1301 Seminole Blvd
Building A – Suite 103
Largo, FL 33770

2555 Enterprise Road
Building 9 – Suite 11-1
Clearwater, FL 33763

Family & Adolescent Counseling Services

Phone: (727) 213-5379
Fax: (727) 213-5370
www.SAYHELP.net

Restoring Relationships and Hope in Individuals and Families

Client Information

DATE:_____

Client Name _____DOB _____ Age _____
Address_____
City _____State _____ Zip Code _____
Home Phone_____ Work Phone _____ Cell Phone _____
E-mail:_____Appointment reminders phone, text or e-mail _____
Do you want this billed to insurance? _____If so, Insurance Company_____
Policy, Member or Subscriber # _____
IF NOT PRIMARY INSURED - NAME OF PRIMARY INSURED AND DOB_____

If Client is a Minor
Parent Name _____DOB_____
Parent Address_____
City _____ Zip Code _____ Referred by_____
Home Phone_____ Work Phone _____ Cell Phone _____
E-mail: _____ Contact preference: phone or e-mail?_____
Employer Name _____ Occupation_____

If Client is a Minor
Parent Name _____ DOB_____
Parent Address_____
City _____ Zip Code _____
Home Phone_____ Work Phone _____ Cell Phone _____
E-mail _____ Contact preference: phone or e-mail? _____
Employer Name _____ Occupation_____

Other Household Members
Names - Ages - Relationship
_____
_____
_____

Current Medications – Names, Dosages, and Prescribing Doctor
_____
_____
_____

Reason for seeking treatment at this time
_____
_____
_____

Notice of Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how Psychological and Medical information about you may be used and disclosed and your access to this information.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

Family & Adolescent Counseling Services (FACS) may *use* or *disclose* your protected health information *(PHI)* for *treatment*, *payment* and *health care purposes* with your consent.

- *PHI* refers to information in your health record that could identify you.
- *Treatment* is when FACS provides, coordinates or manages your health care or related services. An example includes consultation with another provider, such as your Psychiatrist.
- *Payment is* when FACS obtains reimbursement for your healthcare. An example includes when FACS discloses your PHI to your health insurer to obtain reimbursement for your health care.
- *Health Care Operations* are activities that relate to the performance and operation of FACS. An example includes quality assessment and improvement activities.
- *Use* applies only to activities within FACS offices, employing, applying and examining information that identifies you.
- *Disclosure* applies to activities outside of FACS offices such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

FACS may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. FACS will need authorization before releasing any information on your activity at FACS. You may revoke all authorizations at any time in writing. You may not revoke to the extent that (1) FACS has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage.

Uses and Disclosures with Neither Consent nor Authorization

- Child abuse – if FACS knows or suspects such, the law requires reporting.
- Adult and domestic abuse – if FACS knows or suspects such, the law requires reporting.
- Health oversight – if a complaint is being filed against FACS with the Florida Department of Health, the Department has the authority to subpoena confidential mental health information from us relevant to the complaint.
- Judicial or administrative proceedings – if you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and FACS will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform FACS that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered.
- Serious threat to health or safety – when you present a clear and immediate probability of physical harm to yourself, to others, or to society, FACS may communicate relevant information to the potential victim, appropriate family member, law enforcement, or other appropriate authorities.
- Worker's Compensation – if you file a claim, FACS must, upon request of your employer, insurance carrier, authorized rehabilitation provider, or attorney for such furnish your relevant records to those persons.

Patient's Rights:

- Right to request restrictions – on certain uses and disclosures of PHI about you; however FACS is not required to agree to a restriction you request.
- Right to receive confidential communications by alternative means and at alternative locations – you may not want a family member to know you are being treated at FACS and may request that billing be sent to another address.
- Right to inspect and copy – of mental health and billing records about you.
- Right to amend – PHI for as long as it is maintained in record; however, FACS may deny your request.
- Right to an accounting – of disclosures.
- Right to a paper copy – of notices from me.

