ROBIN ERICKSON, PH.D., LMHC, CAP
Professional Counseling Services

Columbia Professional Center
2151 45th Street. Ste 200, West Palm Beach,Fl. 33407-3234
561 312-5288 FAX 561-845-9005

NAME: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY STATE ZIP

SS#_____ SEX M/F MARITAL STATUS _____ DOB_____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

REFERRED BY_____ (Please specify if Courts, Probation, Treatment Center, Hospital, Another Physician/Therapist, Family/Friend, Insurance Co.,Other)

EMPLOYER/SCHOOL_____FULL/PART TIME (CIRCLE ONE)

PERSON RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT_____

FULL ADDRESS (IF DIFFERENT FROM ABOVE) _____

IN CASE OF AN EMERGENCY CONTACT_____PHONE_____

AND RELATIONSHIP TO PATIENT _____**X**_____
SIGNATURE REQUIRED

IS NEED FOR COUNSELING APPT. A RESULT OF: AUTO ACCIDENT____ WORKERS COMP_____ OTHER LIABILITY_____LAWSUIT_____ NONE APPLY_____ DATE OF ACCIDENT_____

Email adress: _____

I AUTHORIZE ROBIN ERICKSON, PH.D., LMHC, CAP TO SUBMIT INSURANCE CLAIMS, INCLUDING ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL/MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS TO ROBIN ERICKSON, PH.D., LMHC, CAP.

I UNDERSTAND THAT ALL CLAIMS WILL BE PROCESSED UNDER ROBIN ERICKSON, PH.D., LMHC, CAP AND I AUTHORIZE PAYMENT AS SUCH. I FURTHER AGREE TO PAY ALL COST OF COLLECTIONS AND ANY SUCH BALANCE, INCLUDING ATTORNEY FEES IF MY ACCOUNT GOES TO COLLECTIONS FOR NON-PAYMENT OF SERVICES RENDERED.

SIGNATURE _____ DATE _____

WITNESS_____

1. Has there ever been a period of time when you were not your usual self and (while not under the influence of alcohol or drugs): PLEASE ANSWER YES/NO TO FOLLOWING:

…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?
YES___NO___
…you were so irritable that you shouted at people or started fights or arguments?
YES___NO___
…you felt much more self-confident than usual?
YES___NO___
…you got much less sleep than usual and found you didn't really miss it?
YES___NO___
…you were much more talkative or spoke much faster than usual?
YES___NO___
…thoughts raced through your head or you couldn't slow your mind down?
YES___NO___
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?
YES___NO___
…you had much more energy than usual?
YES___NO___
…you were much more active or did many more things than usual?
YES___NO___
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?
YES___NO___
…you were much more interested in sex than usual?
YES___NO___
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
YES___NO___
…spending money got you or your family into trouble?
YES___NO___

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? YES___NO___

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please select one response only:
NO PROBLEM MINOR PROBLEM MODERATE PROBLEM SERIOUS PROBLEM

4. Have any of your blood relatives (children, siblings, parents, grand parents, aunts, uncles) had manic-depressive illness or bipolar disorder? YES___NO___

5.Have you ever been told by a professional that you have manic-depression or bipolar disorder? YES___NO___

6. Do you have unwanted ideas, images or impulses that seems silly, nasty or horrible? YES___NO___

7. Do you worry excessively about dirt, germs, or chemicals? YES___NO___

8. Are you constantly worried that something bad will happen because you forgot something important, like locking the door or turning off the lights? YES___NO___

9. Are you afraid you will loose something of importance? YES___NO___

10. Are there things you feel you must do excessively or thoughts you must think repeatedly in order to feel comfortable? YES___NO___

11. Do you wash yourself or things excessively? YES___NO___

12. Do you have to check things over and over or repeat them many times to be sure they are done properly? YES___NO___

13. Do you avoid situations or people you worry about by hurting by aggressive words or deeds? YES___NO___

14. Do you keep many useless things because you feel that you cannot safely throw them away? YES___NO___

LIST ALL HOSPITALIZATIONS: FOR WHAT AND WHEN:

