Individual, Family, Marriage & Group Counseling
P: 407-622-1770
F: 1-407-641-9791

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: ____

Individual, Family, Marriage
& Group Counseling
P: 407-622-1770
F: 1-407-641-9791

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 (*e.g. Natural, Adopted, Step*)	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 (*e.g. Mom, Dad, Sibling,Step*)	Occupation	Describe Him/Her

Individual, Family, Marriage
& Group Counseling
P: 407-622-1770
F: 1-407-641-9791

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: ______________

Medication: ______________________________ Dosage: ____________ ☐ Improves ☐ Prevents ☐ Controls: ______________

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

Individual, Family, Marriage & Group Counseling
P: 407-622-1770
F: 1-407-641-9791

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: __________

Therapist: __________ Location: __________ Dates: __________ Reason: __________

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: ____________________

Individual, Family, Marriage
& Group Counseling
P: 407-622-1770
F: 1-407-641-9791

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

Individual, Family, Marriage
& Group Counseling
P: 407-622-1770
F: 1-407-641-9791

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____

Individual, Family, Marriage
& Group Counseling
P: 407-622-1770
F: 1-407-641-9791

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 provider 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 disable 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:___________________________

Individual, Family, Marriage & Group Counseling
P: 407-622-1770
F: 1-407-641-9791

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.

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.

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.

- *Treatment* 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.

- *Payment* 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.

- *Health Care Operations* 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.

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 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.

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.

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:

- 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. outside of treatment, payment and health care operations.

- 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 PROTECED HEALTH INFORMATION.

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.

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.

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

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)

Individual, Family, Marriage
& Group Counseling
P: 407-622-1770
F: 1-407-641-9791

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: ______________________________________