Associates in Behavioral Counseling
Suite102/ 7800 W. Oakland Park Blvd.
Sunrise, FL 33351
954-742-8400

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

Contact office: Hipaa Officer/ Suite 102/ 7800 W. Oakland PK Blvd./ Sunrise, FL 33351

I, _____, have receiver a copy of this office's Notice of Privacy Practices.

NAME: _____

SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of out Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining the acknowledgment

☐ Other _____

SIGNATURE: _____

DATE: _____

ASSOCIATES IN BEHAVIORAL COUNSELING

7800 W. OAKLAND PARK BLVD STE 102
SUNRISE, FLORIDA 33351

PATIENT INFORMATION

PLEASE PRINT CLEARLY DATE_____

NAME_____ DX (OFFICE USE ONLY)_____

ADDRESS_____ CITY_____

STATE_____ ZIP_____ OCCUPATION_____

HOME PHONE_____ WORK PHONE_____

EMAIL_____ CELLULAR_____

THE BEST WAY TO REACH ME IS: HOME PHONE___ WORK PHONE___ CELLULAR___ EMAIL___

IT IS **OK**___ OR **NOT OK**___ TO LEAVE A MESSAGE REGARDING APPOINTMENT TIMES, ETC.

WOULD YOU LIKE TO ENABLE EMAIL OR TEXT FEATURES WITH YOUR DOCTOR? YES___ NO ___
TO ENABLE TEXT OR EMAIL YOU MUST DOWNLOAD THE SIGNAL APP TO YOUR CELL PHONE

SOC. SEC.#_____ DATE OF BIRTH_____ SEX_____

AGE_____ (CHECK ONE:) SINGLE___ MARRIED___ WIDOWED___ DIVORCED____

EMPLOYED BY_____ CITY_____ STATE_____

SPOUSE, PARENT, EMERGENCY CONTACT_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE_____

NAME OF REFERRAL SOURCE:_____

(CHECK ONE:) INSURANCE __ YELLOW PAGES__ DOCTOR__ LAWYER__ JOB__ EAP__ ADVERTISEMENT__ OTHER__

---------- **INSURANCE PAYMENT ORDER** ----------

INSURED NAME (IF DIFFERENT THAN ABOVE)_____

DOB_____ INSURED SS#_____ POLICY #_____

I hereby assign and direct you to pay directly to

DR. STANLEY B. SEIDMAN, PH.D., P.A. / DBA- ASSOCIATES IN BEHAVIORAL COUNSELING
Belle Terre Medical / Sunrise
Suite 102, 7800 W. Oakland Park Blvd.
Sunrise, Florida 33351

benefits due me out of indemnity under the terms of my policy issued by your company. Payment is authorized upon your receipt of an itemized statement for services rendered me. This policy was in full force and effect at the time that these services were rendered. Payment of this amount as herein directed, in whole or part, shall be considered the same as if paid by your company directly to me.

Authorizations:

I authorize Stanley B. Seidman, Ph.D. P.A. and/or Associates in Behavioral Counseling

I. To release pertinent psychological information to insurers in order to obtain payment. My signature reflects that I have signed a release allowing such information to be transmitted.

II. My signature reflects and confirms my request for professional services and responsibility for all charges incurred.

Name _____

Legal Signature_____ Date_____

(If patient is a Minor, Parent or Guardian must sign.)

PATIENT INFORMATION SHEET - ADDENDUM

Presenting Problem: (Why are you seeking treatment at this time?)

Primary Care Physician: (If you are under the care of more than 1 doctor, list all of them)

Medical Problems or Disabilities:

Current Medication or Allergies: (Name, Dosage, and Prescribing Physician)

History of Psychological/Psychiatric Care: (List names of treatment providers and dates)

Education: (Highest grade/degree attempted/completed; Write name of current school)

Family Information: (List all individuals living with you)

Name	Age	Relationship

Additional Information:

ASSOCIATES IN

BEHAVIORAL
COUNSELING

7800 W Oakland Park Blvd STE 102 . Sunrise, FL 33351-6742
Phone:954.742.8400 . Fax:954.742.0918 . www.abcpsych.com

Patient name: _____ Patient e-mail: _____

1. RISK OF USING E-MAIL/TEXT - Transmitting patient information by EMAIL/TEXT has a number of risks that patients should consider before using EMAIL/TEXT. These include, but are not limited to, the following risks:

a) The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that EMAIL/TEXT that contains protected health information be encrypted. EMAIL/TEXTs sent from _____ and the Practice are not encrypted, so EMAIL/TEXTs may not be secure. Therefore it is possible that the confidentiality of such communications may be breached by a third party.
b) EMAIL/TEXT can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) EMAIL/TEXT senders can easily misaddress an EMAIL/TEXT.
d) EMAIL/TEXT is easier to falsify than handwritten or signed documents.
e) Backup copies of EMAIL/TEXT may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect EMAIL/TEXT transmitted through their systems.
g) EMAIL/TEXT can be intercepted, altered, forwarded, or used without authorization or detection.
h) EMAIL/TEXT can be used to introduce viruses into computer systems.
Practice server could go down and EMAIL/TEXT would not be received until the server is back on-line.
i) EMAIL/TEXT can be used as evidence in court.

