A Better Life Counseling Services
Margot Logan, LCSW

PATIENT INFORMATION SHEET

LAST NAME: _____FIRST NAME:_____MI_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
HOME PHONE: ( )_____ WORK PHONE: ( )_____
CELL PHONE: ( )_____ E-MAIL:_____
DATE OF BIRTH: ___/___/___ SOCIAL SECURITY: _____-___-_____ SEX: MALE □ FEMALE □
MARITAL STATUS: SINGLE □ MARRIED □ OTHER □
LEGAL GUARDIAN OF PATIENT UNDER 18 YEARS OF AGE:_____
RELATIONSHIP TO PATIENT:

_____
EMPLOYER/SCHOOL NAME:

_____
CITY: _____STATE: _____ZIP: _____
DRIVER'S LICENSE NUMBER: _____STATE: _____

INSURANCE INFORMATION
(PLEASE PRESENT INSURANCE CARD TO BE COPIED)

DOCTOR OR AGENCY REFERRED BY: _____
CITY: _____ STATE: _____ ZIP: _____
POLICY NAME HOLDER: _____DATE OF BIRTH: _____
GROUP NUMBER: _____ SS#/ID # _____
EMPLOYER NAME AND PHONE: _____( )_____
INSURANCE PHONE NUMBER TO VERIFY BENEFITS: ( )_____
NUMBER FOR PRE-CERTIFICATION:_____

SECONDARY INSURANCE_____
CITY: _____ STATE: _____ ZIP: _____
POLICY NAME HOLDER: _____DATE OF BIRTH: _____
GROUP NUMBER: _____ SS#/ID # _____
EMPLOYER NAME AND PHONE: _____( )_____
INSURANCE PHONE NUMBER TO VERIFY BENEFITS: ( )_____
NUMBER FOR PRE-CERTIFICATION: _____

READ & SIGN – I ACKNOWLEDGE I AM FINANCIALLY RESPONSIBLE FOR ANY SERVICES RENDERED BY MARGOT LOGAN, LCSW IF INSURANCE IS TO BE FILED, I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION MECESSARY TO PROCESS CLAIMS FOR SERVICES PROVIDED. I FURTHER AUTHORIZE THE RELEASE OF MEDICAL BENEFITS TO MARGOT LOGAN, LCSW A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE_____DATE: _____/___/_____

CLIENT INTAKE INFORMATION
(PLEASE PRINT ALL INFORMATION)

HIGHEST LEVEL OF EDUCATION: ELEMENTARY □ MIDDLE SCHOOL □ HIGH SCHOOL □
COLLEGE □ OTHER □
OCCUPATION: _____
RELIGIOUS AFFILIATION: _____
HOW MANY TIMES HAVE YOU BEEN MARRIED: _____
HOW MANY TIMES HAS YOUR SPOUSE (OR FIANCE) BEEN MARRIED: _____
IF MARRIED NOW, HOW MANY YEARS: _____

FAMILY MEMBERS: (INCLUDE SPOUSE) CHECK IF LIVING AT HOME (x)

NAME	AGE	D.O.B.	RELATIONSHIP	AT HOME
_____	____	_____	_____	□
_____	____	_____	_____	□
_____	____	_____	_____	□
_____	____	_____	_____	□
_____	____	_____	_____	□
_____	____	_____	_____	□

NAME OF EMERGENCY CONTACT: _____
PHONE NUMBER: ( )_____ RELATIONSHIP:_____

PERSON RESPONSIBLE FOR ACCOUNT/BILL: _____
ADDRESS: _____
CITY: _____ STATE: _____ZIP: _____
PHONE NUMBER: ( )_____ WORK NUMBER: ( )_____
RELATIONSHIP: SELF □ SPOUSE □ PARENT □ LEGAL GUARDIAN □
INSURANCE COMPANY: _____
INSURED PERSON: _____SOCIAL SECURITY _____/___/_____

JOB SATISFACTION

JOB SATISFACTION: HIGH □ OK □ LOW □ NONE □
JOB STATUS: SECURE □ IN JEPORADY □ UNEMPLOYED □ RETIRED □ DISABLED □
WORKERS COMP □ SOCIAL SECURITY □
ARE YOU WORKING MORE THAN ONE JOB: YES □ NO □ OTHER □
WHAT OTHER KINDS OF WORK ARE YOU QUALIFIED TO DO: _____
_____

GENERAL HEALTH

HOW WOULD YOU RATE YOUR OVERALL HEALTH:
EXCELLENT □ GOOD □ AVERAGE □ POOR □
PHYSICIANS NAME: _____PHONE: ( )_____
ADDRESS:_____
_
CITY:_____ STATE: _____ ZIP:_____
DATE OF LAST PHYSICAL: _____

I AUTHORIZE MARGOT LOGAN, LCSW TO SHARE INFORMATION WITH MY PRIMARY CARE PROVIDER. YES □ NO □

LIST ALL MEDICATION BEING TAKEN AT THIS TIME:_____
_____
_____
_____
CONTINUE ON BACK IF NEEDED.

