A HEALTHY MIND FOR YOU, INC,
JANNE' LOMASKY, PSY.D.
LICENSED PSYCHOLOGIST PY 7948

# CLIENT INFORMATION

| | |
|---|---|
| DATE | INSURANCE CO. |
| LAST NAME | INSURED'S LAST NAME |
| FIRST NAME | RELATIONSHIP TO CLIENT |
| DATE OF BIRTH | INSURED'S ADDRESS (IF DIFFERENT) |
| SEX | CITY |
| HOME ADDRESS | STATE, ZIP |
| CITY | INSURANCE CO. PHONE NUMBER |
| STATE, ZIP | INSURED |
| EMAIL ADDRESS | INSURED'S ID NUMBER |
| HOME PHONE | GROUP PLAN NUMBER |
| MOBILE PHONE | INSURANCE BILLIGN ADDRESS |
| WORK PHONE | CITY |
| EMERGENCY CONTACT NAME | STATE, ZIP |
| EMERGENCY CONTACT PHONE | REFERRAL? |
| RELATION TO EMERGENCY CONTACT | METHOD OF PAYMENT |

7100 W. CAMINO REAL, SUITE 404
BOCA RATON, FL 33433
EMAIL: DRJLOMASKY@GMAIL.COM
OFFICE:561-777-2021 CELL 561-929-1203

## CONSENT FOR TREATMENT

During our first session, there will be a discussion of the comprehensive evaluation and diagnosis formulation, as well as the method of treatment. The nature of treatment will be described, including its extent, it's possible side effects and possible alternative forms of treatment. If you have any questions regarding the information below I will direct those questions to the clinician.

Confidentiality and privileged communication are the rights of all clients of psychologists, psychiatrist and psychotherapists according to the law of professional ethics. No information about me or the psychological or counseling services provided to me will be released without my specific written permission.

I understand the following are exceptional circumstances where a therapist may be required by law to breach confidentiality:

1. If a court of law issues a legitimate subpoena, the therapist is required to provide the information specifically described in the subpoena.

2. If I indicate intent to kill or hurt myself or someone else, the therapist must act to notify potential helpers or victims if a real danger is believed to exist.

3. If I report or the clinician suspects that I have perpetrated or been victimized by child abuse, neglect or molestation, the clinician is obligated to report this to the authorities if it is or could be a current problem.

4. If I am in psychotherapy and/or being evaluated by order of a court of law, the results of the evaluation many be revealed to the court.

5. If I am a minor, my parents or guardian may be informed of my progress. If they ask, however, the clinician does not have to tell them the details of my conversations in therapy.

I understand that every effort will be made to discuss a breach of confidentiality that is being considered and to resolve the issue to my satisfaction. If I have any questions about the above information, I know that I am free to discuss them with my clinician at any time. I have read the above and understand my therapists social and legal responsibility to make such decisions as necessary. I fully understand the limits of confidentiality in the relationship and the circumstances in which the confidential communication must be breached.

______________________________________________________________________________

Client/Parent/Guardian Signature                                                                 Date

## SESSION/OFFICE PROCEDURES

Welcome!  I will do everything I can to successfully perform the services you are seeking. Before we begin our work together, it is necessary to agree on some basic session/office procedures in order to avoid any future misunderstandings.

1.  Psychotherapy sessions are 50 minutes in length, unless otherwise stipulated by your insurance company or EAP provider or unless another length is agreed upon by both parties.

2.  Sessions should begin at their appointed time.  Emergencies and certain circumstances may cause your session to start or run late.  I will do my best to remain on schedule and I only ask that you, as my client, do the same.

**Cancellations requires TWENTY-FOUR (24) HOURS notice.  Without a 24-hour notice, clients are financially responsible for the FULL FEE for the clinician's time that was scheduled.  The exception will be made due to a valid emergency.**

3.  Payment is expected at each session.  Please be informed that the client is responsible for the full bill and that insurance reimbursement is not a substitute for payment.  It is the client's responsibility to pay any deductible amount, co-insurance or any other balance not paid for by the insurance company**.  A MONTHLY FINANCE CHARGE OF 1.5% WILL BE ADDED TO ANY ACCOUNT WHICH IS THIRTY DAYS PAST DUE.**  Should your account become delinquent beyond ninety (90) days, the option of obtaining a collection agency will be utilized to obtain payment in full.  The client should be aware that confidentiality is not being broken if the collection agency chooses to make public the information of the clients who have delinquent accounts. To avoid such procedures, the client agrees to keep their account current.  The client also agrees to pay $50.00 fee for any returned checks.