_____
_____
_____
_____

LIST ANY ALLERGIES TO MEDICATIONS: _____
_____

YOUR PARENTS COULD BE BEST DESCRIBED AS:

STEP FATHER	FATHER		MOTHER	STEP MOTHER
_____	_____	DISTANT	_____	_____
_____	_____	STRICT	_____	_____
_____	_____	LOVING	_____	_____
_____	_____	RIGID	_____	_____
_____	_____	ANGRY	_____	_____
_____	_____	EXPLOSIVE	_____	_____
_____	_____	COLD	_____	_____
_____	_____	WARM	_____	_____
_____	_____	PERMISSIVE	_____	_____
_____	_____	OPEN	_____	_____
_____	_____	ACCEPTING	_____	_____
_____	_____	RESPONSIBLE	_____	_____
_____	_____	EMOTIONAL	_____	_____
_____	_____	PREDICTABLE	_____	_____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING PROBLEMS:

____NO PROBLEM
____ABDOMINAL PAIN
____DIFFICULT BREATHING
____INTOLERANCE HEAT/COLD
____INDIGESTION
____CANGE IN HAIR GROWTH
____ENURESIS /ENCOPRESIS
____URINARY PROBLEMS
____SEXUAL DIFFICULTY
____POOR COORDINATION
____SORE THROAT/DRY MOUTH
____SWELLING OF ANKLES
____CHEST PAIN
____NECK PAIN
____PALPITATIONS
____HEARTBURN
____STOMACH PROBLEMS
____DIARRHEA/CONSTIPATION
____HEMORRHOIDS
____SPEECH PROBLEMS
____BLURRY VISION
____HEARING PROBLEMS
____MUSCLE WEAKNESS
____FREQUENT COLDS
____COUGH
____NOSE BLEED
____CHILLS
____RASH
____FEVERS
____HOT FLASHES
____SORE GLANDS
____CANCER
____SHAKE / TREMOR
____HYPERTENSION
____HEART PROBLEMS

PHYSICAL LIMITATIONS SPECIFY:_____

_____

_____

FOR WOMEN: ARE YOU PREGNANT? ____ YES ____NO

AGE YOUR PERIOD BEGAN: _____ ENDED:_____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS FOR WHICH YOU OR YOUR FAMILY HAVE BEEN TREATED:

_____	_____	ANEMIA	_____	_____	LIVER PROBLEMS
_____	_____	ARTHRITIS	_____	_____	RESPIRATORY PROBLEMS
_____	_____	ASTHMA	_____	_____	SEIZURES
_____	_____	CANCER	_____	_____	SINUS PROBLEMS
_____	_____	COLITIS	_____	_____	STROKE
_____	_____	DIABETES	_____	_____	THYROID
_____	_____	ENDOCRINE DISEASE	_____	_____	TUBERCULOSIS
_____	_____	GASTRITIS	_____	_____	ULCERS
_____	_____	GLAUCOMA DISEASE	_____	_____	URINARY PROBLEMS
_____	_____	GOUT	_____	_____	V.D.
_____	_____	HEART ATTACK	_____	_____	HIGH BLOOD PRESSURE
_____	_____	LOW BLOOD PRESSURE	_____	_____	HEPATITIS
_____	_____	KIDNEY DISEASE	_____	_____	FAMILY DISEASE

PRIMARY CARE PHYSICIAN: _____ PHONE:_____

ADDRESS:_____

HAVE YOU EVER BEEN SEEN BY ME PRIOR TO TODAY? _____ IF YES WHEN?_____

PLEASE STATE IN YOUR OWN WORDS WHY YOU ARE SEEKING PROFESSIONAL HELP:

