



**Individual, Family, Marriage  
& Group Counseling**  
P: 407-622-1770  
Info@LifeCounselingSolutions.com

### 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 (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. Natural, Adopted, Step)	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: \_\_\_\_\_

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
Visual Trouble.....  Past  Present
Weakness.....  Past  Present
Difficulty Breathing..  Past  Present
Change in Appetite.  Past  Present
Hearing Voices.....  Past  Present
Dizziness.....  Past  Present
Sleep Trouble.....  Past  Present
Tension.....  Past  Present
Intestinal Trouble....  Past  Present
Tiredness.....  Past  Present
Seeing Things.....  Past  Present
Stomach Trouble....  Past  Present
Trouble Relaxing....  Past  Present
Rapid Heart Rate....  Past  Present
Hearing Noises.....  Past  Present
Pain.....  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
Panic.....  Past  Present
Guilt.....  Past  Present
Recent Death.....  Past  Present
Inferiority Feelings..  Past  Present
Shyness.....  Past  Present
Marriage.....  Past  Present
Emotional Abuse....  Past  Present
Temper.....  Past  Present
Bad Dreams.....  Past  Present
Unwanted Thoughts  Past  Present
Impulsive Behavior.  Past  Present
Sexual Problems....  Past  Present
Legal Matters.....  Past  Present
Drug Use.....  Past  Present
Career Choices.....  Past  Present
Children.....  Past  Present
Recent Loss.....  Past  Present
Nervousness.....  Past  Present
Unhappiness.....  Past  Present
Apathy.....  Past  Present
Grief.....  Past  Present
Defective Feelings..  Past  Present
Fears.....  Past  Present
Communication.....  Past  Present
Verbal Abuse.....  Past  Present
Anger.....  Past  Present
Concentration.....  Past  Present
Memory.....  Past  Present
Self-Control.....  Past  Present
Pregnancy.....  Past  Present
Trauma.....  Past  Present
Alcohol Use.....  Past  Present
Ambition.....  Past  Present
Being a Parent.....  Past  Present
Disaster.....  Past  Present
Anxiety.....  Past  Present
Depression.....  Past  Present
Terminal Illness.....  Past  Present
Hopelessness.....  Past  Present
Loneliness.....  Past  Present
Friends.....  Past  Present
Physical Abuse.....  Past  Present
Sexual Abuse.....  Past  Present
Aggressiveness.....  Past  Present
Racing Thoughts....  Past  Present
Loss of Control.....  Past  Present
Compulsivity.....  Past  Present
Abortion.....  Past  Present
Eating Problems....  Past  Present
Trouble with Job....  Past  Present
Making Decisions...  Past  Present
Finances.....  Past  Present
Smoke Cigarettes...  Past  Present



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### 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: \_\_\_\_\_



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### 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 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\_\_\_\_\_



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### CREDIT CARD AUTHORIZATION

Date: \_\_\_\_\_

I, \_\_\_\_\_ authorize Life Counseling Solutions to place my Credit Information on file to charge for services rendered\*. My credit card information is as follows:

Credit Card number \_\_\_\_\_

Billing address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Expiration date: \_\_\_\_\_

Verification Code: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date \_\_\_\_\_

\*No shows and/or appointments not cancelled within 24 hours are considered services rendered.



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### **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 and/or Marriage and Family Therapist.
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 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 \_\_\_\_\_





**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 &amp; 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"> <li>• <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.</li> <li>• <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.</li> <li>• <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.</li> </ul> <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"> <li>• 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.</li> <li>• The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.</li> </ul>	<ul style="list-style-type: none"> <li>• The right to request an amendment to your PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.</li> <li>• 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.</li> </ul> <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 &amp; 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:</p> <p>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:</p> <p>The U.S. Department of Health &amp; 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: \_\_\_\_\_