Kelleen M. Linden, Ph.D., P.A.
12751 New Brittany Blvd. Suite 405
Fort Myers, Fl. 33907
239-454-3655

Parent Information Form

Name_____Date of Birth_____

Street Address_____ City_____ State_____ Zip Code_____

Phone: Home _____Cell _____ Work _____

Email Address: _____

** I authorize Dr. Kelleen Linden's office to leave a message or email (please check all that apply

Home _____ Cell _____ Work _____ Email_____ None of the above _____

Occupation & Place of employment_____

Partner's name_____ Years together or married_____ Number of children_____

How did you hear about Dr. Linden? _____ Reason for counseling? _____

_____

Type of Counseling- Marital_____ Family _____ Individual _____

Check any of the following that applies: Depression____ Anxiety_____ Difficulty relaxing_____ Cries easily_____

Sleep disturbance_____ Increase in alcohol use_____ Sexual dysfunction_____ Thoughts of self-harm_____

Have you ever been in counseling before? _____ If so, when _____

Have you ever been hospitalized for an emotional condition? If yes, list the date and location_____

_____

Do you consume alcohol or any other substances? If so, please list amount and frequency? _____

_____

_____

Are you concerned you may have a substance abuse problem? _____ Past problem? _____ DUI arrest? _____

**Are you involved in any type of legal proceedings or lawsuits that maybe part of your counseling here? _____

If so, please explain: _____

Please list any relevant family history such as Mental health issues, physical or sexual abuse, substance abuse or a family member who committed suicide _____

_____

_____

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Medical/Medication History:

Primary care physician and/or prescribing physician_____

Please list medication/ dosage

_____

_____

_____

Any reaction to the medication: _____

Do you have any current physical problems? Yes ___ No ___ if yes, please explain. _____

_____

Other medical information or known allergies_____

_____

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Child Information Form

Child's Name_____ Child's Birthdate_____

Street Address_____ City_____ State_____ Zip Code _____

Parent(s)/Legal Guardian(s) name _____

Parent(s)/Legal Guardian(s) phone numbers: Mom's Cell/work _____

Dad's Cell/Work_____ Childs' Cell _____

**I Authorized Dr. Kelleen Linden's office to leave a message or email unless otherwise noted below.

_____

Child's School Name/Grade _____

Does the child live with both parents, if not what is the custody schedule and who has legal rights for the child to receive medical treatment? _____

List everyone who lives in the household_____

_____

Are there any legal proceedings (Divorce or Custody issues)? If yes, please explain _____

_____

How did you hear about Dr. Kelleen Linden? _____

Child's Medical Doctor: _____

Any medications: If so, please list _____

_____

Health issues_____

Why does your child think they are here? _____

Check any of the following that applies: Sad _____ Anxious _____ Sleep Disturbance _____

Difficulty Relaxing ____ Cries Easily ____ Angry ____ Behavioral Issues ____ School issues_____

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Is there any family history of Mental Health issues, Physical/Sexual Abuse, Substance Abuse or suicide attempts? If so, please explain_____

_____

Description of Relationship with Father and Mother _____

_____

_____

Description of Relationship with Stepparent, Grandparents, or Significant Others _____

_____

_____

How is your child punished and normally by whom? _____

Please list any family problems or traumatic events (divorce or deaths) _____

_____

_____

Is your child currently experiencing any school issues (schoolwork, classmates or teachers)? _____

_____

_____

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Consent for Counseling Service

Name of Client (Please Print) _____ DOB_____

Name of Guardian (If client is a minor) _____ DOB_____

Address: _____

In case of emergency who should we contact? Please list name and phone number:

I, the undersigned, voluntarily agree to participate in counseling services. I understand that any information obtained will be held in the strictest of confidence except for legal requirements for disclosing this information. I further understand that I can authorize the release of information by completing a written consent form.

I recognize that I have the right to withdraw from therapy at any time, without prejudice, which could void this consent for counseling. I understand that I will be given the opportunity to ask questions about the foregoing to my satisfaction. If at any time, I would like a copy of the office policies which I have agreed to abide by or the Practices to Protect the Privacy of My Health Information" (HIPPA) it will be provided at the time of signing.

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian Date

_____ _____
Signature of Witness Date

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Financial Agreement

Name of Client _____

Name of Responsible Party/Legal Guardian _____

Billing Address _____

_____

Primary Therapist: Dr. Kelleen M. Linden

Fee per visit: $175.00

Cancellation Policy: 48 hours' notice or two working days' notice in advance or the above fee will be charged.
***Please Initial: _____

Special Payment Arrangements: _____

I understood that any portion of the account balance over 90 days old will be subject to a finance charge of 3% per month (or 18% annually). In the event it is necessary for Dr. Linden to secure a third party to collect of my past due account, all fees and expenses for this service is my responsibility. If it should become necessary for Dr. Linden to collect my bill in this manner, I shall relinquish my right to privacy concerning my treatment to the extent necessary to collect on such bill.

I hereby authorize Dr. Kelleen M. Linden's office to release medical information concerning my treatment to my insurance carrier. I hereby acknowledge responsibility and guarantee payment for this account.

*** I authorize benefits to be paid directly to Dr. Kelleen M. Linden_____
Signature of Insured Date

_____ _____
Signature of Client Date

_____ _____
Signature of Responsible Party/Legal Guardian Date

_____ _____
Signature of Witness Date