Erica Huertas, LMHC
5835 Memorial Highway
Suite 19
Tampa, FL 33615
(813) 586-1414
FAX (813) 862-9995

Welcome!

Congratulations on your decision to begin therapy. Please take a few minutes to read and fill out the paperwork attached. The therapy session will be 50 minutes in length. Please be aware that I will make every effort to be available at your appointment time. Thank you.

AIP

Client Information

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Email: _____

☐ When contacted, do not mention agency name.

☐ Do not contact by phone call.

☐ Do not contact by text messages.

☐ Do not contact by email.

Age: _____ Date of Birth: _____ Sex: Male_____ Female _____

Social Security #: _____ Education: _____(last grade completed)

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Other _____

Religion: _____

Emergency Contact

Name: _____ Relationship_____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Billing Information

Insurance Company: _____

Insurance Address: _____

Insurance Phone Number:_____

This insurance policy lists you as: Primary Employee _____ Dependent _____

Relationship: Self____ Spouse ____ Child ____ Other ____

Primary employee's name (if different from client): _____

Primary employee Social Security #: _____ Employer: _____

Member ID or Policy #: _____

You were referred by: _____

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Notice of Therapist Availability

Please be advised that I am not available at all times. I will attempt to return phone calls in a timely manner for brief conversations between sessions, if needed.

In the event that you cannot reach me at any given time (day, evening, weekend, or holiday) and you feel it is an emergency, go to any emergency room for a psychological consultation, or call 911. Keeping yourself safe is your responsibility and if you are unable to do this you must contact 911.

Signature_____

Date_____

Procedure for Telephone Contact

Please note that it is sometimes necessary to notify you of a change in appointment time. Please be assured that your confidentiality is very important and if you cannot be reached a message may be left which will include the therapist name and phone number. Please indicate with your initials which procedure you wish to be followed.

_____ Do not contact me under any circumstances.

_____ Yes, you may contact me as described above.

_____ Yes, you may contact me, but only under these conditions:

_____

_____

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Financial Responsibility/Assignment of Benefits

I hereby assign all medical benefits, which include major medical benefits to which I am entitled, including private carrier and other health plans to Erica Huertas, LMHC. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is as valid as the original. I understand that pre-certification for services by my insurance company does not guarantee payment for services rendered. I understand that I am financially responsible for all charges whether paid or unpaid by an insurance carrier. I hereby authorize Erica Huertas, LMHC to release all information necessary to secure the payment for services rendered.

I UNDERSTAND THAT I WILL BE CHARGED $25.00 EACH TIME I MISS OR CANCEL A SCHEDULED APPOINTMENT IF I FAIL TO CALL TO CANCEL WITHIN 24 HOURS BEFORE MY SCHEDULED APPOINTMENT. I AGREE TO PAY THESE LATE FEES PRIOR TO MY NEXT SESSION. Exceptions to this late-cancel fee include life-and-death emergencies and extreme illness.

I understand that I am required to pay my co-pay at the time of my appointment and that failure to pay my co-pay will release any obligation of Erica Huertas, LMHC to schedule any future appointments until all amounts due by me are paid in full. _____ (initial)

I hereby authorize Erica Huertas, LMHC to release all information necessary to secure all payments. _____ (initial)

Patient Name: _____

Signature: _____

Date: _____

Informed Consent & Agreement For Psychotherapy Services

Introduction. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents before signing it. You may have questions about me, my qualifications, therapy, or anything not addressed here. It is your right to have a complete explanation for any questions you may have, now or in the future. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you.

Information about Your Therapist. Whenever you wish, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about the above, and anything else related to your therapy or other concerns.

Erica Huertas, LMHC is a sole proprietor, license #MH13967.

Fees. The fee for service is **$125** for the initial session and $90.00 per 60 minute therapy session thereafter. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance. Fees are payable at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure.

If a contract with your private insurance provider has been established, terms for payment will be according to the contract.

If for some reason you find that you are unable to continue paying for your therapy, please inform me. I will help you to consider any other options that may be available to you at that time.

Appointment Scheduling and Cancellation Policies. Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. Sessions are prescheduled by appointment and need to be limited to the allotted length of time (usually 60 minutes).

Risks and Benefits of Therapy. Psychotherapy is a process in which we will discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so that you can experience your life more fully. It provides an opportunity to better and more deeply understand one-self, as well as any problems or difficulties you may be experiencing. Psychotherapy is a joint effort between us. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require

substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change unhealthy thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, anxiety, etc. There may be times in which I will challenge your perceptions and assumptions, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships is your sole responsibility.

