

**GRANDE COUNSELING & CONSULTING, LLC**  
**CAROL V GRANDE, LMHC, CEAP, ICADC, SAP**  
**GRANDE COUNSELING & CONSULTING, LLC**  
*INDEPENDENT CONTRACTOR*

**NEW PATIENT INFORMATION**

Welcome to Our Office

Date: \_\_\_\_\_

Patient Name (Please Print)	SS#	Marital Status					Sex		DOB	Age
		S	M	W	D	Sep	M	F		
Street Address		City/State			Zip			Home Phone#		
Client's or Parent's Employer		Occupation (Indicate if student)			How Long Employed			Work Phone		
Employer's / School's Address		City / State			Zip Code			Cell Phone		
Drug Allergies (if any)							Email:			
Spouse / Parent's Name		List who is Primary on Insurance			SS#			Spouse / Parent's DOB		
Spouse / Parent's Employer		Occupation (Indicate if student)			How Long Employed			Work Phone		
Employer's / School's Address		City / State			Zip Code			Cell Phone		
Spouse's Address (if divorced or separated)		City / State			Zip Code			Phone		
<b>PLEASE READ: ALL CHARGES ARE DUE AT TIME OF SERVICE</b>										
Person Responsible for Payment		Street Address			City / State			Zip Code		
Relation to Patient		Phone#			DOB			SS#		
Primary Insurance		Phone#			Insurance ID#			Group#		
Referred By:		Street Address:			City/State			Zip		
Phone#		May we Thank Them?			Comments					

- ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT
- NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS
- HOWEVER, PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE
- IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE

Initial ☐ Received Notice of Privacy Practices

All the information above is deemed correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

## SIGNATURE PAGE

Release of Information, Benefit Assignment, Payment Authorization, Full Disclosure Statement,  
and Agreement to pay for Professional Services

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Patient Name

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Date of Birth

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Social Security Number

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Parent or Guardian Name

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Date of Birth

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Social Security Number

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\_\_\_\_\_: I hereby authorize Carol V Grande (Therapist) and his / her authorized representative to  
(initial) release any information necessary to process my insurance / Medicare claim, acquired in the  
course of my examination or treatment; to allow a photocopy of my signature to be used to  
process my insurance / Medicare claim for the period of a lifetime. I claim any insurance  
benefits due me for services rendered by Carol V Grande (Therapist); and authorized and  
direct my carrier to issue payment checks directly to Carol V Grande (Therapist). Regardless of  
my insurance benefits, if any, I understand I am fully financially responsible for any and all fees  
incurred, and I agree to pay such fees in full. I understand that if payments are more than 30  
days past due, delinquency charges at the lesser of normal rate of 20% or the maximum  
allowable rate will be due on delinquent amounts from the date the payment was due.

\_\_\_\_\_: The insurance information furnished here represents a full disclosure of the insurance/ third  
(initial) party benefits to which I am entitled. I understand that failure to disclose pre-certification /  
second opinion requirements for any and all plans to which I subscribe, may incur full liability  
for professional charges, as a result of non-payment by any carrier.

\_\_\_\_\_: **NO SHOW OR LATE CANCELLATION FEE: This charge is the patient's responsibility and**  
(initial) **may not be charged to the insurance company.** By signing this page, I agree that I am  
responsible for a \$75.00 charge if less than 24 hours notice is given for a cancellation.

\_\_\_\_\_: I understand that payment in full is due at the time of service, unless other arrangements have  
(initial) been made in advance. I agree to pay a \$35.00 fee, plus the amount of the check, should a check  
be returned from the bank for any reason.

\_\_\_\_\_: I authorize release of billing information needed by collection agencies/legal entities to collect  
(initial) unpaid balances.

