ROBIN ERICKSON, PH.D., LMHC, CAP
Professional Counseling Services
4631 N. Congress Ave. Ste 204, West Palm Beach,Fl. 33407-3234
561 312-5288 FAX 561494-0613

NAME: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY ST

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_____

I AUTHORIZE ROBIN ERICKSON, PH.D., LMHC, CAP TO SUBMIT INSURANCE CLAIMS, INCLUDING ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I UNDERSTAND THAT ALL MEDICARE CLAIMS WILL BE PROCESSED UNDER GROUP POLICY OF SNEH KAPILA, M.D.,P.A. AND ROBIN ERICKSON, PH.D., LMHC, CAP, AND AUTHORIZE GROUP TO SUBMITMEDICARE CLAIMS, INCLUDING ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I FURTHER AGREE TO PAY ALL COST OF COLLECTIONS AND ANY SUCH BALANCE, INCLUDING ATTORNEY FEES. I AUTHORIZE PAYMENT OF MEDICAL/MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS TO ROBIN ERICKSON, PH.D., LMHC, CAP.

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

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561 312-5299 ~ FAX 561 494-0613

OFFICE POLICIES

1.) I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ASSURE I KNOW THE DATE AND TIME OF MY NEXT APPOINTMENT, A COURTESY CALL WILL USUALLY BE ATTEMPTED, HOWEVER UNFORESEEN CIRCUMSTANCES HAPPEN, SUCH AS AN MACHINE BEING FULL OR BROKEN, OR A PHONE NUMBER BEING DISCONNECTED. **A 24 HOUR NOTICE IS REQUIRED** BEFORE CHANGING OR CANCELLING APPOINTMENTS, OTHERWISE THE PATIENT WILL BE CHARGED **$75.00** DUE AND PAYABLE AT THE NEXT VISIT. (FIRST NO SHOW OR CANCELLATIONS LESS THAN 24 HRS. WILL BE WAIVED) ***PLEASE NOTE: INSURANCE COMPANIES DO NOT PAY FOR MISSED APPOINTMENTS.**

2.) CASH ACCOUNTS ARE TO BE PAID IN FULL AT THE TIME OF THE VISIT, UNLESS OTHERWISE AUTHORIZED BY **DR. ROBIN ERICKSON.**

3.) THOSE COVERED BY INSURANCE, MUST PAY CO-PAY AT TIME OF EACH VISIT. THE OFFICE IS SET UP TO ACCEPT CASH OR CHECKS ONLY- NO CREDIT CARDS ARE ACCEPTED.

4.) 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.

5.) I UNDERSTAND THAT **DR. ROBIN ERICKSON** DOES NOT RETURN CALLS REGARDING ISSUSES OR QUESTIONS THAT CAN BE DISCUSSED DURING A REGULAR APPOINTMENT. THIS INCLUDES RELATIVES WANTING INFORMATION. SIMPLE DISCOMFORTS,"MEDICATION NOT REALLY HELPING", "BEING VERY UPSET" ARE NOT CONSIDERED EMERGENCIES. IF YOU FEEL YOU CANNOT WAIT FOR AN APPOINTMENT, PLEASE FEEL FREE TO CALL AND BE PLACED ON OUR CANCELLATION LIST AND WE WILL CONTACT YOU IF A SOONER APPT. BECOMES AVAILABLE. "IF I FEEL I CANNOT WAIT FOR AN APPT, I WILL CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM FOR HELP."

INITIALS_____ DATE_____

6.) 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: 30 MIN SESSION- $ 60.00 / 50 MIN SESSION- $120.

7.) 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. 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.

8.) ANY ACCOUNT THAT IS TURNED OVER TO COLLECTIONS WILL BE SUBJECT TO A 33% SERVICE FEE. I UNDERSTAND THAT IF MY ACCOUNT IS SENT TO COLLECTIONS I WILL NOT BE ABLE TO SCHEDULE ANY FURTHER APPOINTMENTS UNTIL THE BALANCE IS PAID OFF.

9.) I UNDERSTAND THAT ANY VERBAL AGGRESSION OR INAPPROPRIATE LANGUAGE OR BEHAVIOR, USED TOWARD OFFICE STAFF OR DR. ERICKSON, EITHER IN PERSON OR BY TELEPHONE, WILL RESULT IN IMMEDIATE TERMINATION OF CARE HERE, OR MAY LEAD TO INVOLVEMENT OF LAW ENFORNCEMENT OFFICERS AS DEEMED NECESSARY.

10.) I UNDERSTAND THAT I WILL CONTACT MY PSYCHIATIRIST REGARDING ALL INQUIRIES REGARDING MY MEDICATIONS. **DR. ROBIN ERICKSON** IS NOT AUTHORIZED TO DISPENSE, CHANGE, ADVISE OR CONSULT WITH YOU REGARDING YOUR MEDICATIONS.

11.) FOR MORE INFORMATION AND RESOURCES, PLEASE FEEL FREE TO VISIT OUR WEBSITE: @ **WWW.ROBINERICKSON.COM**

BY SIGNING THIS FORM, I AM CONSENTING TO TREATMENT AND HEREBY ACKNOWLEDGE I HAVE READ AND UNDERSTOOD THE OFFICE POLICIES AND PROCEDURES. IF YOU HAVE ANY CONCERNS OR QUESTIONS REGARDING THE OFFICE POLICIES, PLEASE SPEAK WITH OFFICE PERSONNEL PRIOR TO SIGNING.

SIGNATURE OF PATIENT/GUARDIAN_____

PRINT PATIENT/GUARDIAN NAME: _____DATE_____

WITNESSED BY_____

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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: _____

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BY SIGNING THIS PAGE I AM ATTESTING THAT I HAVE READ AND UNDERSTOOD THE ATTACHED NOTICE OF PRIVACY PRACTICES THAT WILL BE USED BY THIS OFFICE.

I ALSO UNDERSTAND THAT A COPY OF THIS NOTICE WILL BE PROVIDED TO ME UPON REQUEST.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

WITNESS: _____ DATE: _____

PRINT