# LISA SAPONARO, PH.D.

## LICENSED PSYCHOLOGIST

## PY7494

*Planting the seeds for personal growth*

Client Name: _____ (Mr.) (Mrs.) (Ms) (Dr)

Address: _____, City_____,

State: FL, Zip code_____

Phone Number: Home_____ Cell _____ Leave Message (Y) (N)

Email address: _____

Are there any restrictions on how we may contact you: (Y) (N) If yes, please explain_____

Date of Birth: _____/_____/_____ Sex (M) (F) Social Security Number: _____

Marital Status: (M) (D) (W) (S) (O) Spouse / Partners Name: _____

Check all that apply: ( ) Employed ( ) Retired ( ) Full Time Student ( ) Part Time Student ( ) Other

Employer / School: _____ Occupation / Grade: _____

If employed, how long have you worked there? _____

Please indicate the highest level of education you have completed to date: _____

Primary Care Physician: _____ Phone _____

Current or recent health concerns: _____

Current medications: _____

Do we have your permission to contact your PCP regarding your treatment: (Y) (N)

Are you seeing other physicians for treatment (Y) (N). If yes, please print names and phone numbers

_____

Whom can we thank for referring you? _____

Can we write this person a thank you card? _____ yes _____no

Can we include your name? _____ yes _____no

What is the primary reason for your visit today? _____

When was the last time your recall feeling emotionally well? _____

Have you ever really considered or attempted suicide/homicide? _____ yes _____no When? _____

What do you hope to achieve from our work together?

_____

_____

In case of a medical emergency, who should we call? _____

Phone Number _____

If client is a minor; please affirm that you have the authority to make informed consent decisions on behalf of the child:

Signature _____ Date: _____

7820 Peters Road, Suite E-100 Plantation, FL 33324

Cell (954) 560-9567 Fax (954) 423-0901 www.Lsaponaro.com

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### Financial Information

**Self Pay**

____I do not currently have insurance coverage for mental health services (or do not wish to utilize my benefits) and will assume full responsibility for payment of services received at the time they are rendered.

**Credit Card Authorization**

Accept my signature below as authorization to bill my ___Visa ___ Mastercard ___AMEX___Other

Account # _____ Zip Code _____

Expiration Date _____CVV(3digit number on back of card) _____

For Therapeutic services in the amount of $_____ as they occur for the following client(s)

_____

I give permission to Dr. Saponaro to bill my credit card for missed appointments when not cancelled 24 hours in advance.
The authorization will remain in effect until such time as it is revoked in writing. I certify that I am an authorized signer of the account number provided.

_____

Name as it appears on card Signature Date

**Insurance Information**

Primary Insurance: _____ Type: _____ (HMO, PPO, POS, etc)
Member ID#: _____ Group#: _____
Customer Service #_____
Primary Insured Name: _____ DOB: _____
Relationship to client: _____

Secondary Insurance: _____ Type: _____ (HMO, PPO, POS, etc)
Member ID#: _____ Group#: _____
Customer Service #_____
Insured Name: _____ DOB: _____
Relationship to patient: _____

I hereby attest that I am, at the time of this appointment, an eligible member of the insurance carrier(s) listed above and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all deductible, co-insurance, and services not covered by insurance


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## POLICY AND PROCEDURES
## Consent for Treatment, Authorization for Payment, Cancellation Policy, HIPPA, Outpatient Services Contract

I hereby apply for, and consent, to psychological evaluation and / or treatment by Lisa Saponaro PhD. and affiliates for my child or for myself. I am aware that this consent may be withdrawn by me at any time. **Initial _____**

I understand that it is my responsibility to cooperate with evaluation and or treatment to the best of my ability. I agree that I understand the limits of confidentiality as per Florida state law, Federal law and professional ethical standards. These standards provide for the limited confidentiality of psychotherapist/ client communications including client records. For example; your provider and this office will not disclose or confirm your use of services at this office without your consent. Lawful and legally required exceptions to this privilege of confidentiality include; information of child abuse, elder abuse, the immediate physical danger to yourself or another, a lawful court order or your signed consent. **Initial _____**

I understand that Dr. Saponaro has her own professional malpractice insurance. **Initial _____**

The no show/ late cancellation fee is $175, or the full fee for the missed session. In the event that I do not provide at least 24 hours notice to cancel an appointment I understand that I will be charged $175 or the full fee for my missed session. **Initial _____**

I understand that insurance benefits, if any, will pay only for therapeutic sessions. Time spent on my behalf, or on behalf of my child, that involves telephone calls, preparation of letters or reports, psychological testing or attendance at schools, depositions, legal proceedings or other conferences are my financial responsibility and I will be responsible at the prevailing hourly rate for those services.

