

CGR BEACON CLINIC P.A.
P.O. BOX 496080
PORT CHARLOTTE, FL. 33952
941-629-7855/ 941-629-9589 FAX

NAME _____
PREFER TO BE CALLED _____

DATE OF BIRTH _____ AGE _____ MALE _____ FEMALE _____

SOCIAL SECURITY NO: _____ MARRIED? YES OR NO

ADDRESS _____

HOME PHONE _____ BUS. PHONE _____ CELL _____

EMPLOYER _____
OCCUPATION _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____
RELATIONSHIP _____ CONTACT NUMBER _____

BEST WAY TO CONTACT YOU _____
MAY WE LEAVE A MESSAGE YES NO

PRIMARY INSURANCE _____
PRIMARY ID NUMBER _____

SECONDARY INSURANCE _____
SECONDARY ID NUMBER _____

PRIMARY SUBSCRIBER'S NAME _____
SUBSCRIBER'S BIRTH DATE _____ SOCIAL SECURITY # _____

RELEASE: I AUTHORIZE THE RELEASE OF ANY OR ALL MEDICAL INFORMATION NECESSARY TO
PROCESS THIS CLAIM.

ASSIGNMENT OF BENEFITS: I AUTHORIZE THE PAYMENTS OF MEDICAL BENEFITS DIRECTLY TO
BEACON CLINIC, INC., FOR SERVICES RENDERED. I ALSO REQUEST THE PAYMENT OF GOVERNMENT
BENEFITS (MEDICARE AND FEDERAL BCBS) DIRECTLY TO BEACON CLINIC, INC. INSURANCE: YOUR
INSURANCE MAY OR MAY NOT PAY ALL OR PART OF OUR FEES. ANY BALANCE REMAINING WILL BE
THE RESPONSIBILITY OF THE PATIENT OR GUARDIAN IN ACCORDANCE WITH THE LAW. FAILURE TO
DO SO COULD RESULT IN YOU OR THE GUARDIAN BEING RESPONSIBLE FOR ALL OR PART OF THE
COST INCURRED.

CLIENT SIGNATURE _____ DATE _____

Rights and Responsibilities

You have the right:

- To courteous, kind, competent care.
- To collaborative care with your primary physician, or any of your specialists.
- To ask questions (Questions are good!)
- To an explanation of your treatment plan.
- To learn about your disease and treatment options.
- To be seen within 30 minutes of your appointment (every effort will be made to see you in a timely fashion).
- To have your phone calls returned in a timely manner (We will make every effort to return those calls within one business day).
- To obtain a second opinion.
- To seek treatment elsewhere.
- To know my credentialing, my scope of practice, my training and education.
- To know if I feel I cannot help you..
- To utilize alternative and or adjunctive treatment options (just please let us know).
- To emergency treatment and crisis intervention 24 hours a day (during non office hours please call Crisis Stabilization Unit 941-575-0222, Riverside Behavioral Center 941-627-2474, any Emergency Department or 911.) If you need to be admitted to RBC or CSU, the physician on call will be able to take care of you). (Please take a list of your Medications and allergies with you).

We are not a non-hospital, non- emergency out-patient facility. We do not offer 24 hour care.

- To a reasonable fee for my service.
- To your own thoughts, feelings and behavior. (No physical or verbal abuse will be tolerated, though).
- To not to be judged or shamed if you relapse.
- **To confidentiality and privacy of your diagnosis and care.**

Beacon Clinic reserves the right to refuse treatment for legal or ethical purposes.

_____ (initial)

You are responsible for:

- Notifying us if you cannot make your appointment due to cancellation or no show in a 24 hour period, therefore, a fee will be charged accordingly.
- **Giving us three days notice for any medication refill.**
- Giving us 2 weeks notice for any medication refill of a controlled substance (Xanax, Ativan, Klonopin, Ambien, Sonata, Ritalin, etc). The prescribing of those medications is done only in collaboration with physician.
- To let us know if you have concerns regarding your treatment.
- Being honest. (ie, If you are not taking your medications as directed, please let us know).
- Letting us know all the medications you are taking. (name, dose, time, etc). including over the counter, or herbal supplements. Seeking additional information on your diagnosis, medication and treatment options.
- Help if you feel suicidal (by calling here, CSU: 941-575-0222 or RBC 941-637-2474 9or 911).
- For not giving up (repetitive suicide attempts will not be tolerated)
- Respect the thoughts feelings and behavior of others you encounter in this office, (including maintaining their privacy, and right to confidentiality.)
- Notifying us if you feel you are relapsing, so I can reevaluate and redirect your care.
- Keeping your bill current.
- Providing us with a current accurate address, and way of getting in touch with you.

