Michelle DeLaRosa, LCPC
Michelle DeLaRosa Therapy, LCPC, LLC
3. SIGNATURE FORM (please print and bring to first session)

Acknowledgment of documents: I acknowledge that I have received, read, and understand the Client Agreement document and agree to abide by its terms. I acknowledge that I have been offered a copy of the therapist's Notice of Privacy Practices and agree to its terms as well.

Consent to treatment: I do hereby seek consent to take part in the treatment by Michelle DeLaRosa and participate in services described in the Client Agreement document, or do so on behalf of my child. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time.

Agreement to pay for professional services: I acknowledge that payment is due at the time of treatment and will be paid directly to Michelle DeLaRosa, LCPC. I understand that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all services or items provided to me, to my minor/child, or to the client for whom I have legal responsibility, whether or not they are ultimately reimbursed by insurance or are part of my benefit plan. I understand that filing a claim with my insurance company does not relieve me from my responsibility for payment of all charges. I further agree that in the event of non-payment, I will bear the cost of collection, should this be required. I understand that I am responsible for charges for checks returned due to non-sufficient funds. I also know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and/or do not show up, I will be charged for the appointment.

For those clients using insurance: I hereby assign payment of authorized medical benefits from my insurance carrier to Michelle DeLaRosa, LCPC to release any and all medical information to your insurance carrier and/or attorney for the purposes of claim administration and evaluation, utilization review and/or financial audit. This includes information related to mental health services such as assessments, history, diagnoses, medication information, treatment plans and progress, dates of service, and progress notes. This authorization will expire one year from the last date of service. I may revoke this authorization at any time but revocation will not apply to information already released. Failure to authorize the release of this information may result in your insurance carrier denying claims. Any money received from the above named insurance company over and above my balance due will be refunded to me when my account is paid in full.

It is also understood that if I have a managed care or other insurance plan, some services may not be authorized for payment under my benefit plan. These services may include, but are not necessarily limited to: the evaluation of parent and/or teacher rating scales, teacher (or other collateral) interviews, psychological testing, evaluation of records for diagnostic purposes or treatment planning, report writing and preparation, multidisciplinary school conferences, and biofeedback.
My signature below shows that I understand and agree with all of these statements.

Print Client's Name	Signature of Client (age 12 and older)	Date
Print Parent/Guardian's Name	Signature of Responsible Party (if different than client)	Date
Clinician's Name	Signature	Date

Michelle DeLaRosa Therapy, LCPC, LLC
4. CLIENT INFORMATION FORM (please print and bring to first session)

Client Name:_____
Date of Birth _____/_____/_____ Age:_____ Gender: M F
Address:_____ Apt#:_____
City:_____ State:_____ Zip Code:_____
Marital Status: S M W D Student Status: FT PT not a student
Client's Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___
Employment status: FT PT unemployed disabled retired homemaker
If minor (under age 18): Mother's name:_____ Father's Name:_____
Name(s) of **ALL legal** guardian(s):_____
Client lives with: ❑ Both Parents ❑ Mother ❑ Father ❑ Other:_____
Emergency contact name:_____ Number:_____
Relationship:_____
Please identify the number(s) where we may contact you/leave a message:
Home Phone: _____ Yes No
Work Phone:_____ Yes No
Cell Phone:_____ Yes No Cell carrier's name (e.g., AT & T):_____
E-mail Address:_____
Okay to send correspondence or statements via e-mail? Yes No

Please identify your preferred method of contact for appointment reminders:
❑ Home Phone ❑ Cell Phone ❑ Text ❑ E-mail ❑ No reminder
Your medical care: From whom or where do you (or your child) receive medical care (e.g., Primary Care Physician (PCP), Pediatrician, Internist, Family Physician)?
Doctor's Name:_____ Phone:_____
Do you want me to contact and communicate information with this medical doctor: ❑ Yes ❑ No
Referral: Who gave you my name to call, or where did you find out about my practice?
Name:_____ Phone:_____
May I have permission to thank this person for the referral? ❑ Yes ❑ No
Primary Insurance:
Insurance Carrier Name:_____ Circle: HMO PPO POS
Phone Number:_____
Identification Number:_____ Group Number:_____
Subscriber Name: _____ Insured Date of Birth _____/_____/_____
Insured's Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___
Insurance Claims Mailing Address:_____
Employer of Policy holder:_____
Secondary Insurance:
Insurance Carrier Name:_____ Circle: HMO PPO POS
Phone #:_____ Identification #:_____ Group#:_____
Subscriber Name: _____ Insured Date of Birth _____/_____/_____
Insured's SS#:_____ Employer's Name: _____
Insurance Claims Mailing Address:_____

Please read the following carefully and sign below:
I give permission to Michelle DeLaRosa, LCPC and billing staff to send required information to my insurance company or my EAP. I am aware that I am placing my signature on file. I also understand that I will be responsible for any unpaid balance such as copays, deductibles, and non-covered services. I understand there is a $75.00 fee if I fail to give at least 24 hour notice for cancellation of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions.

_____ _____ _____
Signature of Client (age 12 and older) Signature of Responsible Party (if different than client) Date

Late Cancellation and Missed Appointment Policy

At Michelle DeLaRosa Therapy LCPC, LLC we schedule therapy appointments in which 45-60 minutes is reserved exclusively for you. When a session is cancelled without notice, we are unable to fill this time slot by offering it to another client, a client on the wait list, or a client with an urgent need. In addition we are not able to bill your insurance company for missed sessions. In order to successfully operate we rely on consistent therapy appointments. Therefore we have established the following policy to address cancellations with less than 24 hour notice or no show appointments.

