Child & Family Psychologists
12651 W. Sunrise Blvd. Suite 101
Sunrise, Florida 33323-0906
(954) 587-7520 / (954) 349-2777

Notice of Privacy Practices
Patient Acknowledgment

Patient Name: _____ Date of Birth : _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to the Privacy Officer of this Practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Child & Family Psychologists

Mitchell E. Spero, Psy.D. / Director

Licensed Psychologist / FL# PY004098

Certified & Court Appointed Family Mediator:
Supreme Court of Florida

Sawgrass Medical Center
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Problem solving for all ages…

Revised 06/23/21

ADULT INTAKE FORM

Today's Date:

HOW DID YOU HEAR ABOUT CHILD & FAMILY PSYCHOLOGISTS?

☐ **Family Member Name:** _____ ☐ **Insurance Plan**

☐ **Friend/ Co-worker Name:** _____ ☐ **Online/Advertisement**

☐ **Physician Name:** _____

☐ **Other, Please Specify:** _____

PERSONAL INFORMATION

Last Name: _____

First Name: _____

Middle Name: _____

Date of Birth: _____ **Age:** _____ **Sex: Male** ☐ **Female** ☐

Social Security Number: _____

Driver's License #: _____ **State:** _____

CONTACT INFORMATION

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

May you be contacted at Work? ☐ **Yes** ☐ **No**

Home Phone:

Cell Phone:

Work Phone: **ext** _____

Email Address: _____

MARITAL INFORMATION

Marital Status:

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Spouse's Name: _____

Number of Years Married: _____

FAMILY AND HOME INFORMATION

Children's Names: **Sex:** **Age:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Others Living in the Home:

Name/Relationship: **Sex:** **Age:**

_____ _____ _____

_____ _____ _____

EMERGENCY CONTACT

Last Name: _____

First Name: _____

Relationship: _____

Home Phone:

Cell Phone:

Work Phone: **ext** _____

EMPLOYMENT INFORMATION

Occupation/Job Title: _____

Business Name: _____

Address:

_____

City: _____ **State:** _____ **Zip Code :** _____

Work Phone: _____ **ext** _____

Fax Number: _____

PRIMARY CARE PHYSICIAN'S INFORMATION

Physician's Name: _____

Address:

_____

City: _____ **State:** _____ **Zip Code :** _____

Office Phone: **Ext:**

Fax Number:

GENERAL HEALTH INFORMATION

Do you have any allergies? ☐ **Yes** ☐ **No**

If so, please specify. _____

Do you smoke cigarettes? ☐ **Yes** ☐ **No**

If so, how many a day? _____

Do you drink alcoholic beverages? ☐ **Yes** ☐ **No**

If so, how many per week? _____

PRESCRIBED MEDICATION:

Medication	Dosage	For what condition?	Duration

PSYCHOLOGICAL/PSYCHIATRIC TREATMENT HISTORY

Have you participated in Psychological Treatment? ☐ **Yes** ☐ **No**

Doctor or Therapist Name: _____

Office Address: _____

Office Phone Number: _____

Have you ever been hospitalized for Psychiatric Reasons? ☐ **Yes** ☐ **No**

Dates: _____

Location: _____

FAMILY HISTORY:

Psychological/ Psychiatric	If Yes, Who?
Depression	
Anxiety	
Bipolar Disorder	
Alcohol/Substance Abuse	
Emotional Abuse	
Physical Abuse	
Sexual Abuse	
ADHD	
Schizophrenia	
Other Diagnosis	

If other, please specify:

_____

CHECK CURRENT SYMPTOMS:

Depression	☐	Suicide / Homicidal Thoughts or Actions	☐
Anxiety	☐	Hallucinations	☐
Poor Concentration	☐	Trauma	☐
Irregular Sleep Patterns	☐	Phobias	☐
Interpersonal Conflicts	☐	Low-Frustration Tolerance	☐
Eating Problems	☐	Impulsivity	☐
Memory Problems	☐	Physical Aggression	☐
Isolation	☐	Feeling Overwhelmed	☐
Panic Attacks	☐	Excessive Fears/ Worries	☐
Racing Thoughts	☐	Substance Abuse/Dependence	☐
Low Motivation	☐	Obsessions/Compulsions	☐

List other stressors/symptoms:

LIST TREATMENT GOALS

CURRENT TREATMENT GOALS	
Short Term Goals/Time Frame	**Long Term Goals/Time Frame**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5	**5.**

PATIENT AUTHORIZATION & WITNESS SIGNATURES

_____
Print Patient's Name

_____ _____
Patient's Signature Date

_____
Therapist/Independent Contractor Print Name

_____ _____
Therapist/Independent Contractor Signature Date

FOR THERAPIST USE ONLY

Axis I: _____R/O: _____

Axis II: _____R/O: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF: _____ Highest Year GAF: _____ Termination GAF: _____