By signing I agree to have read all of the above statements.

PRINT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____ COPY GIVEN TO PATIENT: _____

ADULT MEDICAL HISTORY

Height _____ Weight _____ Age _____ Gender _____

ALLERGIES: _____

Primary care physician: _____

Please check those that apply, and specify diagnosis and treating physician:

Pulmonary disorder:

Neurological disorder:

Head injury:

Gastrointestinal problems:

Endocrine disorders (i.e. thyroid, diabetes):

Cardiac disorder:

Urinary/kidney disorder:

Reproductive disorder:

Musculoskeletal disorder:

Hearing/speech/eyesight disorder:

Describe any significant injuries or accidents that you have experienced:

Surgery or Hospitalization	Date(s)	Reason	Length of Stay

CURRENT MEDICATIONS: (Please include vitamins and herbs.) *Continue to back if necessary*

Medication	Dose	Frequency

Family History

Indicate which family members (blood relatives through great grandparents) affected by the following:

High blood pressure _____

Heart attack _____

Neurological disorders _____

Stroke _____

Diabetes _____

Cancer _____

PSYCHO/SOCIAL HISTORY

What state were you born in? _____
Were your biological mother and father together at that time? _____
Did they remain together during your childhood? _____
Were there step mothers? _____ or step fathers? _____
Overall how would you describe your childhood(in a word or a sentence)? _____
How would you describe your mother? (or step mother etc) _____
How would you describe your father? (or step father etc) _____
How many siblings did you have?
Sisters _____ Brothers _____ Stepsisters _____ Stepbrothers _____ Half sisters _____ Half brothers _____
Where are you in the birth order? (oldest, youngest, etc.)? _____
How long have you been in Florida? _____ What brought you here? _____
Would you consider yourself a heterosexual, bisexual, gay/lesbian, or transgender? (please circle)
Have you been married (or in a significant long-term relationship)? _____
How many times? _____ How long has each lasted? _____
Why did the relationship end? _____
How many children or step children do you have? _____
Names and ages _____
Your highest level of education? _____ Primary occupation? _____
If retired, what was your primary occupation before retirement? _____
Have you ever been charged with a misdemeanor or felony? _____
For what? _____
Ever been in the Military? _____ Honorable discharge? _____
Ever filed a lawsuit? _____ or had one filed against you? _____
For what? _____
Have you experienced any trauma or significant life changing event? _____

Experienced any Verbal Abuse? Yes or No By whom? _____
Physical Abuse ? Yes or No By whom? _____
Sexual Abuse? Yes or No By whom? _____
Did you press charges or report incident? Yes or No To whom? _____
Ever had an order of protection, restraining order or domestic violence charge filed against you?
Yes or No

Have you ever filed one against someone? Yes No
Have you ever witnessed domestic violence? Yes or No.
Have you ever hit someone, or broken something in a state of rage or anger? Yes or No
Are you a violent person? Yes or No, Is there anyone else who would say you are? Yes or No

Current living arrangements? (who all in your household)? _____
What are your hobbies and things you enjoy doing? _____
Do you have a religious affiliation? _____
What is the worst part of your life at this time? _____
What is the best part of your life at this time? _____
How would you describe your overall personality? _____
What are your strengths? _____
What are your weaknesses? _____

CURRENT SYMPTOMS

Please check any symptoms you are currently experiencing:

