



GENERAL INFORMATION

Date: _____ How did you hear about us? _____

Full Name: Mr. Mrs. Ms. Miss Dr. _____

Nick Name: _____ Name You Prefer: _____

Age: _____ Date of Birth: _____ Sex: Male Female

Race: White Black Hispanic Asian Other: _____

Parent/Guardian: _____ Relationship: _____

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: Yes No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: Yes No

Home Phone: (_____) _____ May We Leave a Message Here: Yes No

Mobile Phone: (_____) _____ May We Leave a Message Here: Yes No

Work Phone: (_____) _____ May We Leave a Message Here: Yes No

Email Address: _____ May We Send Email Here: Yes No

I would like to be added to Life Counseling Solutions Newsletter to receive free articles, tips and resources: Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary: \$0 to \$10,000 \$20,001 to \$40,000 \$50,001 to \$60,000 \$80,001 to \$100,000
 \$10,001 to \$20,000 \$40,001 to \$50,000 \$60,001 to \$80,000 More than \$100,000

EDUCATION INFORMATION

Last Year of School Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

Are You Currently in School: Yes No. If Yes, What School: _____



RELATIONAL INFORMATION

Current Relational Status: Single Dating Engaged Married Separated Divorced Widowed

Are You Content with Your Current Status: Yes No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: White Black Hispanic Asian Other: _____ Partner's Sex: Male Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: Yes No Unsure Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): Alone Spouse Children Parent(s) Sibling(s)
 Boyfriend Girlfriend Roommate Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Natural, Adopted, Step)</i>	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: Yes No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: Yes No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Mom, Dad, Sibling, Step)</i>	Occupation	Describe Him/Her



MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are You Currently Receiving Medical Treatment: Yes No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (Use Back if Necessary): _____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ Improves Prevents Controls: _____

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Are You Taking these Medication(s) According to Your Doctor's Recommendations: Yes No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

- Headaches..... Past Present Dizziness..... Past Present Stomach Trouble.... Past Present
Visual Trouble..... Past Present Sleep Trouble..... Past Present Trouble Relaxing.... Past Present
Weakness..... Past Present Tension..... Past Present Rapid Heart Rate... Past Present
Difficulty Breathing.. Past Present Intestinal Trouble.... Past Present Hearing Noises..... Past Present
Change in Appetite. Past Present Tiredness..... Past Present Pain..... Past Present
Hearing Voices..... Past Present Seeing Things..... Past Present Other..... Past Present

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

- Stress..... Past Present Nervousness..... Past Present Anxiety..... Past Present
Panic..... Past Present Unhappiness..... Past Present Depression..... Past Present
Guilt..... Past Present Apathy..... Past Present Terminal Illness..... Past Present
Recent Death..... Past Present Grief..... Past Present Hopelessness..... Past Present
Inferiority Feelings.. Past Present Defective Feelings.. Past Present Loneliness..... Past Present
Shyness..... Past Present Fears..... Past Present Friends..... Past Present
Marriage..... Past Present Communication..... Past Present Physical Abuse..... Past Present
Emotional Abuse.... Past Present Verbal Abuse..... Past Present Sexual Abuse..... Past Present
Temper..... Past Present Anger..... Past Present Aggressiveness..... Past Present
Bad Dreams..... Past Present Concentration..... Past Present Racing Thoughts.... Past Present
Unwanted Thoughts Past Present Memory..... Past Present Loss of Control..... Past Present
Impulsive Behavior. Past Present Self-Control..... Past Present Compulsivity..... Past Present
Sexual Problems.... Past Present Pregnancy..... Past Present Abortion..... Past Present
Legal Matters..... Past Present Trauma..... Past Present Eating Problems.... Past Present
Drug Use..... Past Present Alcohol Use..... Past Present Trouble with Job.... Past Present
Career Choices..... Past Present Ambition..... Past Present Making Decisions... Past Present
Children..... Past Present Being a Parent..... Past Present Finances..... Past Present
Recent Loss..... Past Present Disaster..... Past Present Smoke Cigarettes... Past Present



LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1 = Very Little Distress; 10 = Extreme Distress):

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: Yes No. Have You Experienced Them in the Past: Yes No

Have You Ever Attempted Suicide: Yes No. If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: Yes No

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling (i.e. What Are Your Issues, Problems?): _____

Why Have You Decided to Come for Counseling Now: _____

What Do You Hope to Gain or Change by Coming for Counseling: _____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back If Necessary):

Therapist: _____ Location: _____ Dates: _____ Reason: _____

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RELIGIOUS BACKGROUND

Please describe your religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of?

Church attendance? If so, what is the name? _____

Do You Have a Personal Support System: Yes No. If Yes, Who: _____

TERMS OF SERVICE

I hereby give Life Counseling Solutions permission to provide counseling services for the client mentioned above:

Signed: _____ Date: _____



Relationship Questionnaire

This questionnaire is intended to estimate the current satisfaction with your relationship. Circle the number between 1 (completely satisfied) to 10 (completely unsatisfied) beside each issue. Try to focus on the present and not the past.

