Jason Versace, LMHC
100 S. Ashley Drive, Suite 600, Tampa, Florida 33602

WELCOME

Name:_____
First Last Middle/Maiden

Address:_____
City State Zip

DOB:_____ Sex:_____ Age:_____ Marital Status:_____

Cell Phone:_____ May I leave a message? Yes No

Home/Other Phone:_____ May I leave a message? Yes No

Email Address:_____ May I email you? Yes No

Occupation: _____ Employer: _____

If patient is a minor or someone other than the patient is responsible for payment, please complete the following section:

Name: _____

Relation to Patient: _____ DOB:_____ Sex:____ SS# _____

Address:_____
City State Zip

EMERGENCY CONTACT:

Name: _____

Relationship: _____ Phone Number: _____

PRIMARY INSURANCE: Please provide a copy of the front and back of insurance card.

Insurance Name/Plan: _____ Co-Pay:_____

Member/Policy No: _____ Group No: _____

Policyholder: _____ DOB: _____ Relation:_____

SECONDARY INSURANCE: Please provide a copy of the front and back of insurance card.

Insurance Name/Plan: _____

Member/Policy No: _____ Group No: _____

Policyholder: _____ DOB: _____ Relation:_____

RELEASE OF RECORDS: I authorize the release of general medical, as well as psychological, substance abuse, or other information pertinent to my treatment, to any insurance company, adjuster, case manager, attorney, or any other party as may be necessary to process health insurance claims, receive authorization for services (including representing patient in requesting Appeal for coverage of services), or to facilitate collection of any balance due for services rendered. I understand that this authorization releases Psi Wellness Inc. from all legal liability that may arise from the release of the information.

ASSIGNMENT OF BENEFITS/PROCEEDS;FINANCIAL RESPONSIBILITY: I hereby authorize and direct any Payor on my behalf (including health insurance, disability insurance, worker's compensation, liability insurance, Medicare, Medicaid, a government entity, or attorney) to pay any medical and/or government benefits, or from the proceeds of any settlement, judgment or verdict, due to me directly to Psi Wellness Inc (Provider) for services rendered, both by reason of illness or injury, and by reason of any other bills that are due Provider. This is to act as an assignment of my rights and benefits to the full extent allowable under the law and/or to the extent I am obligated to pay Provider for services rendered. I understand that I am and remain personally responsible for deductibles, co-payments, and any professional services not covered and/or not paid by Payor(s). If it becomes necessary to turn my account over for collection, I will be responsible for collection and/or attorney fees. I also understand that Provider may perform a 'Trace" or search to verify my name, social security number and/or mailing address.

- A fee will be assessed on returned checks ($40 fee or the amount charged by Provider's bank, whichever is higher).

A photocopy or digital copy of this document shall be considered as valid and enforceable as the original.

Signature: _____ Date: _____
Signature of Patient/Patient's Parent/Guardian/Responsible Party

Print Name: _____
Signature of Patient/Patient's Parent/Guardian/Responsible Party

Counseling Policies and Consent to Treatment

Health Insurance: In signing this form, you are authorizing Psi Wellness Inc. to contact your insurance company regarding payment of services. Psi Wellness Inc. may need to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the third-party payer or insurance company for the purpose of receiving payment for services rendered. It is your responsibility to understand the benefits of your insurance plan. Any precertification which is required by your insurance company must be done prior to your appointment. If you are using insurance for which Psi Wellness Inc. is out of network, then it will be your responsibility to pay in full at the time of service. You will be given a receipt to provide to your insurance company to receive reimbursement. It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.

Cancellation Policy: Please help us to serve you and others better by keeping your scheduled appointments. If you need to cancel or reschedule, please give me as much notice as possible so we can offer that time to someone else.

Confidentiality: Federal and State laws protect your confidentiality (see 42 I.S.C 290dd-3 and 290ee-3 for federal laws 42 CFR Part 2, 491.0147 FL). Your counselor will not share information with any person outside of Psi Wellness Inc. without your permission except where required by law. Information obtained from minors is not generally shared with parents without permission. HIPPA (Health Insurance Portability and Accountability Act) laws allow you access your file and protect the electronic transfer of information.

Exceptions to Confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, or individual with a disability. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by the judge. We have the option of breeching confidentiality if you report a specific plan or intent to cause serious bodily harm to an identifiable person.

Consent to Treatment: I am seeking voluntary outpatient counseling with Psi Wellness Inc. I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy. I am strongly encouraged to discuss my treatment plan and status in treatment with my counselor. My counselor will also discuss alternatives, procedures, qualifications, and drawbacks to therapy. With my signature below, I acknowledge that I have read, understand and agree to all of the above.

With my signature, I acknowledge that I understand the above information and consent to treatment with Psi Wellness Inc. and my therapist Jason Versace LMHC.

Signature: _____ Date: _____
Signature of Patient/Patient's Parent/Guardian/Responsible Party

Print Name: _____
Signature of Patient/Patient's Parent/Guardian/Responsible Party

Consent for Telehealth Services

By using Telehealth for my appointment, I certify:

- That I have read, or had this form read, and/or had this form explained to me.
- That I fully understand its contents, including the risks and benefits of Telehealth.
- That I agree with the terms and conditions described herein.

I understand that Telehealth or Teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different location than the provider; and hereby consent to receiving health care services via Telehealth over secure video conferencing platform.

I understand that the laws that protect privacy and the confidentiality of my medical information also apply to Telehealth or Teletherapy.

I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation. If other people are in the room, my provider shall be made aware and must agree to their presence.

I understand that there are potential risks involving technology, including but not limited to: internet interruptions and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected. Psi Wellness Inc. will make all reasonable efforts to safeguard the transmission of potential computer virus or other involuntary intrusions, and it is my responsibility to do the same.

I understand that while Telehealth or Teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.

I understand that my health care provider or I can discontinue the Telehealth/Teletherapy services if it is felt that this type of service delivery does not benefit my needs.

I understand that at no time will any audio-video recording of the Telehealth/Teletherapy session be permitted without the expressed written consent in advance by both parties involved.

I have read and understand the information provided above regarding Telehealth/Teletherapy. I consent to the use of Telehealth/Teletherapy in my care.

Signature: _____ Date: _____
Signature of Patient/Patient's Parent/Guardian/Responsible Party

Print Name: _____
Signature of Patient/Patient's Parent/Guardian/Responsible Party

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Authorization For Release of Information

Patient Name: _____ DOB: _____

I hereby authorize Psi Wellness Inc. to release/request (circle one) the following information and records obtained in the course of my diagnosis and treatment. I understand these records may contain confidential information about mental health, behavioral health, treatment, substance abuse or dependency, sexual history and health, and communicable diseases such as HIV/AIDS.

MEDICAL INFORMATION MAY BE (circle one): RELEASED TO / RECEIVED FROM:

Name of Individual/Organization	Address	Number (office/fax)
_____	_____	_____
_____	_____	_____

The information to be released may include (check all that apply):

Course of Treatment — Psychological Assessment/Evaluation
Therapy Notes — Records
Laboratory/Imaging Results — Treatment Recommendations
Other (specify) _____

The purpose for the release of the information is (circle all that apply):

a) Coordination of Care: _____
b) Facilitation of After-Care: _____
c) Other: _____

Signature: _____ Date: _____
Signature of Patient/Patient's Parent/Guardian/Responsible Party

Print Name: _____ Relation to Patient: _____
Signature of Patient/Patient's Parent/Guardian/Responsible Party