I authorize the payment of health benefits to which I am entitled, directly to Lisa Saponaro PhD and I acknowledge that I am responsible for all charges not covered by my carrier. I understand that I am responsible for obtaining authorization directly from my insurance carrier, PPO, HMO, or their legal representative, when requested, or for conducting communications with same to facilitate payment for services.

I understand that payment in full, or co-payments where applicable, are due and payable at the time services are rendered, or as provided by state/federal statute or regulation. Also, should this account be sent to an outside agency for collection of a balance due, I am aware that I will be responsible for all and any fees assessed. **Initial _____**

A copy of the HIPAA Notice of Privacy Practices has been made available to me. **Initial _____**

A copy of Dr Lisa Saponaro's 'Outpatient Services Contract' has been made available to me and I have read it and fully understand the contents, liabilities and limitations contained there-in. **Initial _____**

My signature below indicates that I have read and agree to all policies.

Signature: _____ Date: _____


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## AUTHORIZATION TO RELEASE INFORMATION

Client Name:_____ Telephone (  )_____

DOB:_____ SSN:_____

Authorization for Lisa Saponaro PhD, Inc and the following identified individuals/organizations to use, disclose, and/or exchange my protected health information:

In_____Person/Organization: _____Phone (  )_____

Address:_____ Fax (  )_____

Information Requested:_____

Purpose: _____

In_____Person/Organization: _____ Phone (  )_____

Address:_____ Fax (  )_____

Information Requested:_____

Purpose: _____

I may revoke this consent at anytime by notifying IN WRITING, except to the extent that the provider has taken action and reliance on this consent. Once the uses and disclosure have been made pursuant to this authorization, they may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws. Dr. Saponaro will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent provision of health care is solely for the purpose of creating protected health care information for disclosure to a third party on provision of an authorization for disclosure to such a third party.

I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that if use or disclosure or the requested information will result in direct or indirect remuneration to the provider form a third party, a statement referencing such remuneration will exist in this authorization.

I understand that I may receive a copy of this authorization, upon request.

Signature: _____ Date _____

Signature of Personal Representative of the Patient_____

Description of Representatives Authority to act on behalf of the Patient_____


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### Consent to Therapy/ Psychological Assessment with Psychology Resident

**Client Name: _____ Date: _____DOB: _____**

Dr. Saponaro has a great passion for teaching and incorporates this into her private practice work through the use of student interns as well as through supervision of doctoral and post-doctoral interns who are in the process of finishing their degrees and obtaining licensure.

1. My therapist holds a Master's Degree or higher in a counseling related field and work under the supervision of Dr. Lisa Saponaro.
2. My therapist may practice only under the supervision of Dr. Saponaro, and he or she will discuss aspects of my therapy/ assessment data with Dr. Saponaro.
3. Information discussed in therapy/ assessment sessions may need to be shared with the treatment team or with the parents of individuals under the age of 18.
4. Information discussed in therapy/ assessment sessions is held confidential and will not be shared with other parties without written permission except with concerns related to abuse, neglect, harm to self, and harm to others. My therapist is required to divulge this information to Dr. Saponaro and other parties. Dr. Saponaro may wish to meet or speak directly with you before taking any action should any of these issues be of concern in order to avoid any potential harm to yourself or others.
5. In order to improve the quality of therapy/assessment and supervision, my therapist's supervisor may observe and/or participate in therapy/ assessment sessions.
6. In order to improve the quality of therapy/assessment and supervision, my therapist may make audio or video recordings of our therapy/assessment sessions for the sole purpose of supervision review. Any tapes will be held in a secure place, and information from the tapes will be protected according to professional standard and HIPPA. I may withdraw my consent to allow taping of therapy sessions at any time. Initial here if you consent to audio/video taping of your therapy sessions **Initial _____**