_____

_____

_____

HOW LONG HAVE YOU HAD THESE PROBLEMS AND HAVE YOU ATTEMPTED TO DO ANY-THING ABOUT THIS?_____

_____

_____

_____

PLEASE CHECK ANY ITEMS THAT YOU FEEL APPLY

____ HEADACHES
____ DIZZINESS
____ FAINTING SPELLS
____ NIGHTMARES
____ STOMACH PROBLEMS
____ HEART PALPITATIONS
____ FATIGUE
____ SLEEP PROBLEMS
____ SHAKING
____ DEPRESSED
____ WANT TO HURT SELF
____ SEX PROBLEMS
____ DRUG PROBLEMS
____ UNABLE TO RELAX
____ INADEQUATE
____ WORTHLESS
____ LIFE IS EMPTY
____ STUPID
____ HORRIBLE THOUGHTS
____ INCOMPETENT
____ NERVOUS
____ EVIL
____ COWARDLY
____ OVER AMBITIOUS
____ CAN'T MAKE DECISIONS
____ CONFUSED
____ NAIVE
____ DON'T TAKE VACATIONS
____ WORTHWHILE
____ MEMORY PROBLEMS
____ HOME CONDITIONS BAD
____ ATTRACTIVE
____ CONSIDERATE
____ REGRETFUL
____ LONELY
____ DEFORMED
____ MISUNDERSTOOD
____ RESTLESS
____ CONFIDENT
____ BORED
____ UNLOVED
____ NOT CONFIDENT
____ SYMPATHETIC
____ GOOD PERSON
____ INTELLIGENT
____ CAN'T KEEP A JOB
____ GUILTY
____ PUSHY
____ HATEFUL
____ INFERIORITY FELLING
____ TIMID
____ CAN'T CONCENTRATE
____ CAN'T MAKE
____ FRIENDS
____ CONFIDENT
____ LIKE TEACHERS
____ HAD MANY FRIENDS
____ DID POORLY
____ DISLIKED SCHOOL
____ NEVER SENT TO
____ PRINCIPAL
____ WAS A GOOD STU-
____ DENT
____ WAS EXPELLED

CHILDHOOD ISSUES:

____ SLEEPWALKING
____ CHILDHOOD FEARS
____ HAPPY CHILDHOOD
____ FIGHTING
____ NAIL BITING
____ BED WETTING
____ STAMMERING
____ UNHAPPY CHILDHOOD
____ THUMB SUCKING
____ SHY
____ GOOD RELATIONS

Robin Erickson, PhD., LMHC, CAP
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Client Name: _____

Client's Legal And Ethical Rights To Informed Consent For Psychotherapy

It is every client's legal and ethical right to receive "informed consent" before entering into a psychotherapeutic relationship with a Licensed Mental Health Counselor. You have the right to review with your therapist the nature and expected duration of therapy, the risks and benefits of the therapeutic relationship, the explanation of fees and payment policies, including the involvement of third party payers, and discussing the limits of confidentiality. You have the right to enter into the therapeutic relationship voluntarily, without any coercion from the therapist or any other outside influence. You have the right to ask questions related to informed consent at any time during the therapeutic process, and you have the right to terminate therapy at any time. Generally, informed consent is obtained during the first session. However, if during the first session, the client is in crisis, and the therapist determines that reviewing informed consent would be contraindicated to assisting the client during the initial session, the therapist is to obtain informed consent as soon as possible thereafter.

The Nature and Duration of Therapy

Psychotherapy is a voluntary relationship whereby the therapist is trained to employ a variety of interactive techniques to assist the client to resolve emotional, cognitive, relational, or behavioral problems according to the goals set collaboratively by the client and the therapist. Theories utilized in therapy include, but are not limited to: Cognitive-Behavioral, Person-Centered, Solution Focused, Biopsychosocial model, Family Systems, and 12 Step focused. Interventions commonly used in therapy include, but are not limited to: active listening with reflective feedback, assignment of homework, role play, and validation of client's feelings and perspectives coupled with occasional gentle confrontation. Much of this is what is colloquially known as "talk therapy". All theories and interventions applied are designed to help the client achieve his or her therapy goals in a way that respects the autonomy and personhood of the client. As the therapist-client relationship evolves, the nature and intensity of the intervention is likely to evolve to continue to meet the needs of the client.

Clients can expect each session to last approximately 50 minutes. The duration and frequency of the therapeutic relationship is dependent upon the needs and goals of the client as well as the therapist's ability to effectively address those needs in the therapeutic relationship. Once the therapist believes she has an accurate understanding of the client's presenting issues, the therapist may review this assessment with the client, offering an approximate expected timeline of the therapeutic relationship, the goals of therapy and the sequencing of objectives. It will likely take at least one session and often more before the therapist can reasonably complete this assessment and review with the client. If the therapist determines that the needs of the client are of a nature or intensity beyond what the therapist is trained to provide, the therapist may refer the client to another therapist or seek out consultation with another provider with more experience in the given area of need.

