WELCOME!

# Congratulations!

The hardest step with counseling is making the first appointment and you did it! Here are a few recommendations to keep your momentum so you can maximize your benefits from coaching or counseling:

**Financial Concerns:** If there are any financial issues or concerns we may be able to work with you on this.

**Calendar:** Always remember to have your calendar when you come to TLC and when you call to reschedule:

**Save time:** Having your calendar will save you time and keep you from needing to remember to call us back

**Life gets busy:** Often people forget to call back to reschedule or schedule a follow-up appointment

**Consistency:** Follow-up appointments are important in order to receive the maximum benefits from your first session!

**Canceling or rescheduling:** If you do not receive a reminder call please keep in mind the reminder is a courtesy but we need to leave it up to you to contact us at least two (2) business day prior to your appointment time if you need to reschedule

**Expectations:** Everyone has their own idea of what to expect from counseling varying from watching Dr. Phil or prior experiences. Please discuss your feelings if you feel your expectations are not being met. We can usually address this concern right away.

**Closure:** When things are going well often clients cancel their appointment before letting us know about their progress. We love to hear the good news so it's very

**Directions:**
For directions to our location, please download the maps at totallifecouseling.com/maps

**Bring Forms:**
Please remember to print out your new client registration forms and fill them out prior to your first session. Download the forms @ totallifecounseling.com/forms

Should you need further assistance or an emergency arises before we can meet, please feel free to call 407-248-0030

STRESSLESS
STRESSLESS EDUCATIONAL SERIES

StressLessSeries.com


TOTAL LIFE COUNSELING

TotalLifeCounseling.com

407.248.0030 Info@TotalLifeCounseling.com Total Life Main Office, 1507 S. Hiawassee Road, Suite #101, Orlando, FL 32835

**Individual, Family, Marriage & Group Counseling**
P: 407-248-0030
F: 407-248-0226
Satellite Locations:
Winter Park, East Orlando, Clermont & Lake Mary

**GENERAL INFORMATION**

Date: _____ How did you hear about us? _____

Full name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr _____

Name You Prefer: _____ Age: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female
Other: _____

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____

Parent/Guardian: _____

**CONTACT INFORMATION**

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes or ☐ No

Home Phone: (_____) _____ May We Leave a Message Here: ☐ Yes or ☐ No

Mobile Phone: (_____) _____ May We Leave a Message Here: ☐ Yes or ☐ No

Email Address: _____ May We Send Email Here: ☐ Yes or ☐ No

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

I prefer to be ☐ texted ☐ emailed ☐ phone call ☐ none for appointment reminders.

**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 ☐ $10,001 to $20,000 ☐ $20,001 to $40,000 ☐ $40,0001 to $50,000 ☐ $50,001 to $60,000 ☐ $60,001 to $80,000 ☐ $80,001 to $100.000 ☐ 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 or ☐ No If yes, What School: _____

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**WORK INFORMATION**

Last 5 Work or Volunteer Locations:

1. _____
2. _____
3. _____
4. _____
5. _____

**GENERAL INTEREST**

What is your goal in completing this career assessment?

_____

List any career assessments results you may have done in the past of skills training, assessments, certifications, or workshops in the past?

_____

**LIST YOUR STRENTHFINDER 2.0 STRENGTHS-** To save you time and money please purchase "new" copy of Strengthfinder 2.0 at Barnes & Nobles Business Section and use the code in the book to do the 20 minute test before your session. **BRING YOUR LOGIN TO THE COACHING SESSION TO REVIEW!**

**1.** _____ **2.** _____ **3.** _____

**4.** _____ **5.** _____

**ACTIVITIES, INTERESTS, & STRENGTHS**

What do you do in your spare time? _____

What do you do well? _____

**TERMS OF SERVICE**

*I hereby give Total Life Counseling Center permission to provide coaching or counseling services for the client mentioned above:*

Signed: _____ Date: _____

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

| Issues | Descriptions | Measurable Objectives | Interventions |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Diagnostic Impressions:

Axis I: _____

_____

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# Authorization of Release Form

Our therapists may find it helpful to consult with your attorney, doctor, school, or applicable parties regarding treatment. In order to consult we need your authorization. If applicable, please complete on for each contact.

I, _____, hereby authorize Total Life Counseling Center, 1507 S Hiawassee Rd Suite 101 Orlando, FL 32835 to:

Release information of: _____ _____
Name of Client Date of Birth

To/From:
(family, doctors, psychologist, schools, etc.) _____

Phone #/Email: _____

(Please specify if you only want to authorize for appointments and payments.)

For the purpose of: ☐ Outpatient/Inpatient Counseling ☐ Coordination with schools
☐ Coordination with MD/Psychologist/OT Therapist/Therapist
☐ Coordination with other family members

*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 (optional) _____

_____ _____
Client, Parent, Guardian Date

_____ _____
Witness Date

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# Informed Consent & Release of Liability

Name: (please print): _____

I understand the following:

1. Counseling services are provided by practitioners who 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 Mental Health Counselors, Registered Mental Health Counselor Interns (under the supervision of a License Mental Health Counselor Supervisor).
    a. **Licensed Mental Health Counselors:** Jim West, Jamie Barrett, Matthew Martin, Stephanie Booth, Adriana Carreno, Sherecka Brown, Gemima McMahon
    b. **Licensed Marriage & Family Therapist**: Lyris Steuber
    c. **Licensed Clinical Social Worker**: Dana West
    d. **Registered Mental Health Counselor Intern:** Brandon Feinberg, David Bolanos, Judy Irizarry, Chaliz Demuth, Dawn Helwig, Didem Alpaslan & Jaimie Homan
    e. **Licensed Professional Counselor:** Anna Vita
    f. **School Psychologist:** Dr. Marilyn Card
    g. **Graduate Student Intern:** Valentina Stanley
        i. A graduate student who is earning a Master's Degree in the field of counseling from an accredited graduate program and who is supervised by Licensed Mental Health Counselors by the State of Florida.

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. This 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.

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.

8. I acknowledge that I may be given the option for telehealth when in-office sessions are not available and understand that it is my responsibility to make sure I maintain my own confidentiality while doing a virtual session.

My signature below indicated that I grant informed consent for Total Life Counseling to provide counseling services to myself and or minor members of my family.

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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.

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
Total Life Counseling
1507 S. Hiawassee Road #101
Orlando, FL 32835
(407) 248-0030

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)

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|---|---|---|
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**Acknowledgement of Receipt: Privacy Practice Notice**

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I, _____ have received a copy of Total Life Counseling Center Notice of

Street Address: _____

City: _____ State: _____ Zip: _____

Client Signed: _____ Date: _____

Parent/Guardian Signed: _____ Date: _____

Witnessed Signed: _____ Date: _____