Patrick B. McGinnis, Ph.D., LMHC General Information Form

Welcome to my office. Your cooperation in completing this form will enable me to provide you with the most appropriate assistance.
(Please feel free to write on the back of these pages if you need additional space for any item.)

Personal Information

Name ____
First Middle Initial Last

Birth date ____________________ Age __________ Sex __________

Address

____
Street Apt. #

____
City State Zip Code

At times I send information about current services to your home or email address. If you prefer not to receive mail, please check this box: ☐

Home Phone (_____) __________ _ ________ Work Phone (____) ______________ Ext. _____

Cell Phone (_____) ______________ Email Address ____________________

Who referred you to me? ____________________ May I thank them? Yes ☐ No ☐

Social Security Number ________ - ________ - ________

Your place of employment ______________________________________

Your position or title ______________________________________

How long have you worked there? ____________________

Current Relationship *(Check as Appropriate)*

Single? ___ Married? ___ Live Together? ___ Involved and Live Apart? ___ How long? ___

Your Partner's Name ______________________________ Age ______

Your Partner's Place of Empl. ______________________________

Your Partner's Occupation ______________________________

Your Partner's Phone (______) ____________ Ext. _____ (Home? ____ Or Work____?)

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Previous Significant Relationships

First Name	Began	Ended	How long together	How long apart	Why did it end?

Your Education:

Grade School _____ High School _____ College _____ Graduate Study _____
If College, Your Major: ____

Religion:

Yours ____ Active _____ Inactive _____

Your Partner____ Active _____ Inactive _____

Family Members

Identify all persons who are your children, for whom you assume personal or family responsibility, or other persons who live with you.

Name **Relationship** **Age**

____

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____

Place an asterisk (*) next to those who live with you.

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Health Care Information

Primary Care Physician:

Last Seen: _____________Reason: ____

Current Health Problems: ____

Current Medications: ____

Previous Psychological / Psychiatric / Chemical Dependency Assistance:

	Therapist	*Reason*	*Year Began*	*How Long*
You:				
Your Partner:				

Previous Psychiatric Hospitalization: ____

____

Circle One:

Ever thought you may have a drinking or drug problem? Yes / No Been told? Yes / No

Ever thought you may have a problem with food/eating? Yes / No Been told? Yes / No

Have you ever really considered or attempted suicide/homicide? Yes / No

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Fees Associated with Treatment will be paid by:

Name: ____ Phone: (_____) _________________

Address *(If different)*:

____

In Case of Emergency Call:

Home Phone (_____)_________________ Work Phone (_____)_________________Ext. _____

I hereby request and give consent to receive psychotherapy from Dr. Patrick B. McGinnis, PhD, LMHC.

____

Signature *Date*

Patrick B. McGinnis, PhD, LMHC

Memo of Understanding

Confidentiality and privileged communication are rights of all clients of psychologists and counselors according to the law and professional ethics. No information about you, or the psychological or counseling services provided to you will be released without your permission. There are, however, certain circumstances in which it may be required or helpful to release patient information:

1. If a court of law issues a subpoena, then I am required to provide the information specifically described in the subpoena.
2. If you indicate that you intend to hurt or kill yourself or someone else, then I must act to notify potential helpers or victims if I believe there is a real danger.
3. If you report, or I suspect, that you are a perpetrator of child abuse or molestation, or abuse of the elderly, then I am obliged to report this to the authorities if you identify the victim (and a report has not been previously made). Likewise if you are a child or elder person who is currently being victimized, I may be required to make a report for your protection.
4. If your insurance or managed care company requires me to provide them with patient information, I may release information to them needed to determine coverage or reimbursement.
5. If you are a minor, your parents or guardians must be informed of your progress, if they ask; but I do not have to tell them details.

You have read the above and understand the therapist's social, legal, professional and ethical responsibilities to make such decisions as necessary.

You agree to let me know if you are feeling suicidal or homicidal, so appropriate arrangements can be made to assist you.

