TRANSITIONS COUNSELING

Janie Rhone, MBA, M.S., RMHC-Intern (10475)
1919 NE 45th Street, Suite 121, Ft. Lauderdale, FL 33308
Phone: 954.289.5685 | Fax: 954. 491.4255

PATIENT HEALTH INFORMATION

PERSONAL INFORMATION:

Date: _____

Client Name: _____ SSN or INS ID#: _____

**If client is a minor - name of Custodial Guardian/Parent:* _____

Client Age: _____ Birthday: _____ Sex: _____ Marital Status: _____

Street Address: _____ City: _____ State: _____

Zip: _____ Home Tel: _____ Bus. Tel: _____

Email: _____ Employer or School: _____

Permission to contact you at Home # Yes No **Permission to contact you at Business # Yes No**

Emergency Telephone Name and Number: _____

Referred By: _____

RELATIONSHIP/FAMILY INFORMATION:

Spouse/Partner name: _____ Birthday: _____ Age: _____

How Long Together/Married: _____ Children's Names and Ages: _____

_____

MEDICAL/THERAPY INFORMATION:

Medical Insurance Company: _____

Policy Holder/Insured if Different Than Client: _____

Primary Care Physician: _____ Telephone: _____

Address: _____

Permission to contact primary care physician: YES NO

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MEDICAL/THERAPY INFORMATION (CONTINUED)

Previous Psychiatric/Counseling Experience YES NO

If you answered YES please complete the following to the best of your ability;

Inpatient Outpatient Dates of Treatment: _____

Reason for Treatment: _____

Current Psychotropic Medication _____ Start date(s) _____

Prescribed by: (if different from PCP) _____ **Permission to contact Yes No**

Impacting factors in family history such as, Chronic Illness, Trauma, Chemical Dependency, Mental health, etc.

_____

REASON FOR SEEKING THERAPY AT THIS TIME: _____

RELEASE OF INFORMATION

I hereby authorize and request upon identified need, JANIE RHONE, MBA, M.S., RMHC-INTERN (10475) to release complete counseling records concerning my diagnosis and treatment to (Therapist, Managed Care Company for Utilization & Care Management review, Doctor, Hospital, or School) as identified below.

Name and Address to Whom Information is to be Released _____

_____

I acknowledge that I have the right to inspect and copy the information that I authorize to be disclosed. I also understand that I may revoke this consent at any time by giving written notice to JANIE RHONE, MBA, M.S., RMHC-INTERN (10475). I also understand that my refusal to sign this authorization would prevent disclosure. This authorization is effective one year from the date shown.

Client Signature: _____ **Date:** _____

If Client is a Minor - Signature of Authorized Custodial/Guardian/Parent:

*** Signature:** _____ **Date:** _____

AUXILIARY SERVICES AGREEMENT

In the course of outpatient psychotherapy, if correspondence is required pertinent to your therapy, the following conditions will apply.

All fees (co-pays and/or private payments) must be current and a charge of $60.00 paid prior to correspondence being forwarded. This will apply to each letter at the time it is sent.

Client Signature: _____ **Date:** _____