SPANISH RIVER COUNSELING CENTER

NEW CLIENT INTAKE FORM

ALL INFORMATION IS STRICTLY CONFIDENTIAL

Date: _____

Client 1: _____ Client 2: _____

Address: _____

City: _____ State: _____ Zip: _____

D.O.B. (Client 1): _____ D.O.B. (Client 2) _____

Email Address: (Client 1): _____ Email Address: (Client 2): _____

Cell Phone (Client 1): _____ Cell Phone (Client 2): _____

Work Phone (Client 1): _____ Work Phone (Client 2): _____

Emergency Contact (Name): _____ Emergency (Phone): _____

Relationship to You: _____

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How Long? _____ _____ _____ _____ _____ _____

Have you been here before? ☐ Yes ☐ No If Yes, When? _____

Reason for Seeking Therapy: _____

How did you hear about the Spanish River Counseling Center?

☐ SRC Church Member ☐ Advertising ☐ Website/Web Search ☐ Referral (By Whom?) _____

Who Lives in Your Home Besides Yourself?

Name: _____ D.O.B: _____ Relationship to You: _____

Name: _____ D.O.B: _____ Relationship to You: _____

Do you Worship Regularly (Optional): ☐ Yes ☐ No If Yes, Where? (Optional): _____

Are You Currently Under a Physician's Care? ☐ Yes ☐ No

If Yes, Name of Physician? _____ Reason? _____

Are You Currently Taking Any Medication? ☐ Yes ☐ No If Yes, Reason? _____ How Long? _____

Have You Received Counseling Before? ☐ Yes ☐ No If Yes, By Whom? _____ When? _____

SPANISH RIVER COUNSELING CENTER

PAYMENT AGREEMENT

Responsibilities:

• **Payment is due at the time service is rendered.** We accept cash, check or credit card. If paying by check, please make the check payable to Spanish River Counseling Center (SRCC). There will be a $25 fee charged for any returned checks.

• Full Battery of physiological testing or other psychological, intelligence, educational, learning disability, personality, marital, brain SPECT — and written brain analysis testing have varying fees. Please inquire at the front office.

• Since psychological or education testing is not normally covered by most insurance companies, you are responsible for covering the payment for these services.

• Coaching services are not covered by insurance companies; you are responsible for covering the payment for these services.

• For reasons of confidentiality, we DO NOT make appointment reminder calls. You are responsible for keeping your appointments.

• Cancellation of a session must be made within **24 hours** prior to the scheduled time or you will be billed for the session.

• An invoice may be emailed for any outstanding balance.

☐ Please Initial: "I have read and acknowledge the responsibilities and cancellation policy of the Counseling Center."

Credit Card Information:

Many of our clients prefer that our office keep their credit card on file for ease of payment, and Telehealth sessions. If you would like us to provide this service for you, please indicate your permission below. Please be assured your information will be secure.

☐ Yes, I give Spanish River Counseling Center permission to retain my credit card information.

☐ No, I do not give Spanish River Counseling Center permission to retain my credit card information.

If yes, please give the information to our Office Manager, at the time of payment.

_____

The undersigned certifies that he/she has read the above information carefully, understands its contents, and agrees to comply with the terms of payment as provided.

Signed: _____ Date: _____

Signed: _____ Date: _____

SPANISH RIVER COUNSELING CENTER

THERAPY AGREEMENT

I, _____, have applied for counseling, testing and/or supervisory services at Spanish River Counseling Center, for myself and the following person(s) for whom I am legally responsible.

_____ _____

_____ _____

- I am responsible for any and all indebtedness incurred as a result of services rendered to me or those under my guardianship for any or all therapy or testing.

- I understand that, if, during the course of treatment, the counselor determines that a threat of physical harm including child or elder abuse) to the client or another person is imminent, the appropriate individuals and authorities will be notified. By law, the appropriate authorities must be notified, in accordance with the following Florida statutes: (FS 39.201; FS 39.202; FS 39.204; FS 490.0147; FS491.0147).

- I further agree to indemnify and hold harmless Spanish River Counseling Center, its agents, servants, employees or interns from any claim for damages, or any nature arising out of, or allegedly due to, any counseling, instruction or advice rendered by personnel of Spanish River Counseling Center, or out of any activity related thereto. I accept full responsibility for any decision I make regarding my life.

- I understand that my therapist, therapist supervisor and/or instructor may consult with other professionals on staff at Spanish River Counseling Center, however, my confidentiality will never be compromised.

I have read the above information carefully, understand its contents, and agree under these conditions, to receive services for myself and/or anyone herein designated.

Signed: _____ Date: _____

Signed: _____ Date: _____

SPANISH RIVER COUNSELING CENTER

TEXT MESSAGE REMINDER AUTHORIZATION

For your convenience, Spanish River Counseling Center offers reminders for upcoming appointments via SMS Text Message. This service is offered free of charge, however, standard text messaging rates from your mobile carrier may apply.

Reminders will be sent via SMS Text, and will only include the date/time of your appointment and the service provider's name. Text messages will not be encrypted. Health information could be lost, delayed, intercepted, or inadvertently delivered to the wrong number. By signing below, you agree to accept these terms and conditions listed above, and will not hold Spanish River Counseling Center responsible for events occurring after the text message is sent.

If you would like us to provide this service for you, please indicate your permission below:

☐ Yes, I give Spanish River Counseling Center permission to send appointment reminders via text message to the mobile phone number listed below.

☐ No, I do not give Spanish River Counseling Center permission to send appointment reminders via text message.

