drug Issues			
ADD / ADHD			
Thyroid Issues			
Asthma			
Diabetes			
Stroke			
Dementia			
Stomach Issues			
Seizures			
Heart Issues			
Cancer			
High Blood Pressure			

Current Medications (including any *over the counter* or *herbal preparations*):

Name of Medication	Dosage	For what reason?	How Long?	Side effects(if any)

Continue on back of this sheet, if needed.

Mental Health Care in the past? (such as psychiatrist, psychologist, social worker, nurse, counselor, or psychological testing)

By Whom?	When?	Diagnosis	Type of Treatment	Were you hospitalized?

Continue on back of this sheet, if needed.

Currently using caffeine? ☐Yes ☐No If yes, how much, how often_____ If no, past use?_____

Currently using cigarettes? ☐Yes ☐No If yes, how much, how often_____ If no, past use?_____

Currently using alcohol? ☐Yes ☐No If yes, how much, how often_____ If no, past use?_____

What is the major reason you are seeking help at this time?

How long have you had these problems or symptoms?

How often do they occur?

Why did you decide to seek help now?

What have you tried, in the past, to help yourself?

Who lives with you at home?

Name of person	Relationship to you	Age	Occupation/School

INFORMED CONSENT FOR TREATMENT

Office of RACHEL MOSKOWITZ, M.S., LMHC

When finished, please sign below that you have read and understand the following:

Psychotherapy/counseling is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many methods that may be used to deal with your situation. This will not be like a medical doctor visit in that you will be an active participant in your counseling process, working both during and between your sessions.

Psychotherapy can have benefits and risks. Since therapy can involve discussing an unpleasant aspect of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience or in the outcome of this process. However, you will be involved in the setting of treatment goals, and these should be reviewed and assessed frequently during the course of treatment. **Please note that a clinical hour of therapy is 45-50 minutes.**

Your privacy and confidentiality of your participation in counseling and evaluation will be strictly maintained. This is not the case if you give your written permission for disclosure, or if law requires disclosure. These may include, but are not limited to the following situations: 1) assessed danger to self or others; 2) knowledge, or suspicion of, abuse of a child, elderly, or anyone who can not protect him/herself; 3) receipt of a court order requiring the release of information; 4) matters of national security and 5) a referral from worker's compensation.

Exception to the concept of absolute confidentiality may occur in the normal process of service delivery. This may involve, when appointments are confirmed; a supervisor or colleague consultation; a secretary typing a report; or an insurance company, managed care company, EAP, or other financial intermediary in the billing process. This may require disclosure of such data as diagnosis, treatment plan, historical data, drug and alcohol history, treatment history, presenting problem, and other information. **Your signature below provides permission to release such information.**

Please note that additional charges may be assessed for filling out disability and other such forms and for checks returned unpaid from your bank.

You will be financially responsible for all charges not covered by your insurance program. It is your responsibility to obtain information from your insurance company regarding your benefits, out of pocket expenses, limits, and confirmation that your therapist is a participant on that panel. All fees are due at the time of service.

Signature_____ Date_____

Print name_____

Cancelled, Rescheduled, and Phone Session Appointments

Clients who cancel or reschedule appointments with less than 24 hours notice are responsible for the full fee for the time they have reserved. Exceptions may be made for extenuating circumstances at the sole discretion of the therapist. If your insurance does not cover cancelled sessions, you will be charged at the current private pay rate.

In the event of a situation that requires a phone session exceeding more than 15 minutes, you will be charged the rate of a regular therapy session. In cases where your insurance does not cover phone sessions, you will be billed directly.

In order to avoid incurring unnecessary charges and billing please indicate a credit card that we can charge for missed or rescheduled appointments falling within the 24-hour period.

I, _____ approve my credit or debit card to be charged for my missed appointment or phone session per the terms outlined above.

Name listed on the card:_____

Card #:_____

Security number on card: _____

Expiration date:_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.		