LifeCounseling Solutions

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: _____

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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

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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

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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: _____ 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: _____

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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?

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Circle the Appropriate Response for Each:
Completely Satisfied Completely Unsatisfied

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

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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 S 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: Administrative tasks outside of scheduled therapy sessions, including completion of insurance forms, authorization requests, correspondence, and calls to insurance companies on your behalf will be billed at $20 per 15-minute increment with a 15-minute minimum. You will be notified in advance if administrative work is required, and these services are billed separately from your therapy sessions.

Expert Witness Services & Court Appearances: Court testimony, depositions, and expert witness services are provided at $400 per hour with a minimum 4-hour charge and a $1,500 retainer required 72 hours in advance. Preparation time, travel time, and waiting time are billed at the same hourly rate. Cancellations made with less than 48 hours' notice will result in forfeiture of 50% of the retainer fee. These services are separate from therapeutic services and do not constitute ongoing treatment.

Payment Processing: Returned checks, failed electronic payments, or declined credit card transactions will incur a $25 processing fee to cover administrative costs and bank charges. Multiple payment attempts by your financial institution may result in multiple fees.

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

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)

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		