_____ _____

Client Name (Please Print) Mobile Phone Number

_____ _____

Client Signature Date

SPANISH RIVER COUNSELING CENTER

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

"I hereby acknowledge that I received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the person listed. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

_____

Patient or Representative Name (Please Print)

_____ _____

Patient or Representative Signature Date

Staff Use Only

[ ] Patient Refused to Sign

[ ] Patient Was Unable to Sign Because: _____

SPANISH RIVER COUNSELING CENTER

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE PERTAINS TO THE PRACTICE OF: Spanish River Counseling Center (SRCC), 2400 Yamato Rd. Boca Raton, Florida 33431

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

THIS NOTICE AND ALL OF THESE RIGHTS MAY NOT APPLY TO YOU IN SOME CIRCUMSTANCES WHICH ARE NOT COVERED BY FEDERAL HIPAA REGULATIONS. YOU MAY BE PROTECTED UNDER OTHER FEDERAL AND STATE LAWS.

I. USES AND DISCLOSURES FOR TREATMENT PAYMENT AND HEALTH CARE OPERATIONS

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent to help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you

- "Treatment, Payment and Health Care Operations"

o Treatment is when we provide, coordinate or manage your health care and other services related to your health care.

An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.

- Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

We 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. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information.

We would also need to obtain an authorization before releasing your "psychotherapy notes". "Psychotherapy notes" have a very limited definition under HIPAA rules, and would be notes made about analyses of conversations during a private, group, joint, or family counseling session, which would be kept separate from the rest of your medical record. It is our office practice not to keep "psychotherapy notes" under this definition. Your diagnosis and relevant treatment information, symptom complaints, and information about progress are maintained in "Progress Notes" which document your care.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

We may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If we know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that we report such knowledge or suspicion to the Florida Department of Child and Family Services.

Adult and Domestic Abuse: If we know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, we are required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

Health Oversight: If a complaint is filed against us with the Florida Department of Health, the department has the authority to subpoena confidential mental health information from us relevant to that complaint.

Government: We may disclose the PHI information of military personnel and veterans to government benefit programs relating to eligibility and enrollment.

Impaired Professionals: We may disclose information pertaining to the safety to practice to the Florida Department of Health for health care professionals if we have reasonable reason to believe public safety is endangered or where there would be a statutory duty to report.

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 we 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 us 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. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, we may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

Worker's Compensation: If you file a worker's compensation claim, we must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

Litigation: If you have a pending personal injury claim such as auto accident, malpractice claim, or other situations in which you are eligible to collect damages, your entire records may be subject to disclosure by subpoena or court order and are subject to full disclosure to the payor of any claims we file for services on your behalf You may object, in writing, to a subpoena for such records. In the case of an Independent Medical Examination which is being conducted on behalf of a third party, any information is subject to disclosure to that third party. However, you may have additional rights under State law.

Forensic Evaluation at the request of your attorney: In most circumstances, such evaluations if arranged for and paid through your attorney's office retain a special status of attorney-client privilege until such information is disclosed by your attorney or used for legal purposes. Such evaluations are not protected by rights established under HIPAA.

Law Enforcement: We may disclose health information for law enforcement purposes and special governmental functions only as required by Federal, State, or Local Law.

Business Associates: We have Business Associates with whom we may share your Protected Health Information. Examples include Business Associates who provide coverage while we are out of town, answering services as necessary, shared clerical functions with Business Associates with whom we may share offices with collection agencies or collection attorneys, or technicians who may need to service equipment where necessary information is stored. We cater into agreements with such associates such that they are also obligated to respect the privacy of your Protected Health Information.

Communication with Family: If a family member or close friend calls for scheduling, payment, or changing appointments and in our best judgment, we do not believe you would object, we may communicate minimal necessary information to facilitate scheduling, payments and appointments: With your signed consent, if family members, other relatives, close personal friend, or any other person you identify as participating in your care, minimal necessary health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Unless you notify us otherwise, we may leave messages on your home phone if you utilize an answering machine regarding contacting our office regarding scheduling, or regarding personal or third-party payment.

Marketing: We may contact you to provide you with appointment reminders, with information about treatment alternatives or with information about other health-related benefits or services that may be of interest to you.

Health Research: We may use Personal Health Information to conduct or participate in research studies based upon our clinical and health records. In such cases, any personal identifying information shall be removed. For example, we may collect outcome data on group treatment approaches or we may use data from your record to conduct a study of test patterns in head injury. Of course, we will not conduct any experimental research without a separate informed consent.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents there of your PHI necessary for your health and the health and safety of other individuals.

IV. PATIENT'S RIGHTS AND PSYCHOLOGIST/COUNSELOR'S DUTIES

Patient's Rights:

Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are in counseling. Upon your request, we will send your bills to another address).

Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long, as the PHI is maintained in the record. On your request, we will discuss with you the details of the request process.

Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, we will discuss with you the details of the accounting process.

Right to a Paper Copy - You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

We reserve the right to bill you for the professional time involved in explaining or reviewing these procedures with you.

PSYCHOLOGIST/COUNSELOR'S 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 notify active patients by mail. Returning patients will be notified upon their first visit following a change in policy and procedures. Patients may request a written copy anytime by mailing such a request to: Office Manager, Spanish River Counseling Center 2350 Yamato Rd. Boca Raton FL, 33431.

V. QUESTIONS AND COMPLAINTS

If you are a patient of SRCC and have questions about this notice, disagree with a decision we make about access to your records, believe that your privacy rights have been violated and wish to file a complaint, or have other concerns about your privacy rights, you may contact our Office Manager at (561) 241-2014. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.