Please note that the nature of an outpatient therapeutic relationship implies that the client is able to self regulate and self manage while residing in his or her own home. If you have a psychiatric emergency, it is best you dial 9-1-1 to have your needs met with the greatest urgency. Otherwise, a message may be left on voicemail at (561) 312-5288 and your call will be returned as soon as possible and within one business day. Office hours are during the following times, by appointment only:

Monday – Friday: 9:00 am to 5:00 pm

Requests for urgent appointments can be accommodated as scheduling permits. A counseling session by phone may be considered in special circumstances and must be scheduled during business hours and pre-paid. Please note: insurance companies do not pay for services conducted by phone. Fee for counseling service by phone: 50 min session- $120.

Risks and Benefits of Psychotherapy

Clients have a right to know their diagnosis, if any, and have it explained to them, including all symptoms and reasons the diagnosis is given. Psychotherapy is not an exact science, but there are evidenced-based therapies available to treat each given diagnosis. It is the therapist's responsibility to diagnose accurately, understand the therapies available to treat each diagnosis, and utilize evidenced-based therapies and/or refer to other treating professionals who also specialize in treating the diagnosed disorder. Research on effective therapies continues to evolve, and therapists are responsible for continuing their education to keep abreast of new treatments.

For some disorders, such as severe Depressive and Anxiety disorders, the most effective treatments often include medication in addition to psychotherapy. However, most clients do benefit with medication alone or psychotherapy alone to treat these disorders. Other disorders, such as Schizophrenia and Bipolar Disorder, generally necessitate the use of medication to effectively treat the symptoms. Most clients with these disorders will have great difficulty with self care and self regulation without the use of medication. Psychotherapy is also helpful to assist the client with medication compliance and learning other life skills to optimize client functioning. Other milder or personality disorders respond best to psychotherapy, and medication may not be necessary. Some clients with adjustment or other mild mood disorders may spontaneously resolve themselves without any treatment at all. The therapist is responsible to discuss the client's diagnosis and treatments that are most effective for each client. For more information and resources, please feel free to visit our website: www.robinerickson.com

Fees and Financial Policies

Fees for service are due at the time of each session. per one hour session, and are payable by check, cash, money order, or credit card. Checks and money orders may be addressed to Robin Erickson, PhD.

When applicable, fees may also be charged to third party payers, such as insurance companies. With client permission, the therapist may obtain available coverage offered by the client's insurance provider and review this information with the client. Such information includes, but is not limited to: copay, coinsurance, deductibles, amount of deductible met, and number of sessions allowed by the insurance provider. The therapist will submit insurance claims on behalf of the client for in network providers. The client is responsible for all fees not paid by insurance providers. The client wishing to utilize their insurance provider, or other third party payer, must sign a Release of Information allowing the therapist permission to bill and communicate with their third party payer as needed. This will be covered under separate form.

There is a $50.00 charge for all returned checks; full payment is required in the form of cash or money order. Failure to clear up a returned check within 30 days will result in prosecution procedures with the state attorney's office.

Cancellation Policy

Clients are responsible to give 24 hours notice if they need to reschedule or cancel their appointments. The therapist will make reasonable efforts to confirm the client's appointment at least 24 hours prior to its schedule. Clients will be billed $ 75.00 for any appointments that are missed or changed within 24 hours of their schedule. The reason for this is without proper notice, the therapist will not be likely to schedule another client in the missed appointment slot.

