



**Individual, Family, Marriage
& Group Counseling**

P: 407-248-0030

F: 407-248-0226

Satellite Locations:

Clermont & Winter Park

Patient Information Forms

Patient Name: _____

Date: _____

Parent/Guardian Information

Name: _____ Relationship to Patient _____

Address: _____ City _____ Zip _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Email Address: _____ Place of Employment _____

Occupation: _____

Marital Status: 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 Total Life Counseling Newsletter to receive free articles, tips and resources: Yes No

I hereby give Total Life Counseling Center permission to provide counseling services for the patient mentioned above: Signature of parent or legal guardian:

Signature: _____ *Date:* _____

Patient's DOB: _____ Age: _____ School _____ Grade: _____

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

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

**1507 S. Hiwassee Rd Ste. 101, Orlando FL 32835 – Satellite Offices: Winter Park, East
Orlando, & Clermont**



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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 (hourly sessions are 50-60 minutes)
- Groups are \$48.00 per hour
- Counselor Services: Treatment Summary Requests, Professional Letters, Emails or Phone/Conference calls may be billed, if requested, in 15 minute increments at the individual therapeutic rate for a minimum of 30 minutes.
- Administrative Services: Letters from the front office, insurance forms, authorization requests will be billed a \$15 per 15 minutes with a \$15 minimum.
- Court Appearances and Depositions are \$280 per hour & minimum \$1000 retainer.
- Returned checks are subject to a \$30 fee.

No-show fees are charged for appointments canceled or broken without 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 are anxious to help you receive your maximum allowable benefits.

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.

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

Signature _____ Date _____

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Child/Adolescent Comprehensive Psychosocial Assessment						Staff Notes
Family Information:						_____
Family	Name	Age	Educ.	Occup.	At Home	
Dad						
Mom						
Stepdad						
Stepmom						
Bro/Sis						
“ ”						
“ ”						
Other						
Has your child ever lived with anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who? _____						_____
Is your child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how old was your child? _____						_____
A. Your Child's Development:						_____
Please list the approximate age at which your child:						_____
	Age		Problems			_____
Walked	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
Talked	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
Toilet Trained	_____		<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
Puberty/1 st Menstruation	_____	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
Sexually Active	_____	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
B. Family History:						_____
Has anyone in your immediate family ever had any of the following problems?						_____
1. Epilepsy or Diabetes?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
2. Significant Medical Problems?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
3. Mental Illness Requiring Hospitalization?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
4. Counseling For Emotional Problems?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
5. Current or past use of alcohol/drugs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____
6. Suicidal Behavior?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____



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?

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 _____



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Frequent Colds/Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____	
Rocking, Head Banging? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____	
Coma or Unconsciousness <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____	
Serious Injury Resulting From Accidents? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____	
_____ _____	
Parent or Guardian's Signature _____ Date _____	

Please do not write in space below. For office use only

Issues	Descriptions	Interventions

Diagnostic Impressions:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF: _____ Highest GAF: _____

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Release of Information

I, _____, hereby authorize Total Life Counseling Center, 1507 S. Hiawasse Road, Orlando, FL 32835 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 This form is to document that I, _____, give my permission and

PRINT NAME

consent to the above named clinician to provide psychotherapeutic treatment to me and/or



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_____, who is/are my child/children or for whom I
am

PRINT NAME(S)

legal guardian, custodian, or legal Power of Attorney.

I understand the following:

- Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
- Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
- This therapist is not providing an emergency service, and I have been informed of whom to call in an emergency or during weekend and evening hours.
- Regular attendance will produce maximum benefits, but I am free to discontinue treatment at any time.
- Conversations with the therapist will be almost always confidential. However, the therapist, by law, must report actual or suspected child, spouse, or elder abuse to the appropriate authorities. The therapist also has a legal responsibility to protect anyone I may threaten with violence, harmful, or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. The therapist will make reasonable efforts to resolve these situations before breaking confidentiality.
- I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

I have read and received the *Office Policies & General Information Agreement for Psychotherapy Services* and I agree to the policies. I have also received a copy of the HIPAA Notice of Privacy Practices. I have discussed any concerns about the policies with the therapist **prior** to signing this consent.

Signature: _____

Date: _____



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HIPAA 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. PLEASE REVIEW IT CAREFULLY.

IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (*PHI*). By law I am required to insure that your PHI is kept private. The PHI is information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. "Use" of PHI means when I share, apply, utilize, examine, or analyze information within my office; PHI is "disclosed" when I release, transfer, give, or otherwise reveal it to a third party outside my office. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use of disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to your PHI already on file. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may request a copy of this Notice from me at any time.

I am permitted to use and disclose your PHI without specific prior written authorization 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 would be providing your PHI to your insurance company for processing purposes.
- **Health care operations** include the business aspects of running the office, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

In addition, your PHI may be used without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

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4. If disclosure is compelled by the patient or the patient's representative pursuant to Florida Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the Florida Department of Children and Families reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the Florida DCF Elder/Dependent Adult Abuse reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. For example, in the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. For health oversight activities. For example, I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. For example, I may disclose PHI of military personnel and veterans under certain circumstances. Or in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
15. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
16. I am permitted to contact you, without your prior authorization, to provide appointment reminders/confirmations or information about alternative or other health-related benefits and services that may be of interest to you.
17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. For example, when compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. If disclosure is otherwise specifically required by law.

There are certain uses and disclosures that require you to have the opportunity to object, such as disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

Other uses and disclosures require your prior written authorization. In any other situation not described above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization in writing, to stop any future uses and disclosures (assuming that I have not taken any action subsequent to the original authorization) of your PHI by my office.