4. Dr. Janne Lomasky is a Fee for Service provider and does not participate on any insurance panels.  Dr. Lomasky is considered an Out of Network provider, therefore she will be happy to supply you with a statement that you can submit to your insurance company directly.

______________________________________________________________________________
Client/Parent/Guardian Signature                                                                  Date

## NOTICE OF PRIVACY PRACTICES

### ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that A HEALTHY MIND FOR YOU, INC., and Dr. Janne' Lomasky, has made the Notice of Privacy Practices available to me, and, should I request it, have been given the opportunity to review it.  I understand that a copy can be made available to me upon request.

Further, I understand that A HEALTHY MIND FOR YOU, INC. and Dr. Janne' Lomasky, will use my information as described therein unless I request otherwise.

PRINT NAME_________________________________________________________________

___________________________________________________________________________
Client/Parent or Guardian Signature                                                              Date

**PERSONAL / FAMILY HISTORY:**
*Please provide for all members of your immediate family/household*

Name / Relationship / Age / Occupation or School Grade / Residing with you?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**MARITAL HISTORY**
*Please list all marriages, including your present marriage:*

Name of spouse / Date Marries / Date Terminated / Terminated by Divorce or Death?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**GENDER IDENTITY**

______________________________________________________________________________
______________________________________________________________________________

**SEXUAL ORIENTATION**

______________________________________________________________________________
______________________________________________________________________________

**EDUCATION**
*Please circle highest grade completed and additional training*

0 1 2 3 4 5 6 7 8 9 10 11 12 - College - 1 2 3 4 Graduate School - Yes or No

Vocational School - Yes or No If yes, what vocation? ___________________________________

**FAMILY OF ORIGIN HISTORY**

Father
Is he still living? Y or N If yes, what is his age____ __
If no, age at death and Cause________________________________________________________

Mother
Is she still living? Y or N If yes, what is her age____ __
If no, age at death and Cause________________________________________________________

Brothers - please list those living and their ages:
________________________________________________________________________________
________________________________________________________________________________

Brothers - please list those who are deceased, age at death and cause of death:
________________________________________________________________________________
________________________________________________________________________________

Sisters- please list those living and their ages:
________________________________________________________________________________
________________________________________________________________________________

Sisters - please list those who are deceased, age at death and cause of death:
________________________________________________________________________________
________________________________________________________________________________

**Brief history of alcohol/drug use:**
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Menstrual Problems? Yes or No (If yes, please describe)
________________________________________________________________________________

Number of Children: Living: ____________________ Deceased __________________________
________________________________________________________________________________
________________________________________________________________________________
(if deceased, age at time of death and cause of death)

Any current physical illnesses?   Yes   or   No (if yes, please describe)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Name and phone number of primary physician:

______________________________________________________________________________

Current Medications:  Please provide name, dosage and prescribing physician:

______________________________________________________________________________
______________________________________________________________________________

**CLINICAL HISTORY**

Brief description of reason for scheduling sessions at this time:

______________________________________________________________________________
______________________________________________________________________________

How long have you had this issue, problem or feeling?

______________________________________________________________________________
______________________________________________________________________________

Do you have any court cases pending?  Yes   or   No (if yes, please describe)

______________________________________________________________________________
______________________________________________________________________________

Any previous psychotherapy?  Yes   or   No (If yes, when, with whom and primary reason for sessions at that time)

______________________________________________________________________________
______________________________________________________________________________

If you had previous psychotherapy, how helpful was it?