Limits of Confidentiality

The therapeutic relationship is confidential and subject to Federal HIPAA laws. Simply stated, with few exceptions, what is discussed between the therapist and the client is protected and by law the therapist is not permitted to disclose such information except under legally sanctioned circumstances. The limits of client confidentiality are as follows:

- When the client presents as a danger to self or to others. This includes threats of harm to self, to others, or a client's psychic break from reality such that the client has lost self control to the extent the client presents as a danger to self or to others
- When the client discloses information that suggests another vulnerable person is at risk of harm and may be in need of protection. Such persons include, but are not limited to: a minor child, an elderly person, a pregnant woman, or a person with a mental or physical disability. Please note: Psychotherapists are mandated reporters according to Florida law. It is not our responsibility to determine IF abuse is occurring. However, we are mandated by law to report to the appropriate authorities if there is reason to suspect abuse or if such abuse is directly reported by another person
- When a medical or psychiatric emergency has occurred and the proper referrals are made to care for the clients immediate needs
- If a client decides to file a lawsuit against the therapist or if the client commits a crime on the therapist's property
- When the client has signed a Release of Information authorizing limited and necessary disclosure to the identified party to whom information will be released
- The parent or a legal guardian of any non-- emancipated minor has the right to inspect the minor client's records
- When a client chooses to utilize a third party payer, such as an insurance provider, a Release of Information will be obtained in a separate form to grant permission for necessary and/or requested disclosure. This release of information is necessary to bill third party payers. Sometimes, third party payers require copies of records or discussion of client progress to determine if further treatment is medically necessary and/or covered under the client's plan.

Notice of Privacy Practices

Clients have the right to inspect their records at any time. If the client suspects that information contained in their record is errant, clients have the right to make a note in their records stating as such. However, information contained in the client's record may not be changed or removed once it is placed in the record. Clients have a right to know when disclosures have been made to outside entities during the time period 6 years prior to client's request. Therapists are required to maintain records for a minimum of 7 years, after which records may be destroyed. All requests for paperwork or records must be in writing and a Release/request for information form must be on file. Written documentation, such as a letter are subject to a $30.00 fee per page, Case notes and other records requests are subject to $1.00 per page plus mailing costs. Fees are waived for requests to or from another doctor.

I, _____, acknowledge that my therapist has reviewed informed consent with me, given me opportunities to ask questions, and has made a written copy available to me. I understand that psychotherapy is a voluntary relationship. I acknowledge that the nature, duration, risks and benefits of psychotherapy have been explained to me. Additionally, I acknowledge that fees, limits of confidentiality, and privacy practices have been explained to me. I understand that I can review informed consent with my therapist at any time.

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Signature Date

_____ _____

Therapist Signature Date

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RELEASE/REQUEST FOR INFORMATION

I, _____GRANT PERMISSION FOR THE RELEASE/ REQUEST OF ALL MEDICAL RECORDS TO/FROM **ROBIN ERICKSON, PH.D, LMHC, CAP** INCLUDING STAFF OR RECORDS CUSTODIAN FOR THE PURPOSE OF MEDICAL, PSYCHIATRIC, AND COUNSELING CARE AND TREATMENT.

COPIES OF MY OFFICE RECORDS MAY BE FORWARED TO:

_____ _____

_____ _____

COPIES OF MY OFFICE RECORDS MAY BE REQUESTED FROM:

_____ _____

_____ _____

INFORMATION REGARDING MY CASE MAY BE DISCUSSED/DISCLOSED TO/WITH:

_____ _____

THIS RELEASE ALSO PERMITS THE OFFICE OF **ROBIN ERICKSON, PH.D, LMHC, CAP** TO CONFIRM SCHEDULED APPOINTMENTS IN THE FOLLOWING MANNER: HOME PHONE, ANSWERING MACHINE, VOICE MAIL, WORK PLACE PHONE, CELL PHONE, PAGER, LEAVING A MESSAGE WITH A FAMILY MEMBER. UNLESS OTHERWISE SPECIFIED. PLEASE INITIAL HERE _____ IF OTHERWISE SPECIFIED, PLEASE STATE HERE:
_____.

THIS SIGNED RELEASE OF INFORMATION WILL EXPIRE IN 1 YEAR OR UNTIL WRITTEN NOTIFICATION TO REVOKE CERTAIN APPROVAL FROM THE PATIENT IS SUBMITTED TO THE OFFICE OF **ROBIN ERICKSON, PH.D, LMHC, CAP.**

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ SOC SEC # _____

WITNESS: _____ DATE: _____