Child, Adolescent, Adult
And Family Psychology

By Appointment

Alexander T. Gimon, PhD, PA.

10225 Ulmerton Rd Ste 12B Largo, FL 33771 Phone: 727-584-1551
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PATIENT INFORMATION

*****All Requested MUST be filled out ******

GENERAL INFORMATION FOR CLIENT

Name: Mr. / Mrs. / Ms. / Miss_____

Address: _____City: _____ST. _____Zip:_____

Home: (____) _____-_____Work: (____) _____-_____Cell: (____) _____-_____

E-Mail address: _____SS#_____-_____-_____

Date of Birth: ___/___/_____ Age**:** ____ Gender_____

Marital Status: (Please circle one) Married / Single / Divorced / Separated/Widowed

Emergency Contact: _____ Relationship: _____ Phone #: _____

RESPONSIBLE PARTY FOR BILLS

*****DO NOT PLACE INSURANCE INFORMATION HERE*****

Name: Mr. / Mrs. / Ms. / Miss_____

Address: _____City: _____ST. _____Zip:_____

Home: (____) _____-_____Work: (____) _____-_____Cell: (____) _____-_____

E-Mail address: _____SS#_____-_____-_____

Date of Birth: ___/___/_____ Relationship to Client: Parent / Guardian / Spouse / Other: _____

People living with you

Names:	**Relationship:**	**Names:**	**Relationship:**
1.		5.	
2.		6.	
3.		7.	
4.		8.	

BY SIGNING BELOW I AGREE THAT ALL THE INFORMATION I HAVE LISTED IS CORRECT AND AGREE WITH THE COUNSELING SERVICES PROVIDED BY THIS OFFICE.

Signature: _____ Date: _____

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Psychological License #002952
Fax: (727) 581-5107

MEDICAL INFORMATION

Who referred you to our office?		
Describe your present concerns:	◉ Mild ○ Moderate ○ Moderately Severe ○ Severe ○ A Crisis	
Have you had prior counseling or therapy?	NO ☐	YES (Please Describe):
What was the concern?		
What brings you to counseling now?		
Have you ever been hospitalized for psychiatric treatment?	NO ☐	YES (Please Describe):
Where were you hospitalized?	NO ☐	YES (Please Describe):
How long have your current problems existed?		
Describe any health problems you have	NO ☐	YES (Please Describe):
List any prior surgeries	NO ☐	YES (Please Describe):
What medications do you take?	NO ☐	YES (Please Describe):
What serious illnesses have you had?	NO ☐	YES (Please Describe):

Insurance PRIMARY POLICY Holder Information:

The following REQUESTED information must be filled out **

Primary Policy Information:

Insurance: _____
Name: _____
SS#: ____-___-_____ Date of Birth: ____/_____/_____
Place of work: _____ Work phone: _____

Secondary Policy Information:

Insurance: _____
Name: _____
SS#: ____-___-_____ Date of Birth: ____/_____/_____
Place of work: _____ Work phone: _____

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OFFICE POLICY ON PAYMENT

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 90 days will be charged an interest rate of 1 1/2 percent per month (18% per annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorneys fee.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed charges. As a courtesy to you we will be happy to submit claims to insurance carriers we are contracted with, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____ **DATE:** _____

Patient, Parent, or Guardian

****All Appointments Scheduled for you are times reserved for your care. Should you have to cancel an appointment, we ask that call 24 hours BEFORE (that is 1 day) the scheduled time and date. If we do NOT hear from you, then there will be an automatic charge of $50 for a No Show on the date of the appointment.**

****All Co-pays/Money owed will be collected at the time of service. If there is an outstanding balance of more than 3 CO-PAYS, your next appointment will not be made until a payment has been RECEIVED. ******

***** Please note: it is "your responsibility" to remember your appointments. Reminder calls are a courtesy only!!!! Not mandatory*****