\_\_\_\_\_: I authorize release of information to all my insurance companies except as noted here:  
(initial) \_\_\_\_\_

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Patient or Parent / Guardian Signature

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Date

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Witness

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Date

**CONFIDENTIAL INTAKE  
TO BE COMPLETED BY CLIENT**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Person completing form: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Previous Counseling/Treatment: ☐ No ☐ Yes (If yes, please list therapist(s), dates & outcome)

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**Primary Care Physician:** \_\_\_\_\_ **Date of last physical exam:** \_\_\_\_\_

Medication	Dosage	Date of next Refill	Prescribed by

**Client statement of problem:**

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Please check all symptoms manifested by the client:

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Easily agitated	<input type="checkbox"/> Isolation
<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Obsessive behavior	<input type="checkbox"/> Extreme sadness	<input type="checkbox"/> Suicidal
<input type="checkbox"/> Loss of interest in daily activities		<input type="checkbox"/> Homicidal	<input type="checkbox"/> Panic / Anxiety
<input type="checkbox"/> Decreased concentration		<input type="checkbox"/> Violence	<input type="checkbox"/> Anger
<input type="checkbox"/> Memory loss	<input type="checkbox"/> Irritability	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Change in appearance
<input type="checkbox"/> Weight (+/-)	<input type="checkbox"/> Rebellious / Defiant	<input type="checkbox"/> Excessive guilt	<input type="checkbox"/> Lying
<input type="checkbox"/> Feelings of worthlessness		<input type="checkbox"/> Stealing	<input type="checkbox"/> Flashbacks
<input type="checkbox"/> Loss of sexual desire	<input type="checkbox"/> Hallucinations/Delusions	<input type="checkbox"/> Alcohol use/abuse	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other drug use/abuse: _____	

Who suggested that you come here today? (Check all that are true for you)

<input type="checkbox"/> My own decision	<input type="checkbox"/> Family or partner
<input type="checkbox"/> Employer	<input type="checkbox"/> Court or social services
<input type="checkbox"/> Doctor or other health professional	<input type="checkbox"/> Employee Assistance Program (EAP)

**Family statement of presenting problem:**

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**Grande Counseling & Consulting, LLC: Adults, Adolescents, Couples**  
**Carol V Grande, LMHC, CEAP, ICADC SAP**  
***Grande Counseling & Consulting LLC (Independent Contractor)***

***PRIMARY CARE PHYSICIAN AND/OR REFERRAL SOURCE***  
***COMMUNICATION NOTICE AND LIMITED RELEASE***

An HMO or insurance carrier may request that information about your care be released to your Primary Care Physician (PCP) or other health professional that referred you to this practice. This information is usually communicated in the form of an Outpatient Treatment Report, Referral Source Communication Notice, or some other document. When such notice is required as a condition of your insurance policy, it is usually for the purpose of ensuring continuity of care, coordination of plan benefits, or avoiding duplication of services.

This document will serve as a limited release to provide only the information specified below to your Primary Care Physician or other referral source. If you do not wish this information released you may indicate your wishes below. While I will endeavor to honor your wishes in this matter, if your services are being covered by an HMO or other insurance payer, the written provisions and policies of that organization will prevail.

\_\_\_\_\_ **I want this information released to my Primary Care Physician or other healthcare provider.**

\_\_\_\_\_ **I do not want this information released to my Primary Care Physician or other healthcare provider.**

**PLEASE SIGN BELOW**

**(Patient/Guardian Signature)** \_\_\_\_\_ **Date** \_\_\_\_\_

Physician or other Healthcare Provider: \_\_\_\_\_

Physician/Provider Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**FOR OFFICE USE ONLY**

Dear \_\_\_\_\_:

\_\_\_\_\_ was seen in this office for,

Initial Assessment \_\_\_\_\_ Follow up Appointment \_\_\_\_\_, on the following date \_\_\_\_\_

By Carol Grande, LMHC, CAP, ICADC, SAP

Diagnosis and/or presenting problem (*If Initial Assessment*), or progress to date: \_\_\_\_\_

Initial or follow-up Treatment Recommendations: \_\_\_\_\_

Medications: \_\_\_\_\_

Please call if further information is required.