Child & Family Psychologists/Independent Contractors
INITIAL CONSENT FOR TREATMENT
FINANCIAL AGREEMENT / POLICIES AND PROCEDURES
(Please read and return both pages of this form)

Payment is expected at the time of service, unless other arrangements have been made in writing. I understand and agree that I am responsible for the full bill, and that insurance reimbursement is not a substitute for payment. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance company. I understand and agree that a finance charge of 1.5% per month will be added to accounts which have an overdue balance beyond thirty (30) days. I am aware and agree that should my account become delinquent beyond ninety (90) days an attorney and/or collection agency will be utilized to obtain payment in full, and that I will be charged a reasonable fee for the costs of collection. I understand and agree that confidentiality is not being broken if the collection agency chooses to make public the information that Child & Family Psychologists who is functioning as the billing agent for the Clinical Associate/Independent Contractor providing the Psychological Services. To avoid such procedures I agree to keep my account current. I also agree to pay a $30.00 for any returned check(s).

I hereby assign all insurance major medical benefits, which may include private insurance and/or other health plans to: Child & Family Psychologists who is functioning as the billing agent for the Clinical Associate/Independent Contractor providing the Psychological Services. I hereby authorize the stated assignee to release all information necessary to secure payment. I understand and agree that all phone calls made to verify insurance coverage may be charged to my account. I understand and agree that a charge equal to the full fee will be made for all appointments which are cancelled with less than 24 hours notice, and for scheduled appointments that I miss without providing notification. I understand that my insurance company is not responsible for any payment towards cancelled appointments. However, emergency cancellations will be considered on an individual basis.

At times, adults other than parents or guardians may transport children or adolescents to their sessions. Some teenagers attend sessions without their parents present. All of us have left home without our checkbooks. We often believe that our insurance will pay one amount, when in actuality they pay a lesser percentage towards services rendered. In each of these cases, should one occur, I give my permission for Child & Family Psychologists as the billing agent for my Therapist/Independent Contractor to charge my Visa, MasterCard, American Express, or Discover for the appropriate remaining balance of any unmet deductible on my insurance, any co-payment not made at the time of Psychological Services, or any cancelled or missed appointments with less than 24 hour notification provided.

The Clinical Associates/Independent Contractors working at Child & Family Psychologists will make every effort possible to rapidly return phone calls. However, should an emergency exist after normal working hours, I will contact either University Pavilion Hospital, Memorial Regional Hospital, CPC Fort Lauderdale Hospital, or any other Psychiatric facility of my choice if I am considered to be a danger to myself or to others. Otherwise, I will place a second call to the answering service, and schedule an emergency appointment with my Therapist/Independent Contractor as soon as possible. I authorize and request for my Therapist to carry out Psychological Evaluation, Treatment, and/or Diagnostic Procedures for either myself or my child which are considered to be necessary by my Therapist. I agree to attend sessions knowing there is no guaranteed outcome. However, I am aware that all therapeutic interventions will be theoretically based. If I am dissatisfied with services, I will terminate therapy and accept an appropriate referral. I am aware that my Therapist/Independent Contractor will do his or her best to help me obtain my therapeutic goals. I understand that in situations of suspected physical, emotional, and/or sexual abuse that my Therapist is obligated by law to file an oral and written report to The Department of Children and Families requesting an emergency investigation. The limits of confidentiality relate to situations of danger to self or others. Treatment Summary Letters may be provided by my Therapist with a properly signed Client Information Release Authorization in lieu of releasing the complete psychological records to either myself or any other requesting party. If I attend Group Psychotherapy, I will maintain confidentiality with respect to information disclosed by other patients. I understand that a violation of this confidentiality could potentially result in legal action against me personally. This agreement in its entirety will remain in effect until revoked by me, in writing.

The standard out-patient fees of Clinical Associates/Independent Contractors practicing at Child & Family Psychologists are: $195.00 for a Diagnostic Interview, and $180.00 for each 45 minutes of Psychological Service. In-patient Psychological Services are provided at a rate of $195.00 per 45 minutes, and Psychological Evaluations are conducted at a rate of $300.00 per hour. However, the Independent Contractors are under contract with many insurance companies and are bound to utilize their fee structures. Unless otherwise indicated, the standard fees shall be utilized.

Due to Individual Financial Hardship Situations, reduced fees are sometimes assessed for 20-30 minute sessions. The treatment of clients is never compromised due to their financial situation. I agree to be responsible for a reduced fee of $_____ per session.