___No change   ___Felt worse   ___Somewhat improved   ___Much improved

**CLIENT'S PERSONAL MEDICAL HISTORY**
**N-NO Y-YES (If YES, date, diagnosis)**

ALCOHOL/DRUG ADDICTION______________
AIDS____________________________________ ARTHRITIS_________________________________
ANEMIA/BLOOD DISORDER________________ EMPHYSEMA_______________________________
ASTHMA_________________________________ DIABETES_________________________________
CANCER_________________________________ GLAUCOMA/EYE DISEASE___________________
EPILEPSY________________________________ HIGH BLOOD PRESSURE____________________
HEART DISEASE___________________________ KIDNEY DISEASE__________________________
LOW BLOOD PRESSURE____________________ MENTAL RETARDATION____________________
MIGRAINE HEADACHES____________________ NEUROLOGICAL PROBLEMS_________________
OBESITY_________________________________ PHYSICAL DISABILITIES_____________________
PSYCHIATRIC PROBLEMS___________________ THYROID DISORDER_______________________
TUBERCULOSIS___________________________ ULCER____________________________________
ALLERGIES (IF YES, PLEASE LIST)
______________________________________________________________________________

**CLIENT'S FAMILY OR ORIGIN MEDICAL HISTORY**
**N-NO Y-YES (If YES, date, diagnosis)**

ALCOHOL/DRUG ADDICTION______________
AIDS____________________________________ ARTHRITIS_________________________________
ANEMIA/BLOOD DISORDER________________ EMPHYSEMA_______________________________
ASTHMA_________________________________ DIABETES_________________________________
CANCER_________________________________ GLAUCOMA/EYE DISEASE___________________
EPILEPSY________________________________ HIGH BLOOD PRESSURE____________________
HEART DISEASE___________________________ KIDNEY DISEASE__________________________
LOW BLOOD PRESSURE____________________ MENTAL RETARDATION____________________
MIGRAINE HEADACHES____________________ NEUROLOGICAL PROBLEMS_________________
OBESITY_________________________________ PHYSICAL DISABILITIES_____________________
PSYCHIATRIC PROBLEMS___________________ THYROID DISORDER_______________________
TUBERCULOSIS___________________________ ULCER____________________________________
ALLERGIES (IF YES, PLEASE LIST)
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

History of any serious injuries? If yes, please describe type and date:

______________________________________________________________________________
______________________________________________________________________________

History of any operations? If yes, please describe type and date:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

History of any psychiatric hospitalizations? If yes, please describe in detail:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

History of any depression? If yes, please describe:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

History of any anxiety or anxiety/panic attacks? If yes, please describe:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

History of a unique spiritual experiences? If yes, please describe:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**CLINICAL INFORMATION** - please circle any that might apply to you:

| | | | |
|---|---|---|---|
| Headaches | Dizziness | Fainting Spells | Heart Palpitations |
| Stomach Problems | No appetite | Bowel Problems | Unusual body sensations |
| Tired/no energy | Tired/no interest | Poor sleep | Nightmares |
| Take sedatives | Drinking problem | Feel tense | Loss things |
| Tremors/shakes | Financial Problems | Parent problems | Child problems |
| Court problems | Legal Problems | Disturbing Fears | Disturbing thoughts |
| Fear of losing control | Depressed | Suicidal ideas | Always worried |
| Unable to relax | Unable to have fun | Don't like vacation | Don't like weekends |
| Overanxious | Sexual Problems | Spaciness | Disoriented |
| Shy with people | Can't make friends | Can't make decisions | Can't keep a job |
| No ambition | Feel inferior | Marital problems | Drug problems |
| Hear voices | Visual hallucinations | Unusual mental problems | |

**AVAILABILITY FOR OUR SESSIONS:**

What time, if any are you unable to schedule sessions? `

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Client/Parent/Guardian Signature Date

# Dr. Janne' Lomasky, Psy.D.
# Release of Records

I, _____________________________________________, ____/____/____
(Please print name of client, parent or guardian) Date of birth

hereby authorize the mutual release and disclosure of information between the service provider/parties identified below for the indicated purposes
Janne' Lomasky, Psy.D. and

_____________________________________________________________________________
(Person, title of person, or organization)

**SPECIFIC INFORMATION TO BE DISCLOSED** (Client to initial each item to be disclosed)

___Medical information/lab work
___Psychiatric Evaluation
___Diagnosis
___Treatment Plan
___Psychological Testing
___Psychological Assessment
___Other___________________
___Treatment Records
___Summary of contacts
___Treatment Recommendations
___Summary of progress
___Discharge Summary/Plan
___Prognosis
___Demographic Information
___Nursing Information
___Home Health Care
___Toxicological Report
___Drug Screen
___Medication
___Physical Info
___Other____________