In addition, should you have any concerns regarding the behaviors you observe or relationship you experience with any of the other individuals in this office, you are encouraged to address any concerns with your clinician. If not resolved to your satisfaction, or you do not feel comfortable addressing the other individual you are encouraged to discuss these concerns directly with Dr. Saponaro. You may do this by contacting her at (954) 560-9567. We appreciate your support in helping us train others to achieve excellence in their practice and very much appreciate your feedback concerning our progress.

Having read and understood the above information, I _____
(Print Client Name or Legal Guardian)
Consent to undertake therapy and/or participate in a psychological evaluation with
_____, who holds these qualifications
(Clinician/ Therapist Name)
_____ and works under the supervision of Dr. Saponaro. I am aware that any of the information I relay may be discussed with Dr. Saponaro. I am also aware of my responsibility to advise Dr. Saponaro of any concerns I have regarding the services I receive

| | | | |
|---|---|---|---|
| _____ | | _____ | |
| Signature of Client | Date | Signature of Parent/ Guardian | Date |
| _____ | | _____ | |
| Signature of Clinician | Date | Lisa Saponaro PhD | Date |


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## GOALS CHECKLIST

**Name _____ Date _____**

We offer a variety of treatment approaches. In order to offer you the treatment opportunities most in line. With your reasons for coming to therapy, we would appreciate you completing the following list of possible treatment goals. Please circle the number of those goals that apply to you.
In coming in to therapy at this time, I would like to concentrate on the following:

| | | | |
|---|---|---|---|
| 1 | Reducing my fear of _____ | 26 | Improving my sleep |
| 2 | Having more pleasurable activities | 27 | Reducing my sensitivity to possible criticism |
| 3 | Improving communication with (circle choice) My spouse, children's, friends, coworkers, others _____ | 28 | Learning problem-solving/decision-making Techniques |
| 4 | Expressing myself more assertively | 29 | Talking out a pending decision |
| 5 | Learning to Relax | 30 | Reducing family difficulties |
| 6 | Better managing my health- specify _____ | 31 | Reducing Job difficulties |
| 7 | Better tolerating my mistakes | 32 | Better managing my temper |
| 8 | Better tolerating other's mistakes | 33 | Taking initiative more often |
| 9 | Feeling less guilt | 34 | Receiving medication help |
| 10 | Feeling less depressed | 35 | Decreasing my procrastination |
| 11 | Better accepting the loss/death of _____ | 36 | Better managing time |
| 12 | Increasing my conversation skills | 37 | Decreasing trying to be perfect |
| 13 | Learning how I come across to others | 38 | Not reacting so emotionally |
| 14 | Not taking disappointments so hard | 39 | Allowing myself to express feelings more |
| 15 | Doubting myself less | 40 | Feeling more self-confident |
| 16 | Thinking more positively | 41 | Discussing my thoughts of harming myself |
| 17 | Improving my sexual relationship | 42 | Discussing mu thoughts of harming others |
| 18 | Controlling my eating or weight | 43 | Adjusting better to a past incident specify _____ |
| 19 | Controlling my alcohol use | 44 | Adjusting better to a recent change/ incident specify _____ |
| 20 | Changing my habit of _____ | 45 | Becoming more optimistic |
| 21 | Controlling my use of drugs | 46 | Improving self-awareness |
| 22 | Better managing my pain | 47 | Adopting a more healthy attitude about_____ |
| 23 | Learning how to improve friendships | 48 | Worrying less about _____ |
| 24 | Reducing uncomfortable thoughts of _____ | 49 | Other (specify)_____ |
| 25 | Learning more effective parenting skills | 50 | Other (specify)_____ |

Now, please review your list and decide which three (3) goals you most wish to discuss/change at this time.
My three most important goals are (Write in the goal number below):
First _____
Second _____
Third _____


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