I hereby authorize and request, Child & Family Psychologists to share any or all information with all Independent Contractors, Employees. and Tenants within the office for the purpose of Clinical Case Review and/or Independent Consultation. I understand that this professional communication authorization which may include Educational, Psychiatric, Legal, Medical and Psychological Information is subject to revocation by me at any time. In the event I do not revoke this consent in writing, this release will expire when the purpose for which the consent was given has been accomplished.

I have read and understand each of the stated points of both pages of Child & Family Psychologists'/Independent Contractors' Consent For Treatment: Financial Agreement / Policies and Procedures. I agree to provide Child &Family Psychologists with an up to date copy of my insurance card and driver's license. Dr. Mitch Spero is the owner of Child & Family Psychologists. All of the Mental Health Professionals are Independent Contractors or Tenants and not Employees of Child & Family Psychologists. Each and every one of the Clinical Associates who work at Child & Family Psychologists conduct their own individual practice of Psychology on our premises, but their treatment is not directed or controlled by Dr. Spero and/or Child & Family Psychologists. I agree to hold Dr. Spero and Child & Family Psychologists harmless of any Professional Liability with regard to the Psychological Evaluation and or Treatment of patients seen by Independent Contractors or Tenants working at Child & Family Psychologists. A photocopy of this agreement will be considered as valid as an original. If the patient is a minor, I hereby give my permission as a parent for my child to attend Psychotherapy and/or undergo Psychological Evaluation at Child & Family Psychologists. I am aware that it is my sole responsibility to notify my child's other parent of these Psychological Services. Please complete, sign and return this form.

_____
Print Name of Patient

_____ _____
Signature of Patient(if over the age of 18) Date

_____
Print Name of Parent or Guardian (if applicable)

_____ _____
Signature of Parent or Guardian (if applicable) Date

_____ _____
Signature of Witness Date

The Patients of Child & Family Psychologists
The Office Cancellation / No-Show Policy

1. If you are unable to attend your scheduled appointment, we require that you call us to cancel your session with a minimum of 24 hours notice. Otherwise, you will be charged $50.
2. If you do not attend your scheduled appointment, and do not call to cancel, you will be charged our full and customary fee. (Insurance can not be charged for missed/canceled appointments).

Please understand that if time is designated for you from our schedules, this precludes our ability to schedule other patients in the office at that time. However, we do understand that extenuating circumstances may arise over which you have no control, and for these isolated situations, no fee will be charged. In any event, please call our office as soon as you know that you will not be able to attend your scheduled session. Thank you for your cooperation.

I have read, understand, and agree with the entire contents of this form:

Thank You,
Dr. Mitchell E. Spero / Director of Child & Family Psychologists

_____
Printed Name of Patient

_____
Signature of Patient/Parent or Guardian Date

_____
Please Print Name of Parent or Guardian only if the patient is under 18 years old.

Child & Family Psychologists/ Independent Contractors

Patient Financial Responsibility Agreement

The office of Child & Family Psychologists and its Independent Contractors request that a copy of your Credit Card number be placed into your confidential secure file.

Your Credit Card will only be used for the following reasons:

- Unpaid co-payments
- Unpaid no-show and/or late cancellation fees
- Returned Check Fees
- Any and all insurance monies that are not paid by your insurance company including: deductibles not paid, health funds that expire or have a lack of funds for payment, cancelled or expired policies, funds due as a result of lapses due to changes in insurance policies, or benefits denied by your insurance company

I give my permission for Child & Family Psychologists as the billing agent for my Psychologist/ Therapist/ Independent Contractor to charge my Visa, Master Card, American Express, or Discover Card for the above listed reasons.

Credit Card Information:

Please mark Credit Card type and complete the information requested below:

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

_____ _____
Account Number Expiration Date

_____ _____
Security Code on the back of Credit Card Zip Code

_____ _____
Cardholder's Signature (to be kept on file) Date

_____
Cardholder's Printed Name

Child & Family Psychologists

PATIENT INFORMATION RELEASE AUTHORIZATION

Mitchell E. Spero, Psy.D. / Director

Licensed Psychologist / FL# PY004098

Certified & Court Appointed Family Mediator:
Supreme Court of Florida

Sawgrass Medical Center
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Problem solving for all ages…

Revised 06/23/21

PATIENT NAME**:** _____ Age: _____
(Please Print/Last, First, M.I.)