Licensed Mental Health Counselor Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, We will mail a letter to you indicating a change has been made and provide you a copy of the updated notice.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision made by FACS or believe that your privacy rights have been violated and wish to file a complaint, you may send a written complaint to: Family & Adolescent Counseling Services - Rick Morris, LMHC 1301 Seminole Blvd – Suite 103 Largo, FL 33770. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on June 13, 2007. We reserve the right to make changes in this notice. Any changes made to this notice will be posted in the office.

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Informed Consent for Treatment and Office Procedures

Family & Adolescent Counseling Services (FACS) would like to welcome you to our services and thank you for entrusting your family to us. During the initial visit you will be asked to complete routine forms which will consist of new client information forms, informed consent for treatment, and a release of information (if needed).

In general, the number of sessions required for treatment will depend on the issues to be addressed, the recommendations made in the treatment plan, and your commitment to working through the treatment. You are free at any time to terminate treatment if you wish. If you have behavioral health insurance coverage FACS will direct bill to your insurance company. However, please be advised you are fully responsible for any co-pays, co-insurance and any amounts your insurance company does not pay. By signing this statement, you authorize FACS to bill and receive payment from your insurance company on your behalf.

Individual and Family Therapy Sessions are **45-50 minutes** in duration with a fee of $125-175 per session. This includes individual, couples, and family psychotherapy. Telephone sessions (cannot be billed to insurance) can be arranged and will be charged at the regular session rate (prorated based on 15 minute segments). **Please note that all cancellations require a 24-hour notice. If such notice is not given, the session will be billed the regular session fee.** Checks/Debit Transactions returned by your bank will be assessed a $35.00 non-sufficient funds charge.

_____***(initial) Probation or mandatory clients missing or cancelling three appointments will have services terminated.***

If any clinician from FACS is subpoenaed for a deposition or to testify, the session will be billed at the usual hourly rate, plus travel time billed at the same rate. Evaluations/reports for court cases, social security, and other written reports and treatment summaries etc. will also be charged at the usual hourly rate prorated in 15 minute segments.

Please be assured that all information received from you will be kept **strictly confidential** (as required by law). Absolutely no information will be released about you or your case to anyone without your written authorization and consent. Please note there are exceptions to the law of confidentiality. Such instances include but are not limited to the following:

I have voluntarily entered into treatment, or give my consent for treatment if the client is a minor who is under my legal guardianship with Family & Adolescent Counseling Services. The rights, risks and benefits associated with the treatment have been explained to me.

- I consent to the evaluation and treatment process with Family & Adolescent Counseling Services.
- I understand that I have the right to withdraw from treatment at any time.
- I have read and understand the Privacy Policy set forth by HIPAA.
- **I understand the Limitations of Confidentiality as noted below:**
  - **Duty to Warn and Protect -** When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
  - **Abuse of Children and Vulnerable Adults -** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
  - **Minors/Guardianship -** Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
  - **Insurance Providers -** (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

_____ _____

Printed Name of Client | Date

_____ _____

Signature of client; if under 18, Signature of Parent/Legal Guardian | Signature of Witness

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CREDIT CARD AUTHORIZATION

I _____, authorize Family & Adolescent Counseling Services to keep my signature on file and to charge my credit or debit card for the balance of charges related to all transactions not paid by my insurance (if applicable) or my co-payment. If I do not have insurance my counseling fees will be charged to this account as services are rendered.

I authorize Family & Adolescent Counseling Services to charge my credit/debit card for professional services as follows:

- Recurring charges for services for each session.
- I understand and agree that my card will be charged a $75.00 fee for cancellations with less than 24 hours notice and for appointments I miss without notice as agreed to in the Consent to Treatment form I signed.
- I understand this form is valid throughout my treatment unless I cancel the authorization in writing. I will not dispute charges ("charge back") for sessions I have received or appointments I missed according to the above policy.

Charges will appear on your credit card statement as **FACS Largo, FL**

Verification/Security Code = (MC/Visa/Discover: the 3-digit code on back by signature line. AmEx: above card number, upper-right hand side)

Card Type (circle one): Visa MasterCard Discover American Express

Credit/Debit Card #: _____

Verification/Security Code: _____

Expiration Date: _____

Name as Printed on Card: _____

Billing Address _____

Billing City, State, Zip _____

Billing Phone Number _____

Email Address _____

Client Signature _____ Date _____

FACS Employee Signature _____ Date _____