- | | |
|---|--|
| <input type="checkbox"/> Poor appetite and/or weight loss | <input type="checkbox"/> Excessive preoccupation with sex |
| <input type="checkbox"/> Overeating and/or weight gain | <input type="checkbox"/> Excessive shopping/spending |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Talking too fast |
| <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> High-risk activities |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Very little need for sleep |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Shoplifting or stealing |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Gambling to escape problems |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Use of alcohol or drugs to feel better |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Binge eating |
| <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Regular use of laxatives |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Excessive exercising |
| <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Self-induced vomiting |
| <input type="checkbox"/> Loss of interest in usual activities | <input type="checkbox"/> Self-mutilation |
| <input type="checkbox"/> Loss of interest in sex | <input type="checkbox"/> Inattentive |
| <input type="checkbox"/> Isolating from friends/family | <input type="checkbox"/> Careless mistakes |
| <input type="checkbox"/> Poor self-care | <input type="checkbox"/> Changes in energy level (up or down) |
| <input type="checkbox"/> Critical of self | <input type="checkbox"/> Forgetful |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> Suicidal plan | <input type="checkbox"/> Disorganized |
| <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Trouble listening |
| <input type="checkbox"/> Often angry | <input type="checkbox"/> Avoid mental tasks |
| <input type="checkbox"/> Physically aggressive toward others | <input type="checkbox"/> Feeling driven or on the go |
| <input type="checkbox"/> Throwing or breaking things during arguments | <input type="checkbox"/> Fidgeting a lot |
| <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Often interrupting others |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Tiring easily | <input type="checkbox"/> Nightmares related to past trauma |
| <input type="checkbox"/> Racing heartbeat | <input type="checkbox"/> Recurrent thoughts of past trauma |
| <input type="checkbox"/> Tightness in chest | <input type="checkbox"/> Re-experiencing past trauma |
| <input type="checkbox"/> Fear of having heart attack | <input type="checkbox"/> Angry outbursts |
| <input type="checkbox"/> Fear of dying | <input type="checkbox"/> Difficulty with memory |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Hearing things others don't |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Seeing things others don't |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Obsessing about things |
| <input type="checkbox"/> Fear of losing control | <input type="checkbox"/> Theme? _____ |
| <input type="checkbox"/> Numbness or tingling sensations | <input type="checkbox"/> Feeling that people are out to get you |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Feeling that people are always watching you |
| <input type="checkbox"/> Stomachaches | |
| <input type="checkbox"/> Frequent pain | |

Is there anything else we need to know to provide you with the best treatment options?

What did you need from this appointment (what is your expectation)?

CGR BEACON CLINIC, P.A.

Consent and Authorization

I, _____ authorize Beacon Clinic, Inc. to obtain and/or release information regarding _____ from/to: _____ (Patient Name)

- Physicians, clinicians, therapists: (only as identified below)

- Pharmacy
As designated on any refill request _____

- Attorney: (only as identified below)

- Other: (only as identified below)

- Specific information requested:

All efforts will be made to protect your privacy and maintain confidentiality as described in Florida statutes.

Signature: Patient/Parent/Guardian _____

Date _____

Witness: _____

**Charlene Rosenfield, A.R.N.P., B.C., Kathleen Kaloski, A.R.N.P, B.C.
Thomas Wilingham, M.D., Donna Chimato, M.S., L.M.H.C.
Gerald N. Ross, Ed.D., Christina Rooney, M.A., L.M.H.C.
Chantelle Grant, LC.S.W., Suzanne Morgenroth-Desio, L.M.H.C.
Charles Starks, Ed.D., L.M.H.C.**

FEE AGREEMENT FOR TESTIMONY

The undersigned Client, or as parent or guardian of the Client, hereby agrees that in the event any clinician affiliated with CGR Beacon Clinic, P.A. d/b/a Beacon Clinic (hereafter the "Clinic") is subpoenaed to provide deposition or court testimony, that the client or guardian shall pay the clinician, in advance of the date of testimony, at the clinician's hourly rate then in effect, for all time to be expended in connection with deposition or court testimony, including all time expended in preparation for testimony and traveling to and from the location of testimony, as well as all costs of duplicating any records or documents when copies are require . Furthermore, in the event legal proceedings become necessary to compel payment in accordance with the terms of this agreement, the undersigned agrees to pay all reasonable attorney's fees incurred by the clinician or the Clinic in connection therewith. The undersigned acknowledges and agrees that this Fee Agreement for Testimony is given as an inducement for the Clinic and its clinicians to provide professional services to the client.

Client signature

Print Name: _____

Date: _____

Parent/guardian signature

Print Name: _____

Date: _____

Parent/guardian signature

Print Name: _____

Date: _____

