

**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 [totallifecounseling.com/maps](http://totallifecounseling.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](http://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](http://StressLessSeries.com)



[TotalLifeCounseling.com](http://TotalLifeCounseling.com)





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? \_\_\_\_\_ May we send a thank you gift?

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/Gaurdian: \_\_\_\_\_ Relationship: \_\_\_\_\_

CONTACT INFORMATION

Street Address: \_\_\_\_\_ Suite/Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ May We Send Mail Here:  Yes or  No

Mailing Address or Post Office Box: \_\_\_\_\_

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

Work 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  \$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 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?

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

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**LIST YOUR STRENGTHFINDER 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: \_\_\_\_\_

**1507 S. Hiawasse Rd Ste. 101, Orlando FL 32835**  
**Satellite Offices: Winter Park, East Orlando, Clermont & Lake Mary**



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

<b>Issues</b>	<b>Descriptions</b>	<b>Measurable Objectives</b>	<b>Interventions</b>

Diagnostic Impressions:

Axis I: \_\_\_\_\_  
\_\_\_\_\_



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. Hiawasse Road, Orlando, FL 32835 to:

\_\_\_\_\_ Release To \_\_\_\_\_ Release from \_\_\_\_\_ Exchange Written and/or Oral Communication

\_\_\_\_\_ Psychiatric \_\_\_\_\_ Medical \_\_\_\_\_ Family
\_\_\_\_\_ Psychological \_\_\_\_\_ Counseling \_\_\_\_\_ Appointments/Payments

from the records of: \_\_\_\_\_ Name of Client \_\_\_\_\_ Date of Birth

To: \_\_\_\_\_

Phone #/Email: \_\_\_\_\_

- For the purpose of: [ ] Outpatient 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 \_\_\_\_\_

Client, Parent, Guardian \_\_\_\_\_ Date

Witness \_\_\_\_\_ 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 intake is ... per hour, follow up sessions are ... per hour, or if paid by cash or check ... per hour (\$5 per hour cash or check discount) effective September 1st, 2012.
Payment methods: Checks and cash must be received before the session if sent via mail. If payment has not been received, the session must be rescheduled.
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.
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 double the therapeutic hourly rate. This would include travel expenses and time away for the office. Payment is to be made in advanced and any unused funds will be refunded.
Returned checks are subject to a \$42 fee.
A cancellation fee equivalent to the cost of the session is charged for appointments with credit/debit only that are no show or canceled without a 2-business days advance notice unless there is an emergency or illness.
Returned checks are subject to a \$42 fee

Disclosure:

Please be aware if for any reason we do not receive payment, your information may be used during a debt collection.

For your convenience, and to secure future appointments, please enter credit card information below. I authorize TLC to place my credit card information on file to charge for any applicable/outstanding fees.

(Optional) CC# \_\_\_\_\_ Exp: \_\_\_\_\_ CVC: \_\_\_\_\_

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.

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:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
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.
Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
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.
I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

By signing below, I agree to the terms above:

Signature \_\_\_\_\_ Date \_\_\_\_\_





## 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, Dr. Jada Jackson & Mayeling Angelastro
  - b. **Licensed Marriage & Family Therapist:** Dr. Leslie Hamilton & Lyris Stueber
  - c. **Licensed Clinical Social Worker:** Dana West
  - d. **Registered Mental Health Counselor Intern:** Anna Vita, Teresa Kovach, Stephanie Booth, Marilyn Card, & Jesse Ewing
  - e. **School Psychologist:** Marilyn Card
  - f. **Graduate Student Intern:** Shawn Gordon
    - i. 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.

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.

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> <li>• The right to request an amendment to your PROTECTED HEALTH INFORMATION.</li> </ul>	<p>outside of treatment, payment and health care operations.</p> <ul style="list-style-type: none"> <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: The Privacy Officer Total Life Counseling 1507 S. Hiwassee Road #101 Orlando, FL 32835 (407) 248-0030</p> <p>For more information about HIPAA or to file a complaint: 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 Total Life Counseling Center Notice of

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Client  
Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian  
Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed  
Signed: \_\_\_\_\_ Date: \_\_\_\_\_



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### DIRECTIONS

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. Hiwassee 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 Hiwassee 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 Hiwassee 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 Hiwassee Road. Take Left on Hiwassee 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 Hiwassee Road. Take Right on Hiwassee 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 1950 Lee Road Suite 115, Winter Park, FL 32789:**

- From Kissimmee: Get on FL-528 W/FL-528 Toll W in Orange County from N John Young Pkwy. Take I-4 E to FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck in Fairview Shores. Take exit 88 from I-4 E. Use the right 2 lanes to turn right onto FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck (signs for Eatonville/Winter Park). Destination will be on right.
- From Tampa: Get on I-275 N from N Florida Ave. Follow I-4 E to FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck in Fairview Shores. Take exit 88 from I-4 E. Use the right 2 lanes to turn right onto FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck (signs for Eatonville/Winter Park) Destination will be on the 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. Use the right 2 lanes to turn right onto FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck (signs for Eatonville/Winter Park) Destination will be on the right.
- From Daytona/Sanford/Lake Mary/Altamonte Spgs/Longwood: Take I-4 W toward Winter Park to Lee Road Exit 88. Take Left on Lee Road Use the right 2 lanes to turn right onto FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck (signs for Eatonville/Winter Park) Destination will be on the right.

#### **East Orlando Office – 1850 N Alafaya Trail #1A Orlando, FL 32826**

- From 408: Heading east, take the Alafaya trail exit. Head South on Alafaya Trail (SR 434) by taking a left. Cross E Colonial and it will be on the left hand side across from the race track/Bubbalous.

#### **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. We are in the same building as TV Repair next to Jack's Barbecue Wait in the reception area until you are called.

#### **Lake Mary: 1325 South International Pkwy Suite 2221 Lake Mary, FL 32746**

- From I-4 East: Take exit 98 toward Lake Mary/Heathrow. Turn slight left onto W Lake Mary Blvd. Turn left onto S International Pky. Pass through 1 roundabout.
- From I-4 West: Take exit 98 toward Lake Mary/Heathrow. Turn right onto W Lake Mary Blvd. Take the 1<sup>st</sup> left onto S International Pky. Pass through 1 roundabout.
- Follow the roundabout until the Lake Mary Professional Complex (continue in roundabout past Oakmont Community Sign). The Lake Mary Professional Complex parking lot is next to the Hyatt Place just before the Walgreens. The office is located in building #1325 near the center of the complex. You may take the elevator or stairs to the second floor. The office number is 2221. You will see our TLC signs on a few of the windows, but the door reads Scott Martin Financial (we share the office). You may come into the yellow waiting room and have a seat and your counselor will come get you at your appointment time. If you have challenges finding the office please call the TLC main number at (407)-248-0030.

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