THE COUNSELING & FAMILY WELLNESS CENTER

1385 W. SR-434 SUITE 207 LONGWOOD, FL 32750

CLIENT INFORMATION

Date ___________________ Referred by _____________________________ Therapist ___________________________________

Client Name ____ Date of Bird _____________________ Age ____________
Soc. Sec No.: _____________________________ Address ______________________________ City ___________________________
State, Zip: _______________________ Res Phone ____________________________ Work Phone: ___________________________
Cell: _____________________ Okay to leave voice message? YES ____ NO ____ E-mail __________________________________
Education ____ Occupation ____
Marital Status ________________________ Years Married __________ Previous Marriage _______________________________
Religion ____ Active? ____

INMEDIATE FAMILY

Name	Relationship	Age	Where Residing

(OFFICE USE ONLY)

DSM: ___________

COPAY: ___________

What is presenting the issue that brings you here today?
____
____

Previous Counseling / Psychotherapy (with whom and when)
____
____

MEDICAL INFORMACION
Primary Care Physician (PCP) ____ Phone __________________________________

Current Medications | Prescribed by
_______________________________________ | _______________________________________
_______________________________________ | _______________________________________

INSURANCE INFORMATION: Do you have out-patient mental health coverage benefits? Yes ______ No _______
Insurance Company ____ Policy No. ____________________________________

FEES AND CHARGES

1. Counseling and Psychotherapy fees are $ _______ per 45-50 minutes. For sessions exceeding 50 minutes, you may be billed proportionally.
2. Telephone consultation and other professional activities rendered on behalf of the client are also billed. Short telephone "check in" or scheduling coordination phone calls are never billed.
3. Payment is due at the time of service.
4. You will be given a receipt for insurance purposes. The assignment of payment to the therapist instead of the policyholder is agreed to by your signature below.
5. Co-Payments are sometimes established by your insurance company and will be due at the time of service.
6. In addition to the co-payment mentioned above, the balance of the fee not covered by your insurance is also billable. You will receive a statement indicating the amount due on your account, which is due at the time received.
7. Missed appointments, other than a genuine emergency or illness, will be billed for missing unless notification is made 24 hours in advance.
8. In a circumstance where problems are encountered in receiving payment for serviced rendered, you may be billed additional charges to cover the cost of time and expenses incurred to obtain payment.

I understand that The Counseling & Family Wellness Center is providing professional services to me and/or my family. I hereby agree to assume full financial responsibility for payment of all treatment charges incurred, as outlined above.

Signature of Responsible Party(s): ______________________________________ Date: _________________________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

This notice describes The Counseling & Family Wellness Center privacy practices and that of:

- All staff authorized to enter information into our file, or provide you with mental health services.
- All sub-contracted psychotherapists and providers of comprehensive assessments.

These entities may share your confidential health care information ("Information") with each other for treatment, payment or other purposes described in this notice.

Your information may be released to other mental health professionals affiliated with The Counseling & Family Wellness Center for the purpose of providing you with quality healthcare.

Your information may be released to Medicare, Medicaid, an HMO, or other third parties for the purpose of receiving payment for providing mental health services.

You and your legal guardian have the right to know who accessed your information and for what purpose, if that access was provide outside the normal treatment and administrative operations of The Counseling & Family Wellness Center.

You and your legal guardian have the right to obtain a paper copy of this Notice of Privacy Practices upon request.

The Counseling & Family Wellness Center is required by law to protect the privacy of your information. The information will be kept confidential, and you will be provided with a list of duties or practices that protect your information.

The Counseling & Family Wellness Center will only disclose your information when required to do so by Federal, State or Local law.

The Counseling & Family Wellness Center will abide by the terms of the notice. The Center reserves that right to make changes to the notice and continue to maintain the confidentiality of your information.

You have a right to complain to The Counseling & Family Wellness Center if you believe that your privacy rights have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

The Counseling & Family Wellness Center
At: *Santiago Fallon*
1385 West State Road 434, Suite 207
Longwood, Florida 32750

I, ____ have been informed of The Counseling & Family Wellness Center Privacy Practices**.**

____ _____________________
Client Date

____ _____________________
Legal Guardian Date

____ _____________________
Other Date

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INFORMED CONSENT

I voluntary agree to participate in counseling sessions and/or consent to the participation of my child in counseling. I understand that my psychotherapist is a licensed professional in independent practice affiliated with The Counseling & Family Wellness Center.

I understand these sessions are confidential and the Counselor will keep confidential anything the Client says with the following exceptions: (1) The Client directs the Counselor to tell someone else, (2) The Counselor determines that the Client is a danger to self or others, (3) The law requires disclosure, such as in the case of child abuse or when ordered by a court disclose information, (4) Information shared in confidence with a supervisor or a professional colleague.

I understand that primary modality of therapy will be “talk therapy”, which may sometimes include relaxation, deep breathing and hypnotherapy.

I understand that health insurance companies often require advance notice of services and that the Client be given a diagnosis providing a medical necessity for counseling or psychotherapy. I consent to the release of information and notification of my insurance company to determine benefits and to secure payment. I understand that any diagnosis will become part of my permanent insurance records.

I understand that services will be rendered in a professional manner consistent with ethical standards of the profession and that I can discontinue counseling session at any time. I have had a chance to ask questions in advance and have my questions satisfactorily answered.

I also understand that all clinical information will be kept confidential, expect as stipulated in Florida Statutes 39,394, and Health Insurance Portability and Privacy Act, as described in the Privacy Notice. The clinical record is the property of, and will be retained by the assigned counselor. Authorized personnel of The Counseling & Family Wellness Center may review my clinical record for the purpose of billing, clinical supervision, consultation, auditing and compliance. Portions of my information will be used for billing and payment purposes. This notice will be kept for a period of seven (7) years.

I have knowledge of the Client’s Rights and Responsibilities Policy. I may revoke my consent for any and all services at any time.

____ __________________
Client Signature Date

____ __________________
Parent or Legal Guardian Date