1. List the things that your partner does that please you:

2. What would you like your partner to do more often?

3. What would your partner like you to do more often?

4. How do you contribute to difficulties in the relationship?

5. What are you prepared to do differently in the relationship?

6. Is there a problem of alcohol/substance abuse?

7. Have you or your partner participated in any of the following activities:
 - Swinging
 - Pornography
 - Fetishes

8. Do you often try to anticipate your partner's wishes so that you can please them?

9. What are your goals or what do you hope to accomplish?



Circle the Appropriate Response for Each

	Completely Satisfied										Completely Unsatisfied									
General Relationship	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Personal Independence	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Spouse Independence	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Couples Time Alone	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Social Activities	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Occupational or Academic Progress	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Sexual Interactions	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Financial Issues	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Household/Yard Responsibility	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Parenting	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Daily Social Interaction	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Trust in Each Other	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Decision Making	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Resolving Conflicts	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Problem Solving	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Support of One Another	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10



Authorization of Release

I, _____, hereby authorize Life Counseling Solutions, 220 Lookout Place, Suite 150, Maitland, Florida 32751 to:

_____ Release To _____ Release from _____ Exchange Written and/or Oral Communication

_____ Psychiatric _____ Medical

_____ Psychological _____ Counseling

from the records of: _____
Name of Client Date of Birth

To: _____

For the purpose of: Outpatient Counseling Coordination with schools Send Thank You Card for Referral
 Coordination with MD/Psychologist/OT Therapist/Therapist

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire on _____

Client, Parent, Guardian Date

Witness Date



Financial Policy

Payment Policy:

We are committed to providing you with the best possible care. Payment for services is due at the time of service. We accept cash, checks, Master Card, and Visa.

Our fees:

- Individual, Family and Marriage Sessions are _____ per hour (therapy sessions are 50 minutes).
- Groups are _____ per session.
- Counselor Services: Treatment Summary Requests, Professional Letters, and Phone/Conference calls will be billed, if requested, at the individual therapeutic rate for a minimum of 30 minutes.
 - Emails will be charged in 15-minute increments at the individual therapeutic rate (15 minute minimum).
- Administrative Services: Letters from the administrative office, insurance forms, authorization requests and/or calls to your insurance company will be billed at \$15 per 15 minutes (15 minute minimum).
- Court Appearances and Depositions are \$280 per hour & minimum \$1000 retainer.
- Returned checks are subject to a \$30 fee.
- A cancellation fee is charged for appointments that are no show or canceled without a 24 hours advance notice unless there is an emergency or illness. The no-show fee is equivalent to your normal session fee.

Policy on Insurance Reimbursement:

If you have medical Insurance that provides coverage for mental health counseling, we want to help you receive your maximum allowable benefits, however, it is your responsibility to pay for services at the time of service and then work with your insurance company for any reimbursement.

We will be happy to help you process your insurance claim form for your reimbursement. A completed insurance form must accompany any such request at each visit. You are responsible for mailing it to the insurance company and tracking your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, called "Usual, Customary and Reasonable" (UCR).
Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.
5. I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

If you have any questions about our financial policy please do not hesitate to ask us. We are here to help you.

Signature _____ Date _____



Informed Consent & Release of Liability

Name: (please print): _____

I understand the following:

1. Counseling services are provided by Life Counseling Solutions whose counselors have earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and who have been licensed by the state of Florida as a Mental Health Counselor.
2. Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
3. Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
4. The counselor is not providing an emergency service; therefore, at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance. We do not provide an on-call service at this time.
5. Regular attendance will produce maximum results, but I am free to discontinue treatment at any time. A final closure/summary session is highly recommended to get the greatest benefits.
6. I understand that my counseling records & conversations with the counselor are kept confidential, except where disclosure is required by law (i.e. abuse of a child, elderly or disabled person; potential harm or threat to self or others and specific information subpoenaed by a court of law.)
7. I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

My signature below indicated that I grant informed consent for Life Counseling Solutions to provide counseling services to myself and or minor members of my family.

Signature: _____ Date: _____



Notice of Privacy Practices

This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

<p>The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.</p> <p>Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.</p> <ul style="list-style-type: none"> • <i>Treatment</i> means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc. • <i>Payment</i> means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services. • <i>Health Care Operations</i> include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc. <p>In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by</p>	<p>law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.</p> <p>Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.</p> <p>You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:</p> <ul style="list-style-type: none"> • The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. • The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations. • The right to request an amendment to your PROTECTED HEALTH INFORMATION. 	<p>outside of treatment, payment and health care operations.</p> <ul style="list-style-type: none"> • The right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION. <p>We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.</p> <p>You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.</p> <p>For more information about our Privacy Practices, please contact: The Privacy Officer Janie Lacy, LMHC, NCC 220 Lookout Place, Suite 150, Maitland, Florida 32751 407-622-1770</p> <p>For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 877.696.6775 (toll-free)</p>
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Acknowledgement of Receipt: Privacy Practice Notice

I, _____ have received a copy of Life Counseling Solutions
Notice of Privacy Practices.

Street Address: _____

City: _____ State: _____ Zip: _____

Client
Signed: _____ Date: _____

Parent/Guardian
Signed: _____ Date: _____

Witnessed
Signed: _____ Date: _____