NEW DIRECTIONS COUNSELING CENTER L.L.C.

5121 South Lakeland Dr. Lakeland, Fl. 33813
Phone (863) 606-5922 Fax (863) 606-5921

PATIENT INFORMATION											
Last Name	First Name		M.I.	D.O.B.	Sex M F	Today's Date					
Address		City	State	Zip	SSN						
Home Phone	Cell Phone	Marital Status S, M, W, Div, Sep	Employer (or School) Name								
Primary Care Physician		Psychiatrist	Referred by								
Is it okay to confirm appt. by text? YES NO		Please provide phone number to text to:	Phone company carrier:								
SPOUSE INFORMATION											
Last name	First name		M.I.	D.O.B.							

I hereby give consent to New Directions Counseling Center (NDCC) to provide whatever treatment they may deem necessary to the patient above. I authorize NDCC and its staff to release my insurance carrier and its agents any information concerning health care advice, evaluation or treatment needed to determine those benefits or the benefits payable for related services. I hereby request payment of authorized benefits and/or any other, including supplemental insurance, benefits for me to be paid directly to New Directions Counseling Center for any services provided to me by NDCC. I authorize the office of NDCC to release or exchange information to staff and providers within NDCC. I understand personal information will not be provided to outside providers without my signature on a general release of information form. Confidentiality will be suspended if I am a danger to myself or others, if child or elder abuse is suspected, if issued a court order, or if otherwise prescribed by law. I understand I am responsible for charges incurred for services if they are not covered by my insurance and the co-pay is due before each session. Should it become necessary to collect the charges through an attorney or other collections processes, I shall be responsible for all court costs, attorney's fees and collections expenses. I understand I will be responsible for a $50.00 fee if I fail to show up at an appointment without at least 24 hours advance notice for each occurrence. Repeated occurrences might result in the termination of services.

Permission to Treat a Minor

I _____ (parent/guardian) give permission to _____, to see my child _____ for therapeutic services with or without me being present during sessions.

ALL PATIENTS PLEASE SIGN.

_____ _____ _____ _____

PATIENT SIGNATURE DATE SPOUSE /GUARDIAN SIGNATURE DATE