MEDICAL HISTORY

LIST ALL PROBLEMS, ALLERGIES, & SURGERIES INCLUDING DATES:_____
_____
_____
_____

HAVE YOU EVER HAD PREVIOUS THERAPY OR BEEN HOSPITALIZED FOR A NERVOUS OR MENTAL DISORDER: YES □ NO □ IF YES WHEN:_____
WHERE: _____FOR HOW LONG: _____
WHO WAS YOUR DOCTOR OR THERPAIST: _____
HAVE YOU EVER ATTEMPTED SUICIDE: YES □ NO □
IF YES WHEN:_____

REFERRAL SOURCE: FRIEND □ MD □ ATTORNEY □ COURT □ AGENCY □
FORMER CLIENT □ YELLOW PAGES □ EMPLOYER □
EAP □ OTHER_____

CANCELLATION/ NO SHOW POLICY

I AGREE TO ATTEND ALL SCHEDULED APPOINTMENTS. I UNDERSTAND THAT FAILURE TO CANCEL AN APPOINTMENT WITHOUT TWENTY-FOUR (24HR.) HOUR NOTICE OR NOT SHOWING UP FOR AN APPOINTMENT WILL RESULT IN A TWENTY DOLLAR FEE. REPEAT OFFENSES OF THE POLICY MAY RESULT IN PERMANTENTLY BEING REMOVED FROM THE SCHEDULE FOR SERVICES.

SIGNATURE:_____DATE:_____

DESCRIPTION OF THE PROBLEM: THE FOLLOWING IS A LIST OF AREAS IN WHICH YOU MAY BE EXPERIENCING SOME DIFFICULTY. PLEASE CHECK ANY OF THE SYMPTOMS THAT MAY APPLY TO YOU OR WHICH HELP DESCRIBE A PROBLEM YOU ARE HAVING.

A. PYHSICAL CONCERNS

1. CHANGE IN
- □ SLEEP
- □ APPETITE
- □ PHYSICAL ENGERY
- □ GENERAL HEALTH
- □ WEIGHT
- □ INTEREST IN ACTIVITY

2. INCREASED USE OF:
- □ ALCOHOL
- □ DRUGS
- □ PAIN RELIEVERS
- □ ANTACIDS
- □ LAXATIVES
- □ DIET PILLS
- □ SLEEPING PILLS

3. RECENT HISTORY OF:
- □ NAUSEA & VOMITING
- □ DIARRHEA
- □ FEVER
- □ CHEST PAIN
- □ SHORTNESS OF BREATH
- □ PALPITATIONS(POUNDING HEART)
- □ RAPID BREATHING
- □ SEVERE HEADACHES
- □ HEAD INJURY
- □ LOSS OF CONSCIOUSNESS
- □ LOSS OF MEMORY
- □ CHANGE OF VISION
- □ DIFFICULTY IN SPEECH
- □ LOSS OF BALANCE
- □ SWOLLEN JOINTS
- □ CHILLS
- □ SKIN RASH
- □ MISCARRIAGE
- □ ABORTION
- □ SIEZURE(S)
- □ NUMBNESS
- □ PARALYSIS
- □ DIZZINESS
- □ TINGLING
- □ BLACKOUTS
- □ DELIRIUM TREMORS
- □ FLASHBACKS
- □ ILLNESS
- □ HOSPITALIZATION
- □ BLEEDING
- □ INFECTION
- □ SWEATS

B. PSYCHOLOGICAL CONCERNS:

1.THOUGHTS OF:
- □ SUICIDE
- □ HARMING SELF
- □ HARMING OTHERS

2. EXPERIENCE OF:
- □ VIVID DREAMS
- □ NIGHTMARES
- □ DECREASED NEED FOR SLEEP
- □ HEARING VOICES
- □ SEEING VISIONS
- □ BEING OUT OF BODY
- □ THOUGHT CONTROL
- □ RACING THOUGHTS

3. FEELINGS OF:
- □ ANXIETY
- □ DEPRESSION
- □ DREAD
- □ DESPAIR/HOPELESSNESS
- □ LOW SELF WORTH
- □ JEALOUSLY
- □ TENSION
- □ RAGE
- □ PERSECUTION
- □ BOREDOM
- □ LONELINESS
- □ GUILT
- □ HIGH ENERGY