DATE OF BIRTH: _____ S.S.#:_____

I, _____, hereby authorize and request, Dr. Mitch Spero, All Clinical Associates/Independent Contractors/Tenants and All Employees of Child & Family Psychologists to:

☐ Release information to:
☐ Request information from:
☐ Share information with:

_____
(All Staff of the: School, Hospital, Physician, Attorney, or Individual)

_____
(Address)

_____
(Area Code – Phone Number)

The following documents may be released:

☐ Progress Notes ☐ Psychological Test Results ☐ All documents in file

The following may be released for the purpose of continuity of care: (Check appropriate area)
All and every:
☐ Psychological ☐ Psychiatric ☐ Legal ☐ Educational ☐ Medical
Other:_____

I understand that this professional communication authorization, which may include: Psychological, Psychiatric, Legal, Educational, and Medical Information is subject to a written revocation by me at any time to Child & Family Psychologists. In the event I do not revoke this consent in writing, this release will expire when the purpose for which the consent was given has been accomplished or upon termination of my treatment at Child & Family Psychologists or on (date of expiration, if preferred) _____. I understand that only information gathered by this facility is subject to this release and said information cannot be released by the facility receiving the information for any purpose. A photocopy of this information release authorization will be considered as valid as the original.

I understand that information sent or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Guardian, if applicable Date

_____ _____
Signature of Witness Date

Revised 01/15/2021

Child & Family Psychologists

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☐ Release information to:
☐ Request information from:
☐ Share information with:

_____
(All Staff of the: School, Hospital, Physician, Attorney, or Individual)

_____
(Address)

_____
(Area Code – Phone Number)

The following documents may be released:

☐ Progress Notes ☐ Psychological Test Results ☐ All documents in file

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☐ Release information to:
☐ Request information from:
☐ Share information with:

_____
(All Staff of the: School, Hospital, Physician, Attorney, or Individual)

_____
(Address)

_____
(Area Code – Phone Number)

The following documents may be released:

☐ Progress Notes ☐ Psychological Test Results ☐ All documents in file

The following may be released for the purpose of continuity of care: (Check appropriate area)
All and every:
☐ Psychological ☐ Psychiatric ☐ Legal ☐ Educational ☐ Medical
Other:_____

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_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Guardian, if applicable Date

_____ _____
Signature of Witness Date

Revised 01/15/2021

_____

Patient Name

MENTAL STATUS EXAMINATION / M.S.E.

"FOR PROVIDERS USE ONLY"

ATTITUDE AND GENERAL BEHAVIOR

Appearance (Describe):_____

_____

Psychomotor activity: hyperactive☐ hypoactive☐ WNL ☐

Affect: appropriate☐ congruent☐ full-range☐ bright☐ angry☐ inappropriate☐

Mood: anxious☐ labile☐ angry☐ expansive☐ depressed☐ euphoric☐

other: _____

Behavior: calm☐ guarded☐ bizarre☐ agitated☐ withdrawn☐ fearful☐ sarcastic☐

seductive☐ hostile☐ impulsive☐ other: _____

COGNITIVE FUNCTIONING:

Orientation: person☐ place☐ time☐ situation☐

Sensorium: alert☐ drowsy☐ confused☐

Insight: poor☐ fair☐ good☐

Judgment: intact☐ impaired☐

Intellect: below-average☐ average☐ above-average☐ superior☐

Memory: Recent: intact☐ impaired☐ Remote: intact☐ impaired☐

Concentration: Recent: intact☐ impaired☐ Remote: intact☐ impaired☐

THOUGHT PROCESS/CONTENT:

Associations: logical☐ circumstantial☐ tangential☐ disordered☐ loose☐

ideas of reference grandiose☐ other:

Speed of Associations: normal☐ slow☐ blocking☐ flights of ideas☐ other: _____

Delusions: Yes☐ No☐ Explain: _____

Preoccupation: Yes☐ No☐ Explain: _____

Obsessions/Compulsions: Yes☐ No☐ Explain: _____

Suicidal Potential: Yes☐ No☐ Past☐ Present☐ Ideations☐ Intent☐ Actions☐

Explain:_____

Homicidal Potential: Yes☐ No☐ Past☐ Present☐ Ideations☐ Intent☐ Actions☐

Explain:_____

_____ _____

Signature of Independent Contractor Date

_____

Printed Name of Independent Contractor

Telehealth Disclosure

Zur Institute, Inc. (Form used with Legal Consent)© 2020

Therapist Name: _____ License # _____
Phone: 954-587-7520 / 954-349-2777 Fax: 954-587-7527

Telemedicine Informed Consent

I (please print) _____ hereby consent to engage in telemedicine (e.g., internet or telephone based therapy) with my assigned therapist as the main venue for my psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with Florida law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated.

Please provide us with your email address in order for us to add you to The Child and Family Psychologists Mailing List and for us to contact you:

Email: _____

***** I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Print Name: _____ Signature: _____ Date: _____