

Lisa Saponaro Ph.D.  
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Client Name: \_\_\_\_\_ (Mr.) (Mrs.) (Ms) (Dr)  
Address: \_\_\_\_\_, City \_\_\_\_\_, FL \_\_\_\_\_  
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? \_\_\_\_\_  
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? \_\_\_\_\_  
If client is a minor; please affirm that you have the authority to make informed consent decisions on behalf of  
the child:  
Signature \_\_\_\_\_ Date: \_\_\_\_\_

## 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

Account # \_\_\_\_\_ Expiration Date \_\_\_\_\_ CVV \_\_\_\_\_

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

**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** \_\_\_\_\_

In the event that I do not provide at least 24 hours notice to cancel an appointment I understand that I will be charged 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: \_\_\_\_\_

**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:

\_\_\_\_\_ Person/Organization: \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Address: \_\_\_\_\_ Fax (     ) \_\_\_\_\_

Information Requested: \_\_\_\_\_

Purpose: \_\_\_\_\_

\_\_\_\_\_ 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 \_\_\_\_\_

09/21/2010

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