4. FEAR OF:
- □ LOSS OF CONTROL
- □ DEATH
- □ BEING ALONE
- □ OBJECTS
- □ ANIMALS
- □ PLACES
- □ SITUATIONS
- □ BEING POSSESSED
- □ BEING INSANE
- □ CANCER
- □ AIDS
- □ EXPOSURE
- □ PUNISHMENT

C. SOCIAL/OCCUPATIONAL CONCERNS:
- □ SPOUSE
- □ FAMILY MEMBER
- □ CHILD
- □ FRIEND/PEER
- □ WORK SUPERVISOR

2. PROBLEM WITH:
- □ FINANCES
- □ LEGAL AUTHORITIES

3. VICTIM OF:
- □ BAD ACCIDENT
- □ RAPE
- □ PHYSICAL ABUSE
- □ SEXUAL ABUSE
- □ HARRASSMENT
- □ SLANDER
- □ MALPRACTICE
- □ DISFIGUREMENT
- □ VIOLENT CRIME
- □ WAR INJURY
- □ NATURAL DISASTER
- □ WITNESS TO VIOLENCE/DEATH
- □ SPOUSE ABUSE/CHILD ABUSE
- □ CULT GROUP/PRACTICE
- □ DISCRIMINATION
- □ VANDALISM

FOR CHILDREN:

4. DEVELOPMENTAL HISTORY:

WEEKS GESTATION _____

BIRTH WEIGHT _____

APGAR ____(1 MIN) _____(5 MIN)

FOR CHILDREN:

CHECK ALL THAT APPLY:
- □ PREG/DELIVERY PROBLEMS
- □ IN UTERO ALCOHOL/DRUG USE
- □ FAILURE TO THRIVE
- □ SMOKING DURING PREGNANCY

TYPE OF LABOR:

□ SPONTANEOUS □ INDUCED

TYPE OF DELIVERY:

□ NORMAL □ BREECH □ CESAREAN

AGES FOR DEVELOP. MILESTONES:

SITTING _____

CRAWLING _____

TALKING _____

WALKING _____

POTTY TRAINING _____

EATING SOLIDS _____

USING SIPPY CUPS _____

USING 2 WORD PHRASES ____

NO PROBLEMS _____

ON THE SCALE BELOW, PLEASE ESTIMATE THE SEVERITY OF YOUR PROBLEM:

□ MILD □ MODERATE □ SEVERE □ EXTREME □ INCAPACITATING

WHAT ARE YOUR GOALS FOR THERAPY: _____

_____

_____

ADDITIONAL COMMENTS:_____

_____

_____

CONSENT FOR PSYCHOTHERAPY AND/OR BEHAVIORAL HEALTH TREATMENT
INFORMED CONSENT

I HEAREBY CONSENT TO ENTER TREATMENT WITH MARGOT LOGAN, LCSW I UNDERSTAND THAT ALL INFORMATION DISCLOSED DURING THE COURSE OF THERAPY WILL BE HELD IN CONFIDENCE WITH THE EXCEPTION OF INTERVENTION WITH THREATS OF HARM TO MYSELF OR OTHERS, ALLEGATIONS OF CHILD ABUSE OR NEGLECT AND/OR COURT ORDERED DISCLOSURES. I UNDERSTAND THAT MARGOT LOGAN, LCSW HAS A LEGAL AND ETHICAL OBLIGATION TO DISCLOSE THIS INFORMATION AND WILL MAKE EVERY EFFORT TO DISCUSS THIS WITH ME SHOULD THE NEED ARISE. I UNDERSTAND THAT ALL INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND WILL NOT BE RELEASED TO ANYONE WITHOUT MY PRIOR SPECIFIC WRITTEN PERMISSION.

I UNDERSTAND THAT I WILL EXPECT TO BE AN ACTIVE PARTICIPANT IN MY TREATMENT. I WILL COMMIT MYSELF TO KEEPING MY APPOINTMENTS AS SCHEDULED. I ACKNOWLEDGE THAT THERE IS NEVER A GUARANTEE IN THE OUTCOME OF MY THERAPY.

I UNDERSTAND THAT PAYMENT ARRANGEMENTS FOR SERVICES ARE MY RESPONSIBILITY. I UNDERSTAND THAT I WILL BE EXPECTED TO NOTIFY THE OFFICE OF THE NEED RESCHEDULE AN APPOINTMENT AT LEAST 24 HOURS IN ADVANCE.