I UNDERSTAND AND AGREE TO ABOVE

X _____

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FOR SELF/PRIVATE PAY CLIENTS
Professional Services Fee Agreement

I, _____ (Please circle) (client, parent, guardian, and/or account guarantor) request Alexander T. Gimon, PhD, PA to provide Psychological Evaluation and/or treatment professional services to: _____ beginning on _____ and continuing until modified in writing by the undersigned or Dr. Gimon. I understand that Dr. Gimon's fees are $__120.00_ per 60 minute hour (prorated to actual time spent) and are due at the time of service unless otherwise arranged with Dr. Gimon (as noted below).

I acknowledge that finance charges may be applied for past due accounts over 30 days in the absence of suitable alternative payment arrangements. I agree to pay any reasonable collection, attorney fees and/or court costs in the event a collections procedure is implemented.

_____ _____
Client/ Parent/ Guardian Date

ACCOUNT PAY AGREEMENT
(To be completed only when account arrangements are made.)

Account payment arrangements:

I, _____ agree to pay $_____._____ per _____ due on the _____ day of the _____ on the account of _____ on the current balance of $_____._____ until the debt is paid in full. Finance charges may apply if I default on any payments.

_____ _____
Authorizing Signature Account Name (Please Print)

_____
Authorization Name (Please Print)

_____ _____
Parent/Guardian/Account Guarantor Witness

_____
Date

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NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT

I, _____ am a patient of Alexander T. Gimon, PhD, PA. I have been made aware of the "Notice of Privacy" Policy. **I have chosen the following action: (Please initial the appropriate choice of 3 or make comments on number 4 as desired.)**

1. _____ I have requested and received a copy of the Notice of Privacy Policy.
2. _____ I have reviewed the Notice of Privacy Policy. I do not choose to receive a copy.
3. _____ I have been made aware of the Notice of Privacy Policy and do not choose to either review or receive a copy of it.
4. _____
   _____
   _____
   _____

We are required to present this notice to you one time. Should you change your mind in the future, please advise the staff or the privacy officer.

Thank you,
Alexander T. Gimon, PhD
Privacy Officer

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

(This form is must be signed after the client receives a copy of the "CLIENT ACKNOWLEDGEMENT FORM")

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AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

CLIENT'S NAME: _____ D/O/B: _____ SS#:____-___-_____

This authorization is for_◯_ (single) _◯_ (continuing disclosure, valid **for one year only,** after the date of my signature as it appears below. The representative or patient may revoke this authorization at any time upon written notification but revocation has no effect on action previously taken.

THIS AUTHORIZES:

Alexander T. Gimon Ph.D. and Associates to (circle one or both) **release** or **obtain** records:
10225 Ulmerton Rd #12B Largo, Fl OR 3115 Citrus Tower Blvd., Clermont, Fl.
Phone Number: (L)-727-584-1551 OR (C) 352-241-8540 Fax for Both:727-581-5107

FROM THE PERSON OR PLACE LISTED BELOW:

Name:_____
Phone #: _____
*Fax#:*_____
Address: _____
Relationship to Client: _____

To (release or obtain) general medical as well as psychiatric/ psychological information from my medical record in accordance with Florida statutes (394,459 (b), 381,181,609(2) (f), 90.503, 458.21, v 396.112, 397.053, 490.32, 90.42 and Florida law 42 cfrii

The release of any information concerning the performance of any tests, cousenling and the results and treatment thereof is also authorized. **I understand that my records have a priviledged and confidential status. I am waiving that status for the purpose contained within this authorization.**

THE SPECIFIC INFORMATION REQUESTED IS:

- ☐ Psychiatric Evaluation
- ☐ Treatment Plan
- ☐ Psychosocial Assessment
- ☐ Narrative Summary
- ☐ Psychological Testing
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Report of Consults
- ☐ Education
- ☐ OTHER:

Client: _____ Date: _____

Representative: _____ Date: _____