During the therapeutic process, many people find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You should discuss with me any concerns you have regarding your progress in therapy. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Discussion of Treatment Plan. It is my intention to provide services that will assist you in reaching your goals. Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various treatment approaches according to the problem that is being treated and my assessment of what will best benefit you. These approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, developmental, and/or psycho-educational techniques.

I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. If you have any unanswered questions about any of the procedures used in the course of your therapy, possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments through referrals or recommendations.

Termination of Therapy. The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals.
You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session if at all possible.

Professional Consultation. Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your situation.

Collaboration with Other Professionals. In order to provide quality services, I often need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a release of information authorizing these exchanges; in some cases, I may not be able to provide services without this.

Records and Record Keeping. I may take notes during session and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are the sole property of the therapist. Should you request a copy of my records, such a request must be made in writing. I typically maintain records for ten years following termination of therapy. After ten years, your records may be destroyed in a manner that preserves your confidentiality.

Confidentiality. The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder, or dependent adult abuse; cases in which I am court-ordered to testify or produce records; or as outlined in the "Notice of Privacy Practices".

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that I utilize a "no secrets" policy when conducting family or marital/couples therapy**. This means that I do not keep secret information gathered in individual conversations (whether on the phone or in an individual session) if the information revealed in some way violates the integrity of the couples/family therapy (such as revealing an affair, substance problem, or intent to leave the relationship). Such information will need to be revealed to the other partner for therapy to effectively continue. Please feel free to ask me about my "no secrets" policy and how it may apply to you.

Psychotherapist-Patient Privilege. The information disclosed by you, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. **You should be aware that you might be waiving the psychotherapist-patient privilege regarding your entire treatment if you make your mental or emotional state an issue in a legal**

proceeding. You should address any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

Patient Litigation. I will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with patients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any patient's legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate for such services of $90.00 per hour.

E-mail and Phone Communication. Some patients prefer to communicate about appointment times or other administrative issues via e-mail. Although information stored on my computer is encrypted, e-mail transmitted through regular services is not encrypted. This means that a third party may be able to access information in an e-mail and read it, since it is transmitted over the Internet. In addition once the e-mail is received by you, someone may be able to access your e-mail account and read it. This may include your employer if you use a work-related e-mail address. E-mail should be considered to be more similar to a "post-card" than to a sealed letter, and for that reason I discourage sending any clinical or other sensitive information via e-mail.

Please initial the options that meet your needs. You can change this at any time by communicating to me in writing.
__ I do not wish to receive any treatment-related information via e-mail.
__ I understand the risks of unencrypted e-mail, and do hereby give permission for Erica Huertas to contact me or to reply to me via unencrypted e-mail. Please provide preferred e-mail address_____
Occasionally, we e-mail newsletters or similar informational material. We do not share our lists with anyone. Would you like to receive these? o Yes o No
If yes, please provide preferred e-mail address_____

Acknowledgement

By signing below, Patient(s) acknowledge that Patient(s) have reviewed and fully understand the terms and conditions of this Agreement. Patient(s) have discussed such terms and conditions with the therapist, and have had any questions with regard to its terms and conditions answered to Patient(s)' satisfaction. Patient(s) agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Therapist. Moreover, Patient(s) agree to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____	_____	_____
Patient Name (please print)	Signature of Patient (or authorized representative)	Date

_____	_____	_____
Patient Name (please print)	Signature of Patient (or authorized representative)	Date

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Adult Self-Report Form

Chief Concern

Please describe the main difficulty that has brought you to see me:

Your medical care (From whom or where do you get your medical care?)

Clinic name:

Phone:

Doctor's name:

Address:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Your current employer

Employer:

Work phone:

Address:

Occupation:

Length of time with this employer:

Please indicate any restrictions on calls:

Present relationships

How do you get along with your spouse or partner?

How do you get along with your children?

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No
Please indicate which type of treatment (circle one): Inpatient Outpatient Both
If yes, please indicate:
When:

From Whom:

For What:

Results:

Have you ever taken medications for psychiatric or emotional problems? Yes No
If yes, please indicate:
When

From Whom:

For What:

Results:

List of Symptoms

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes

finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Family:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Job/school performance:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Friendships:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

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Financial situation:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Physical health:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Anxiety level / nerves:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Mood:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Eating habits:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Sleeping habits:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Sexual functioning:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Alcohol / drug use:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Ability to concentrate:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Ability to control anger:
1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

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Substance Use

Do you currently consume alcohol? Yes No
If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No
Have family members or friends expressed concern about your drinking? Yes No
Do you currently use non-prescribed drugs or street drugs? Yes No
Do you have a history of problematic use of prescription or non-prescription drugs? Yes No
Do you have a family history of alcohol or drug problems? Yes No
If yes, please describe:

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.

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