**PURPOSE & NEED FOR THE DISCLOSURE**

___Appropriateness for treatment
___Referral for service
___Coordination of treatment
___Treatment planning
___Improve Assessment
___Relevant for treatment
___Family Involvement
___Discharge planning
___Other_______________

I understand that the service providers named above are released from all legal liability that may arise from the release of the information requested. I further understand that Janne' A. Lomasky, Psy.D. will not place conditions upon my treatment on whether I give authorization for the requested disclosure. I understand that I have the right to reuse this authorization and it has been explained to me that failure to sign this authorization may have the following consequences:

_____________________________________________________________________________

I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations (chemical abuse/addiction clients), and Florida Statues 294.459(9b) and/or 90.503 psychiatric/psychological information, and that re-disclosure of this information without my additional written authorization is prohibited. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Janne' A. Lomasky, Psy.D. I also understand that revocation of the authorization is not effective to the extent that action has been taken in reliance upon it.

Unless sooner revoked, this consent expires six (6) months after the date of the consent (__/__/__) or on the following earlier date, event or condition: ____________________________________________
This authorization permits Janne' A. Lomasky, Psy.D. to reserve the right to disclose information in any manner that is deemed appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically unless I have specifically requested in writing that the disclosure be made in a certain format. I will be given a copy of this authorization for my records.

I certify that I have read all the information above and that I understand and agree to it content.

_______________________________________________ ___/___/___
Personal representative/guardian/parent signature
If you are signing as a personal representative, please describe your authority to act for this individual__________________________________________________________________________

*A HEALTHY MIND FOR YOU, INC,*
*JANNE' LOMASKY, PSY.D.*
*LICENSED PSYCHOLOGIST PY 7948*

## CARDHOLDER INFORMATION

Name: ______________________________________________________________________

Billing Street Address: __________________________________________________________

City: ______________________________ State: ___________ Zip: ____________________

Email: _______________________________________________________________________

Home Phone: ____________________________ Cell Phone: __________________________

## CREDIT CARD INFORMATION

Credit Card Type: ___MasterCard ___Visa ___American Express ___ Discover Card

Card Number: ________________________________________________________________

Expiration Date: ___/___

CVC: _________________ Billing Zip ode_____________________________________________

Cardholder Signature____________________________________________________________

Date: ___________________

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# INFORMED CONSENT TO CONDUCT ONLINE COMMUNICATION, CELL PHONE AND TEXTING OF OCNFIDENTIAL INFORMATION

I understand that I may choose to conduct email, cell phone or texting correspondence with Janne' A. Lomasky, Psy.D. regarding clinical work being done provided for me or for my minor child,

____________________________________________

I have considered and understand the risks, benefits and alternatives to the use of email and other forms of online communication with Janne' A. Lomasky, Psy.D. I understand that every effort will be made to maintain the confidentiality of our communication.

However, even with our best efforts, Janne' A. Lomasky, Psy.D. cannot guarantee the confidentiality of any information transmitted in this format. I understand that no communication on the internet, cell phone or texting can be guaranteed completely free from potential breach of confidentiality in transit by hackers or internet services providers or by others who had access to this account on the computer.

I TAKE FULL RESPONSIBILITY FOR THE SECURITY OF TREATMENT RECORDS ON MY COMPUTER AND CELL PHONE IN MY OWN PHYSCIAL LOCATION. Janne’ Lomasky, PSY.D. will not be held liable for any breach of confidentiality regarding electronic or paper records taking place on my end.

______________________________________________________________________
Signature

______________________________________ _______________________________
Print Name Date

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## CANCELLATION POLICY

**A 24 HOUR CANCELLATION NOTICE IS REQUIRED, OTHERWISE THE USUAL FEE WILL BE CHARGED**

**PLEASE BE ADVISED THAT FRIDAYS, EVENINGS AND WEEKENDS ARE NOT CONSIDERED BUSINESS DAYS AS OUR OFFICE IS CLOSED**

______________________________________________

Patient/Parent/Guardian Signature

_________________

Date

7100 W. CAMINO REAL, SUITE 404
BOCA RATON, FL 33433
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