2. CONDITIONS FOR THE USE OF EMAIL/TEXT Practices cannot guarantee but will use reasonable means to maintain security and confidentiality of EMAIL/TEXT information sent and received. Practice and Physician are not liable for improper disclosure of confidential information that is not caused by Practice's or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) EMAIL/TEXT is not appropriate for urgent or emergency situations. Practice and Physician cannot guarantee that any particular EMAIL/TEXT will be read and responded to within any particular period of time.
b) If the patient's EMAIL/TEXT requires or invites a response from Practice or Physician, and the patient has not received a response within two (2) business days, it is the patient's responsibility to follow-up to determine whether the intended recipient received the EMAIL/TEXT and when the recipient will respond.
c) EMAIL/TEXT must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via EMAIL/TEXT.
d) All EMAIL/TEXT will usually be printed and filed in the patient's medical record.
e) Office staff may receive and read your messages.
f) Practice will not forward patient identifiable EMAIL/TEXTs outside of the Practice without the patient's prior written consent, except as authorized or required by law.
g) The patient should not use EMAIL/TEXT for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Practice is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
i) This consent will remain in effect until terminated in writing by either the patient or Practice.
j) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by EMAIL/TEXT with Practice.

3. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of EMAIL/TEXT between the Practice, Physician and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by EMAIL/TEXT. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge _____ and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such EMAIL/TEXT.

Patient signature _____ Witness Signature _____

Date _____ Date _____

SYMPTOM CHECKLIST

Name: _____ Date: _____

Please check those items that have applied to you during the past 6-12 months.

_____ Difficulty falling asleep
_____ Fear of being alone
_____ High blood pressure
_____ Recurrent negative thoughts
_____ Waking in the middle of the night
_____ Fear of public places
_____ Allergies
_____ Waking earlier then intended
_____ Fear of crowds
_____ Asthma
_____ Concern over your health
_____ Legal problems
_____ Pain (in back, neck or shoulders)
_____ Financial problems
_____ Feeling bored
_____ Feeling hopeless
_____ Family violence
_____ Feeling helpless
_____ Tension headaches
_____ Migraine headaches
_____ Increased smoking or drinking
_____ Blood sugar problems
_____ Preoccupation with details
_____ Serious illness
_____ Panic attacks
_____ Marital problems
_____ Teeth grinding/clenching
_____ Problems with children
_____ Feeling worthless
_____ Feelings of guilt
_____ Temper outbursts
_____ Sweaty palms
_____ Feeling "burned out"
_____ Work stress
_____ Loss of interest in sex
_____ Preoccupation with sex
_____ Thoughts of death or suicide
_____ Face or jaw pain
_____ Vomiting
_____ Tearfulness or crying
_____ Nightmares
_____ Feeling lonely
_____ Diarrhea
_____ Frequent urination

_____ Heart racing or palpitations
_____ Knots in stomach
_____ Driving phobia
_____ Impatient with people
_____ Poor appetite
_____ Overeating
_____ Social isolation
_____ Painful urination
_____ Indigestion
_____ Feeling emotional
_____ Significant weight gain or loss
_____ Chest pains or tightness
_____ Moodiness
_____ Dizziness
_____ Not being assertive enough
_____ Feeling inadequate
_____ Loss of interest in things
_____ Tingling/numbness in hands or feet
_____ Use of medications
_____ Feeling frustrated
_____ Loss of energy (fatigue)
_____ Feeling hostile
_____ Cold hands or feet
_____ Loss of concentration
_____ Inability to relax
_____ Family stress
_____ Feeling faint
_____ Dwelling on the past
_____ Excessive worry
_____ Restlessness
_____ Seizures or passing out
_____ Feelings of emptiness
_____ Suspicious of people
_____ Feeling life is unfair
_____ Nail biting or hair pulling
_____ Feeling loss of control over life
_____ Loss of self-confidence
_____ Recurrent colds & coughs
_____ Difficulty making decisions
_____ Memory lapses
_____ Feeling angry
_____ Feeling of time pressure
_____ Sleeping too much