SIGNED:_____ DATE: _____

WITNESSED:_____ DATE: _____

OFFICE POLICIES

IT IS IN THE POLICY OF THIS OFFICE TO FILE YOUR INSURANCE. IT IS TH RESPONSILITY OF THE PATIENT TO OBTAIN AUTHORIZATION FOR YOU FIRST VISIT. IF YOU HAVE NOT OBTAINED AUTHORIZATION FOR THIS VISIT, YOU WILL BE RESPONSIBLE FOR THE ENTIRE CHARGE. PLEASE NOTIFY US IF YOU HABE NOT RECEIVED AN AUTHORIZATION AND WE WILL RESCHEDULE.

IF YOU HABE UNITED HEALTHCARE MEDICAID HMO, YOU MUST CALL UNITED BEAHVIORAL HEALTH FOR AUTHORIZATION FOR YOUR FIRST VISIT. IF YOU HAVE NOT OBTAINED AUTHORIZATION FOR THIS VISIT, YOU WILL BE RESPINSIBLE FOR THE ENTIRE CHARGE. PLEASE NOTIFY US IF YOU HAVE NOT RECEIVED AN AUTHORIZATION AND WE WILL RESCHEDULE.

IT IS THE POLICY OF THIS OFFICE THAT CO-PAYMENTS ARE DUE PRIOR TO SEEING THE THERAPIST. IF YOU HAVE FORGOTTEN YOUR CO-PAYMENT, YOU WILL BE REQUIRED TO PAY YOUR CO-PAYMENT, PLUS THE MISSED CO-PAYMENT AN YOUR NEXT VISIT TO THE OFFICE. IF YOU ARE UNABLE TO PAY YOUR CO-PAYMENT AT THAT TIME, YOU WILL BE ASKED TO RESCHEDULE.

I HAVE READ AND UNDERSTAND THE ABOVE.
SIGNED:_____ DATE: _____

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

PATIENT NAME: _____
DATE OF BIRTH: ___/___/___ SOCIAL SECURITY NUMBER: _____/___/_____

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND HAVE BEEN GIVEN AN OPPORTUNITY TO READ A COPY OF THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE ANY QUESTIONS REGARDING THE NOTICE OR MY PRIVACY RIGHTS, I CAN CONTACT MARGOT LOGAN, LCSW AT 407.739-6059.

SIGNATURE OF PATIENT/CLIENT DATE

SIGNATURE OF PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE* DATE

IF YOU ARE SIGNING AS A PERSONAL REPRESENRARIVE OF AN INDIVIDUAL, PLEASE DESCRIBE YOUR LEGAL AUTHORITY TO ACT FOR THIS INDIVIDUAL (POWER OF ATTORNEY, HEALTHCARE SURROGATE, ETC.)

_____
_____
_____

☐ PATIENT OR CLIENT REFUSES TO ACKNOWLEDGE RECEIPT.

SIGNATURE OF STAFF MEMBER DATE

RELEASE OF INFORMATION

REQUEST AND AUTHORIZE:

MARGOT LOGAN, LCSW
1155 S. Semoran Blvd.
Suite 1150
Winter Park, Florida 32793
(407) 739-6059

TO RELEASE INFORMATION TO AND FROM: (NAME/ADDRESS OF AGENCY, OFFICE OR PERSON)

_____
_____
_____
_____

REGARDING PATIENT: _____DATE OF BIRTH_____
ADDRESS: _____
_____
_____
_____

THE INFORMATION TO BE RELEASED FOR A PERIOD OF 12 MONTHS FROM THE DATE SIGNED.

I AUTHORIZE THE ABOVE NAMED AGENCY(S), PERSON, OR OFFICES TO EXCHANGE VERBAL (TELEPHONE) AND WRITTEN INFORMATION. AS SPECIFIED ABOVE FOR THE PURPOSE AND TREATMENT PERIOD INDICATED. I HOLD HARMLESS MARGOT LOGAN, LCSW IN REGARD TO THE USE OF INFORMATION AUTHORIZED FOR RELEASE OF EXCHANGE. I UNDERSTAND THAT THIS FORM IS NOT REQURIED AS A CONDITION FOR TREATMENT AND THAT IT MAY BE REVOKED BY ME IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. IN THE ABSENCE OF REVOCATION, THIS CONSENT WILL EXPIRE 12 MONTHS FROM THE VALID SIGNATURE. A COPY OF THIS AUTHORIZATION IS AS AUTHENTIC AS THE ORIGINAL SIGNED AUTHORIZATION OF RELEASE. AN ORIGINAL WILL BE RETAINED IN THE MEDICAL REPORT.

PATIENT SIGNATURE:_____DATE: _____

LEGAL RESPONSIBLE OTHER SIGNATURE: _____ DATE: _____

WITNESS: _____DATE: _____