You understand that the fees for each session of psychotherapy, hypnotherapy, testing, or other services are outlined on the accompanying sheet, unless otherwise reduced in writing according to your ability to pay. Sessions extending beyond 50 minutes or any telephone consultations over 10 minutes will be charged on a pro-rated basis for the additional time. The charge for a returned check is $20.00. The fee is generally paid at the end of each session. You understand that you are responsible for the above fees, regardless of whether your insurance covers the services provided or whether the insurance check is sent to you directly. Please bring up and discuss any fee concerns with me as they occur. In the event of failure to pay for professional services, you agree to pay for the costs of collection and reasonable attorney's fees and expenses including those of appeal. For any future legal or court-related services, you agree to pay the prevailing hourly fees. To avoid being charged for a missed session, you agree to notify me at least 24 hours prior to your appointment if you need to cancel or change the time.

Your signature indicates that you have read and understood this Memo of Understanding.

______________________________ _______________________

Signature Date

Patrick B. McGinnis, PhD, LMHC

Fee Schedule

Individual Therapy_______$150 per session (45-50 minutes) *
Couples Therapy_________$180 per session (45-50 minutes) *
Telephone Counseling_____$100 per session (45-50 minutes) – you call me at the specified appointment time. The fee must be paid in advance.
Skype Counseling________$100 per session (45-50 minutes) The fee must be paid in advance.
Court Appearances_______$200 per hour (including attorney phone conversations or
or Reports interviews, any required collateral interviews, document review, report writing, and transportation (if required). A retainer is to be paid in advance.

* Note: Individual or Couple sessions extending beyond the reserved appointment time, or any telephone consultations over 10 minutes, will be charged on a pro-rated basis for the additional time.

Fees are generally paid prior to, or at the time of, each session; while online credit card payments must always be made at least one hour in advance (credit cards are accepted in the office). Please bring up and discuss any fee concerns with me as they occur and especially prior to your session.

The charge for a returned check is $20.00. You understand that you are responsible for all fees, regardless of whether your insurance covers the services provided or whether the insurance check is sent to you directly. In the event of failure to pay for professional services, you agree to pay for the costs of collection and reasonable attorney's fees and expenses including those of appeal. For any future legal or court-related services, you agree to pay the prevailing hourly fees.

To avoid being charged for a missed session, you agree to notify me at least 24 hours prior to your appointment if you need to cancel or change the time. You understand that the fees for each session of psychotherapy, hypnotherapy, testing, or other services are outlined above, unless otherwise reduced in writing. Your signature indicates that you have read and understood this schedule of fees.

_________________________________ _______________________________
Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice describes how medical/mental health information about you may be used and disclosed, and how you may obtain access to this information. Please review it carefully.

I, Patrick McGinnis, am dedicated to protecting your medical/mental health information and will only release information in accordance with state and federal laws and the ethics of the counseling profession.

Uses and Disclosure of Protected Health Information
I maintain the confidentiality of your mental health information as required by law. I will use your protected health information for the purpose of providing counseling services, obtaining payment for service, and conducting related service operations. Your information may be used or disclosed *only* for these purposes unless you have requested and signed an *Authorization for Release of Information*. The above-mentioned disclosures and any communication to you may be made orally, in writing, by facsimile, or by telephone.

Treatment
I will use your protected health information to provide, manage, and/or coordinate care and related services. This includes the coordination with your health care provider if applicable, consultants, and potential referral sources.

Electronic Storage and Transmittal of Information
Portions of your protected information will be stored as electronic data in my possession. Reports, insurance billing, etc, may be sent to the authorized receiver electronically such as by email or fax. We may have contact with each other by telephone or email during or after your treatment. You acknowledge that while every attempt will be made to ensure your privacy that these transmittal methods are not totally fool proof and cannot be guaranteed.

Other Uses or Disclosure of Your Information NOT Requiring Your Consent
There are some instances where I may be required to use and disclose information without your consent, such as, but not limited to: • Information that you and/or your child(ren) provide about physical or sexual abuse which, under Florida State Law, I am obligated to report to the Department of Children and Families; • Information leading me to believe that you are in danger of harming yourself or others; • Information shared with law enforcement if a crime is committed on my premises; • Information as required by law, such as a Court Order.

I/we have read and received a copy of this HIPAA “Notice of Privacy Practices.”

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CLIENT SIGNATURE   Date