\_\_\_\_\_  
LMHC, CEAP, ICADC, SAP

2950 Halcyon Lane #701, Jacksonville, FL 32223 Phone: (904) 292-2407 Fax: (904) 292-2409

# Grande Counseling & Consulting, LLC (independent contractor)

## PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Carol Grande, Beginnings Counseling and Recovery and its representatives to use and disclose my protected health information to carry out:

- Treatment
- Obtaining payment from third party payers (i.e. insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of "Notice Of Privacy Practices", which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected. Revocation may not impede this office's ability to collect for payment of services.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Print Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

# BRIEF MOOD SURVEY \*

(PAST WEEK)

**Instructions:** Put a Check (✓) after each item to indicate how you have been feeling during the past week, including today.  
**Please answer all the items.**

	0--Not At All	1--Somewhat	2--Moderately	3--A lot	4--Extremely
Depression					
1. Sad or down in the dumps					
2. Discouraged or Hopeless					
3. Low self-esteem					
4. Worthless or inadequate					
5. Loss of pleasure or satisfaction in life					
Please Total Your Score on Items 1 to 5 Here →					
Suicidal Urges					
1. Do you have suicidal thoughts?					
2. Would you like to end your life?					
Please Total Your Score on Items 1 to 2 Here →					
Anxiety					
1. Anxious					
2. Frightened.					
3. Worrying about things over and over					
4. Tense or on edge					
5. Nervous					
Please Total Your Score on Items 1 to 5 Here →					
Panic					
1. Sudden feelings of terror or overwhelming fear					
2. Sudden terrifying panic attacks that come out of the blue					
3. Suddenly feeling you're going crazy or cracking up					
4. Suddenly feeling you're about to suffocate or pass out					
5. Suddenly feeling you'll have a stroke, heart attack or die					
Please Total Your Score on Items 1 to 5 Here →					
Anger					
1. Frustrated					
2. Annoyed					
3. Resentful					
4. Angry					
5. Irritated					
Please Total Your Score on Items 1 to 5 Here →					

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# Grande Counseling & Consulting, LLC (Independent Contractor)

2950 Halcyon Lane #701  
Jacksonville, Florida 32223

Phone: (904) 292-2407  
Fax: (904) 292-2409

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## NOTICE OF PRIVACY PRACTICES

This Notice describes how Medical Information about you may be used and disclosed and how you can get access to this information.

Please Review it Carefully.

### Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated but we must give you this important information. This is a shorter version of the full, legally required, NPP which is posted in the reception area and available to you upon request. Please refer to the full version for more detailed information. If you have any questions our Privacy Officer will help you understand our procedures and your rights. His or her name and address are at the end of this Notice.

We will use the information about your health that we get from you or from others mainly to provide you with treatment, arrange for payment for our services, and for some other business activities, which are called in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

While your health information is private, there are some times when the law requires us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to prevent or reduce the threat.
2. Some lawsuits or court proceedings
3. If a law enforcement official requires us to do so
4. For workers Compensation and similar benefits

There are some other situations like these that do not occur very often. They are described in the full version of the NPP.

### Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way that is more private for you. For example you can ask us to call you at home, and not at work, to confirm or reschedule an appointment. We will try our best to do as you ask.
2. You may ask us to limit what we tell people involved in your care or payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement unless it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have a right to request to see your health and billing records. You may request copies of your records but we may charge you. Note that some notes kept by the therapist may not be available to you.
4. If you believe the information in your records is incorrect or missing, you can ask us, in writing, to make some kind of changes (corrections) to your health information, along with the reasons you feel the changes are warranted. We retain the right of final determination whether the changes are made.
5. You have a right to a copy of this notice, and the full version of the NPP. If we change this NPP we will post the new version in our waiting area.
6. You have a right to file a complaint if you believe your privacy rights have been violated. You can file the complaint with our Privacy Officer or the Dept of Health and Human Services. All complaints must be filed in writing.

If you have questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is Carol V Grande at 904-292-2407.

The effective date of this notice is April 14, 2003

**Grande Counseling & Consulting, LLC**  
**Independent Contractor**  
**Financial Policies**

Please carefully read the information found below detailing our financial policies. It is important to us that you have a complete understanding of these policies. We reserve the right to amend or make changes to these policies and will notify you in writing. If you have any questions or concerns, please let us know.

