



# WELCOME**P**ACK

**CLIENT INTAKE, INFORMATION, FORMS & RELEASES**

**ADULTS**

# Congratulations. Here are your first steps.



## KEEP IN MIND...

The hardest step with counseling is making the first appointment and you did it!

To ensure you properly navigate your engagement with Total Life Dallas, here are a few recommendations to keep your momentum so you can maximize your benefits from coaching or counseling:

### 1 Financial Concerns

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

### 2 Calendar

Always remember to have your calendar when you come to TLC and when you call to reschedule.

### 3 Save time

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

### 4 Life get busy

Often people forget to call back to reschedule or schedule a follow-up appointment

### 5 Consistency

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

### 6 Canceling & 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

### 7 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.

### 8 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 important to have that final session to celebrate your counselor!



SERVICING TEXAS WITH HQ IN DALLAS

## TLC | Dallas Telehealth services available throughout Texas!



Select your choice of Licensed Counselors or Life Coach professionals



Access your therapy online or face-to-face (Dallas only)



Work through life's challenges with real-world action plans that build your life's vision while positioning you for success.

Access therapy online from  
anywhere in the State of Texas!

VIRTUAL / IN-  
PERSON (DALLAS)

VIRTUAL IN TEXAS



**STATE OF TEXAS**

## CONTACT US

# Access Help & Resources

You should always get the help and resources you need. This is important contact information and resource lines

### Our Address

1500 Dragon St, Ste 160,  
Dallas, TX 75207

### Phone & Email

469.757.5215  
Info@TotalLifeCounseling.com

### Immediate Help & Emergency

911  
Emergency  
  
988  
National Suicide Prevention  
Hotline



**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: \_\_\_\_\_**CONTACT INFORMATION**

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ May We Send Mail Here: ☐ Yes ☐ NoHome Phone: (\_\_\_\_\_) \_\_\_\_\_ May We Leave a Message Here: ☐ Yes ☐ NoMobile Phone: (\_\_\_\_\_) \_\_\_\_\_ May We Leave a Message Here: ☐ Yes ☐ NoEmail Address: \_\_\_\_\_ May We Send Email Here: ☐ Yes ☐ NoI would like to be added to Total Life Counseling Newsletter to receive free articles, tips and resources: ☐ Yes ☐ NoI 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 ☐ No. If Yes, What School: \_\_\_\_\_**RELATIONAL INFORMATION**Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ WidowedAre 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: \_\_\_\_\_

Dallas Office: 1500 Dragon St, Ste 160, Dallas, TX 75207



If Separated or Divorced, How Long: \_\_\_\_\_ If Widowed, How Long: \_\_\_\_\_

Partner's Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. \_\_\_\_\_

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. Biological, 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 Effectuated You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Mom, Dad, Sibling, Step)	Occupation	Describe Him/Her

Do You Have a Personal Support System: ☐ Yes ☐ No. If Yes, Who: \_\_\_\_\_



**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..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Dizziness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Stomach Trouble.... <input type="checkbox"/> Past <input type="checkbox"/> Present
Visual Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Sleep Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Trouble Relaxing.... <input type="checkbox"/> Past <input type="checkbox"/> Present
Weakness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Tension..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Rapid Heart Rate... <input type="checkbox"/> Past <input type="checkbox"/> Present
Difficulty Breathing.. <input type="checkbox"/> Past <input type="checkbox"/> Present	Intestinal Trouble... <input type="checkbox"/> Past <input type="checkbox"/> Present	Hearing Noises..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Change in Appetite.. <input type="checkbox"/> Past <input type="checkbox"/> Present	Tiredness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Pain..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Hearing Voices..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Seeing Things..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Other..... <input type="checkbox"/> Past <input type="checkbox"/> 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..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Nervousness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Anxiety..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Panic..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Unhappiness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Depression..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Guilt..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Apathy..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Terminal Illness..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Recent Death..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Grief..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Hopelessness..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Inferiority Feelings.. <input type="checkbox"/> Past <input type="checkbox"/> Present	Defective Feelings.. <input type="checkbox"/> Past <input type="checkbox"/> Present	Loneliness..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Shyness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Fears..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Friends..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Marriage..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Communication..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Physical Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Emotional Abuse.... <input type="checkbox"/> Past <input type="checkbox"/> Present	Verbal Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Sexual Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Temper..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Anger..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Aggressiveness..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Bad Dreams..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Concentration..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Racing Thoughts.... <input type="checkbox"/> Past <input type="checkbox"/> Present
Unwanted Thoughts <input type="checkbox"/> Past <input type="checkbox"/> Present	Memory..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Loss of Control..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Impulsive Behavior.. <input type="checkbox"/> Past <input type="checkbox"/> Present	Self-Control..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Compulsivity..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Sexual Problems.... <input type="checkbox"/> Past <input type="checkbox"/> Present	Pregnancy..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Abortion..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Legal Matters..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Trauma..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Eating Problems.... <input type="checkbox"/> Past <input type="checkbox"/> Present
Drug Use..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Alcohol Use..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Trouble with Job.... <input type="checkbox"/> Past <input type="checkbox"/> Present
Career Choices..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Ambition..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Making Decisions... <input type="checkbox"/> Past <input type="checkbox"/> Present
Children..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Being a Parent..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Finances..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Recent Loss..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Disaster..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Smoke Cigarettes... <input type="checkbox"/> