Dr. Lily Corsello (954) 822-8874
100 County Road, Big Pine Key, FL 33043

Date:_____

Please Print:

Client's Legal Name_____
Last **First** **M.I.**

Home Address_____
Street **City** **State** **Zip**

Client's Date of Birth _____ **Age:**_____ **Gender: Male**_____ **Female**_____

How did you hear about us?_____

Home Telephone # _____ **Cell Telephone #** _____
Area Code/Number **Area Code/Number**

Marital Status: (Please circle one) S M W D **# of children:** _____

Occupation: _____ **Name of Employer**_____

If client is a minor or student, name of school _____

Primary Care Physician (PCP)_____ **PCP Phone #**_____

EMERGENCY CONTACT

Name _____ **Relationship**_____

Home Phone #_____ **Cell Phone#**_____

PRIMARY INSURANCE COMPANY

Insurance Co. Name: _____**Circle one: PPO HMO Other**

Address:_____
Street **City** **State** **Zip**

Phone #. _____**Group Plan #:** _____ **Member Insurance I.D. #**_____

Name of Insured _____ **Insured's Date of Birth**_____

Relationship to Insured: Self _____ **Spouse** _____ **Child** _____ **Student over 18** _____

SECONDARY INSURANCE COMPANY

Insurance Company Name: _____

Address: _____
Street **City** **State** **Zip**

Phone # _____**Group Plan #:** _____ **Member Insurance I.D. #**_____

Name of Insured _____ **Insured's Date of Birth** _____

Relationship to Insured: Self_____ **Spouse** _____ **Child** _____**Student over 18**_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of health insurance benefits for mental health care to Dr. Lily Corsello, LMHC. This is a lifetime authorization. I permit a copy of this authorization to be used in place f the original. I understand that I am in all cases personally responsible for payment of my bill, including any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION/CONSENT FOR TREATMENT

I authorize the release of any medical information/diagnosis to my Primary Care Physician (PCP) and other health care providers for coordination of care. I authorize release of medical information/diagnosis necessary to process my health insurance claim form; and I, on behalf of the patient whose name appears above, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the licensed mental health therapist.

24-HOUR CANCELLATION POLICY

I understand that the success of my counseling therapy depends on my commitment to, and the consistency of scheduled counseling appointments. I understand preparation time goes into each appointment when the counselor meets with the counselee. I agree to give Dr. Lily Corsello a 24-hour advance notice of cancellation of scheduled appointments. Except for emergency reasons, if I cancel on the day of a scheduled counseling appointment, I understand I will be billed for the counseling session as though I had attended. I also understand that my insurance company cannot be billed for my own missed appointments.

SIGNATURE: _____ **DATE:**_____

Name_____

MENTAL HEALTH HISTORY

What are the major issues/concerns, in ***your*** opinion, for which you are coming to see the counselor today?

_____
_____
_____

When did these issues/concerns begin?_____
_____

Have you ever seen a mental health counselor, psychologist and/or psychiatrist before?
Circle one: YES NO

If yes, who have you seen, when, & why (answer below):

	Name of Professional	Dates	Reason
1.	_____		
2.	_____		
3.	_____		

Have you ever been diagnosed by a counselor, psychologist, or psychiatrist with a mental or emotional disorder? Circle one: YES NO If so, when?_____

What was the diagnosis(ses)? _____

Have you ever been hospitalized/institutionalized for mental or emotional disorders and/or received in-patient or out-patient counseling therapy? Circle one: YES NO

Is there a history of mental/emotional illness in your father or mother's family? Circle one:
YES NO

If yes, who was the family member or who were the family members and what was/were their conditions? _____
_____

What would you like counseling to do for you, and what personal goals would you like to achieve through counseling?

_____
_____

What medications are you presently taking?_____
_____
_____

What health issues have you had physically?_____
_____
_____
_____
(Please list just above anything such as high blood pressure, asthma, heart disease, lung disease, high cholesterol, migraine headaches, fibromyalgia, etc.)

Please list any surgeries and dates: _____
_____
_____
_____