Cancelling your appointment last minute hurts three people: you, your therapist, and another client who could have benefitted from the time that you forfeited.

We realize that on rare occasions an event may occur in your life that requires the canceling of a scheduled appointment with less than the required 24 hours. We will do our best to offer you a timely rescheduling of your appointment the same week, which would waive the cancellation fee. But often we do not have available time slots. Nevertheless, keep in mind that regardless of the understandable reason for cancelation, you still will be charged if you do not keep the appointment or reschedule within the same week.

As of January 1, 2018, a missed appointment fee of $75 will be charged to your credit card on file with us at the end of the business day of your appointment unless you contact us and make other arrangements.

Thank you for your understanding of and cooperation with this policy. Feel free to contact us with questions.

I have been informed of the policies and procedures at Michelle DeLaRosa Therapy, LCPC, LLC and consent to providing my credit card information to cover any late cancelled or failed appointment charges.

Signature_____ Date _____

Signature _____ Date_____

Therapist Signature _____ Date _____

Authorization to Charge Credit/Debit Card

I authorize my therapist, Michelle DeLaRosa LCPC, with Michelle DeLaRosa Therapy, LLC to keep my signature and credit/debit card information on file in order to charge therapy session copays for any appointments for my minor child in which I, as guardian, am not present. I also authorize charging the card on file for appointments with my therapist that are not cancelled 24 hours before the scheduled appointment time for therapy services provided to:

_____ (Therapy Client's Name: Please Print)

Cancellations, Missed Appointments: If I miss or cancel an appointment with less than 24-hours notice, the card listed below will be charged full session fee of $75, regardless of the reason for the missed appointment. _____ (Initial)

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured, and is unlikely to be tampered with, I agree to assume the risk if the credit card information is compromised. I understand that charges for my session copay or late cancel fee will be charged at the end of the business day in which my appointment is scheduled. Additionally, I agree that the card listed below may be charged by my therapist, Michelle DeLaRosa, with Michelle DeLaRosa Therapy LLC in order to settle any outstanding balances accrued by the above listed client upon termination of therapy within one week of termination. I understand that if a charge back fee is incurred or a retrieval fee of is incurred I am responsible for these fees. Initial _____

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact my therapist, Michelle DeLaRosa, with Michelle DeLaRosa Therapy LLC for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed. Initial _____

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name [print]:_____
Signature_____

Relationship to client:_____

Billing Address:_____

Card Type (circle one): Visa Mastercard Discover Amer Express

Acct. Number: _____

Exp. Date: _____ Security Code (on back of card) _____

I understand that my therapy sessions will be charged via this form and not by swiping my card by the close of the business day of the missed appointment unless cancelled 24 hours in advance:

Cardholder Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CLIENT HISTORY
Counseling Program

Name: _____ Date: _____

What concern(s) brings you to Counseling?

_____

_____

_____

What changes do you want to see as a result of coming to Counseling?

_____

_____

_____

Client's Medical History

Currently under a doctor's care: _____**Yes** _____**No**

Doctor(s) involved in your care: _____

Health problems (include allergies): _____

Medication currently used: None

Medication	Dosage	Doctor Prescribing	Why Prescribed

Past Hospitalizations - Medical, Psychiatric, Chemical Dependency: None

Date (s)	Reason (s)	Hospital

Previous Counseling, EAP or Chemical Dependency Services: None

Facility/Counselor Name	Date (s)	Reason (s)	Helpful?

Symptom Checklist

Please complete for each person attending the first appointment

Client's Name: _____ Date: _____

Person Completing Form: _____

Please check how often these symptoms occurred *in the last 6 months.* If you are a parent completing this form for your child/adolescent, please provide your child's/adolescent's symptoms *in the last six months.*

SYMPTOM	Never or rarely	A few times a month	Nearly every day	SYMPTOM	Never or rarely	A few times a month	Nearly every day
Guilt Feelings				Hopeless about future			
Worrying				Thinking about death			
Too much energy				Thinking about suicide			
Aggressive				Problems with family members			
Uncontrolled temper				Brooding about the past			
Afraid of work/school				Crying excessively			
Afraid of leaving house				Feeling down or sad			
Sleep walking				Nightmares			
Problems falling asleep				Feeling anxious			
Problems staying asleep				Feeling panicky			
Memory loss				Problems with anger			
Trouble making decisions				Feeling jealous			
Feeling alone				Feeling impatient			
Difficulty concentrating				No confidence in self			
Sudden mood changes				Shortness of breath			
Restlessness				Fast heart beat			
Easily Distracted				Chest pains			
Problems getting along				Feelings of unreality			
Feeling worthless				Lying			
Overly tired				Problems at home			
Poor or no appetite				Alcohol use			
Over eating				Drug use			
Bingeing				Blackouts			
Food preoccupation				Stomach Problems			
Vomiting				Uncontrolled thoughts			
Sleeping too much				Uncontrolled behavior			
Hearing voices				Physical abuse of self or others			
Problems at work/school				Emotional abuse of self or others			
Stealing				Other:			

Symptom Checklist

Please complete for each person attending the first appointment

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Person Completing Form: _____

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Bingeing				Blackouts			
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Vomiting				Uncontrolled thoughts			
Sleeping too much				Uncontrolled behavior			
Hearing voices				Physical abuse of self or others			
Problems at work/school				Emotional abuse of self or others			
Stealing				Other:			