**List of Fees & Services**

Initial Evaluation:	<b>\$150</b>	Missed appointment Fee:	<b>\$75</b>
Therapy session (53+ minutes):	<b>\$125</b>	Letters/Forms completed	<b>\$65</b>
Phone Support past 5min:	<b>\$25 per 15 min</b>		

**Note:** We will contact your insurance carrier for verification of benefits/coverage. Any co-pay is due at the time of the session.

**Cancellation/Rescheduling & Arrival Time Policy**

If you are unable to make your scheduled appointment, please contact the office **24** hours in advance. If you do not show for an appointment or do not give proper notice of cancellation or need for rescheduling, you will be charged a **\$75 fee**. This is a fee to you, as insurance companies do not pay for missed appointments. Also, note that if you arrive late for your appointment, you are forfeiting that time.

**Court Services-** Court services are **not** part of mental health treatment. If you require involvement in any court proceedings, additional fees will apply. Court related fees are not covered by insurance. Court appearances and depositions are billed to the individual requesting the testimony. The fee for these services is \$200/hour with a required minimum fee of \$600 paid 7 days in advance. Payment is accepted in Cash, Check or Money Order. There are no refunds. Report writing is billed at \$150 per hour and required 2 hours be paid in advance. A charge of \$1 per page will be made for copying any records.

**Insurance and Payment Agreement**

\*I acknowledge that it is my responsibility to know and understand my insurance plan benefits.

\*I will notify **Carol V Grande, LMHC, CEAP, ICADC, SAP** of any changes in my insurance coverage or participation and provide proper documentation.

\*I understand that all fees for services, co-pays, co-insurance amounts and deductibles are due at the time of the service.

\*I understand that there is a **\$35** fee for a returned check. I understand checks may no longer be accepted if a check is returned for insufficient funds-payment will need to be paid in cash.

\*I understand an account is considered delinquent if there has not been a payment made within 30 days following written notification of the balance due. **Any portion of the account balance over 30 days past due will be submitted to a collection agency and accrue interest.**

\*I also agree to **pay all collection costs** on any unpaid balance on my account, generally 50% of balance.

**\*I acknowledge responsibility for any payments due to Carol V Grande, (Grande Counseling & Consulting, LLC) for services provided or fees as previously outlined above.**

**Your signature below indicates that you have read, understand and agree to comply with all the terms and conditions explained above.**

**Print Full Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Beginnings Counseling & Recovery

2950 Halcyon Lane Ste #701

Phone: (904) 292-2407

Jacksonville, Florida 32223

Fax: (904) 292-2409

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## Credit/Debit Card Authorization

Please complete the following information. This form will be securely stored in your file and may be updated upon request at any time. This is your consent to make payment for services via credit/debit card.

In case of late cancellations and no shows for scheduled sessions, you will be charged a \$75.00 fee. If a check is returned unpaid, you will be charged the amount of the check and an additional \$35.00 is assessed for the returned check.

I, \_\_\_\_\_ hereby authorize  
**Carol V Grande, LMHC, CEAP, ICADC, SAP** to bill my credit/debit card at the usual fee for professional services including all of the following:

\*Missed appointments (\$75.00 fee)

\*Appointments that I have cancelled with less than 24 business hours' notice (\$75.00)

**Please note-The following charges will be subject to a 5% transaction fee.**

\*Appointments and/or co-payments that I elect to pay by credit/debit card

\*Fees not covered by insurance payments made to client rather than provider.

**Please complete the information below:**

Account Type: Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ AMEX \_\_\_\_\_ Discover \_\_\_\_\_

Cardholder Name (as it appears on card) \_\_\_\_\_

Account Number \_\_\_\_\_

CVV2 (3 digit number on back of Visa/Mc, 4 digits on front of AMEX) \_\_\_\_\_

Expiration Date \_\_\_\_\_

Billing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

By signing below, I am authorizing **Carol V Grande, LMHC, CEAP, ICADC, SAP** to bill my credit/debit card at the usual fee for professional services. I will not dispute charges ("charge back") for session I have received or appointments I have missed according to the above policy.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_