YOU HAVE CERTAIN RIGHTS REGARDING YOUR PHI

- The right to see and get copies of your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but know who does, I will advise you how you can get it. You will receive a response from my office within 30 days of receiving your written request. Under certain circumstances, I may feel that I must deny your request, but if I do, I will give you in writing the reasons for the denial. I will also explain your right to have my denial

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reviewed. If you ask for copies of your PHI, I will charge you not more than \$0.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as the cost, in advance.

- The right to request limits on uses and disclosures of your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.
- The right to choose how I send your PHI to you. It is your right to ask that your PHI be sent to you at an alternate address (for example, your work address rather than your home address) or by an alternate method. I am obliged to agree to your request, providing that I can give you the PHI in the format you request without undue inconvenience.
- The right to get a list of the disclosures I have made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, such as treatment, payment, or health care operations, sent directly to you or your family; neither will the list include disclosures made for national security purposes to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years, unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including address, if known), a description of the information disclosed, and the reason for disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which I will charge you a reasonable sum based on a set fee for each additional request.
- The right to amend your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone else. My denial must be in writing and must state the reasons for denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and will advise all others who need to know about the change(s) to your PHI.
- The right to complain about my privacy practices. If, in your opinion, I may have violated your privacy rights, or if you object to a decision made about access to your PHI, you are entitled to file a complaint to me. You may also send a written complaint to: Secretary of the Department of Health and Human Services; 200 Independence Avenue S.W.; Washington, D.C. 20201

This Notice is effective as of April 15, 2003, and a copy of it will be provided to you upon request.



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DIRECTIONS-- SEE MAPS ON NEXT PAGE

Greetings and thank you for contacting Total Life Counseling Center. We consider it a privilege to serve you and look forward to working with you. Below are instructions to our offices. You can also go to our website and click the Office Locations Link and click on the office you are attending. Then you can enter your address for directions.

Metro West Office @ Metro West Professional Plaza, 1507 S. Hiawassee Road Suite 101, Orlando FL 32835:

- From Kissimmee N. on Turnpike to EXIT 259, Take I-4 toward Tampa to the Kirkman Rd Exit 75B and take Kirkman 2.6 miles. Take Left on Metro West Blvd for 1 mile. Take Right on Hiawassee Road .3 miles and turn between the McDonalds on the right and our Building. Then immediately turn right again into the parking lot behind the building.
- From Tampa I-4 East to Orlando and take the Kirkman Rd Exit 75B and take Kirkman 2.6 miles. Take Left on Metro West Blvd for 1 mile. Take Right on Hiawassee Road .3 miles and turn between the McDonalds on the right and our Building. Then immediately turn right again into the parking lot behind the building.
- Downtown Orlando/East Orlando: Take the 408 West to Hiawassee Road. Take Left on Hiawassee Road for 2 miles. Cross Raleigh Street and our building is past the McDonalds on the left. However, our parking lot access is behind the McDonalds. So after Raleigh Turn into the Winn Dixie Shopping Plaza and turn right between McDonalds & the Winn Dixie to access our parking lot behind the Building.
- From Clermont/Ocoee/Winter Garden/Oakland/Montverde: Take the 408 East to Hiawassee Road. Take Right on Hiawassee Road for 2 miles. Cross Raleigh Street and our building is past the McDonalds on the left. However, our parking lot access is behind the McDonalds. So after Raleigh Turn into the Winn Dixie Shopping Plaza and turn right between McDonalds & the Winn Dixie to access our parking lot behind the Building.

Winter Park Office at Lee World Center, 1850 Lee Road Suite 215, Winter Park, FL 32789:

- From Kissimmee N. on Turnpike to EXIT 259, Take I-4 East toward Orlando/Downtown 11.4 miles to Lee Road. Take Right on Lee Road .7 miles to Lee World Center on Right.
- Take I-4 East toward Orlando/Downtown to Lee Road in Winter Park. Take Right on Lee Road EXIT 88 .7 miles to Lee World Center on Right.
- Downtown Orlando/East Orlando: Take I-4 East toward Orlando/Downtown to Lee Road in Winter Park. Take Right on Lee Road EXIT 88 .7 miles to Lee World Center on Right.
- From Daytona/Sanford/Lake Mary/Altamonte Spgs/Longwood: Take I-4 West toward Winter Park to Lee Road Exit 88. Take Left on Lee Road .7 miles to Lee World Center on Right.

East Orlando Office - UCF Area, 1850 N. Alafaya Trail Building 1-A Orlando, FL 32826

- From 408: Heading east, take the Alafaya trail exit. Head North on Alafaya Trail (SR 434) by taking a left. Cross over East Colonial Drive, and take your second left. You will have to make a U-turn right into the office complex. You've gone too far if you are at Office Suites Plus. They are right next to each other. The office faces the Radison Hotel and Office Suites Plus. You can park in the front or back.

Clermont Office-(Corner of Pearl St and Hwy 27) 100 N US Hwy 27 Unit B Minneola, FL 34715

- From Winter Garden/Ocoee/Oakland: Take Colonial/Hwy 50 West through Clermont. Head North on 27 building next to Jacks barbecue (yellow building with green awning next to Jacks Barbecue in the rear). From Downtown Clermont Minneola or Groveland: Head North on 27 building next to Jacks barbecue. Yellow building with green awning next to Jacks Barbecue in the rear Park in rear of building. Wait in the reception area until you are called.

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