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

GENERAL INFORMATION

Patient Name: _____ Date: _____
Patient's DOB: _____ Age: _____ School _____ Grade: ___

Parent/Guardian Information

Parent/ Guardian Name: _____ Relationship to Patient _____
Address: _____ City _____ Zip _____
Home Phone: _____ Business Phone: _____ Cell Phone: _____
Email Address: _____ Place of Employment _____
Occupation: _____
Marital Status: circle one
Single / Engaged / Married How Long ____? **Divorced** How Long ____? **Widowed** How Long ____?

Name of Person or Establishment who referred you _____
In case of emergency contact: _____ Relationship _____ Phone _____

I would like to be added to Life Counseling Solutions Newsletter to receive free articles, tips and resources: □ Yes □ No
I hereby give Life Counseling Solutions permission to provide counseling services for the patient mentioned above: Signature of parent or legal guardian:

Signature: _____ *Date:* _____

Has patient received counseling from a Pastor, Psychiatrist, or other counselor? **Yes** or **No**
If yes, who: _____ When: _____
What was the previous chief complaint or diagnosis: _____
Has anyone in your family been treated for a mental disorder? **Yes** or **No**
If yes, Who & What were they treated for? _____

_____

Physician's Name: _____ Date of last physical exam: _____
Significant past medical conditions and years _____

_____

Current medical conditions (include any known allergies or dietary concerns) _____
_____
Medications/dosage patient is currently taking and for what reason: _____
_____
Briefly describe major reasons for coming to counseling and what you hope to accomplish: _____
_____
_____
_____

Severity of Problem: ☐ Crisis ☐ Severe ☐ Moderate ☐ Mild

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CHILD/ADOLESCENT COMPREHENSIVE PSYCHOSOCIAL ASSESSMENT

Family Information:

Family	Name	Age	Education	Occupation	At Home
Dad					
Mom					
Stepdad					
Stepmom					
Bro/Sis					
Bro/Sis					
Bro/Sis					
Bro/Sis					
Other					

STAFF NOTES:

Has your child ever lived with anyone else? **YES** or **NO**

If so, who? _____

Is your child adopted? **YES** or **NO**

A. Your Child's Development:

Please list the approximate age at which your child:

	Age	Problems
Walked	_____	**YES** or **NO**
Talked	_____	**YES** or **NO**
Toilet Trained	_____	**YES** or **NO**
Puberty/1st Menstruation	_____	**YES** **NO** **N/A**
Sexually Active	_____	**YES** **NO** **N/A**

B. Family History:

Has anyone in your immediate family ever had any of the following problems?

1. Epilepsy or Diabetes? **YES** or **NO**
2. Significant Medical Problems? **YES** or **NO**
3. Mental Illness Requiring Hospitalization? **YES** or **NO**
4. Counseling for Emotional Problems? **YES** or **NO**
5. Current or past use of alcohol/drugs? **YES** or **NO**
6. Suicidal Behavior? **YES** or **NO**

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C. Your Child's Behavior:

1.	Does your child get along well with others?	**YES**	**NO**	**SOMETIMES**
2.	Does your child follow instructions?	**YES**	**NO**	**SOMETIMES**
3.	Is your child appropriate with pets?	**YES**	**NO**	**SOMETIMES**
4.	Does your child have self-control?	**YES**	**NO**	**SOMETIMES**
5.	Has your child ever set a fire?	**YES**	**NO**	**SOMETIMES**
6.	Does your child cry easily?	**YES**	**NO**	**SOMETIMES**
7.	Has your child ever used alcohol or other drugs?	**YES**	**NO**	**SOMETIMES**
8.	Has your child ever experienced problems with the law?	**YES**	**NO**	
9.	Has your child ever talked about, threatened or tried to harm himself or herself?	**YES**	**NO**	
10.	Has your child ever threatened to or harmed others?	**YES**	**NO**	
11.	Has your child ever used tobacco products?	**YES**	**NO**	

D. Your Child's Education:

1. What school is your child attending? _____
2. In what grade is your child? _____
3. Has your child attended a special education program? **YES** **NO**
4. Has your child repeated, skipped or had an interruptions in his/her education? **YES** **NO**
5. How many days has he/she missed this year? _____

E. Activities, Interests and Strengths:

1. What does your child do in his/her spare time? _____
   _____
2. What does your child do well? _____
   _____

F. **Spiritual:**

Please describe your child's religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of as we meet with him/her? _____
_____
_____

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G. Health

Has your child experienced any of the following? If yes, when?

Soiling or lack of bowel control?	**YES**	**NO**
Urinary problems?	**YES**	**NO**
Seizures or Convulsions?	**YES**	**NO**
Eye/Ear Problems?	**YES**	**NO**
Complications from high fever?	**YES**	**NO**
Persistent Headaches?	**YES**	**NO**
Persistent Stomach Aches/Nausea or vomiting?	**YES**	**NO**
Sleeping Problems?	**YES**	**NO**
Physical, Sexual or Emotional Abuse?	**YES**	**NO**
Poor Appetite?	**YES**	**NO**
Significant Weight Loss or Gain?	**YES**	**NO**
Frequent Colds/Respiratory?	**YES**	**NO**
Rocking, Head banging?	**YES**	**NO**
Coma or Unconsciousness	**YES**	**NO**
Serious Injury Resulting from accidents?	**YES**	**NO**

Parent or Guardian's Signature **Date**

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PLEASE DO NOT WRITE IN THE SPACE BELOW. FOR OFFICE USE ONLY

ISSUES	DESCRIPTIONS	MEASURABLE OBJECTIVCES	INTERVENTIONS

DIAGNOSTIC IMPRESSIONS:

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: Current GAF: _____ **HIGHEST GAF:** _____

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AUTHORIZATION OF RELEASE

I, _____, hereby authorize Life Counseling Solutions, 670 N Orlando Ave, Suite 103, 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

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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 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_____

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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: _____

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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
670 N Orlando Ave, suite 103
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)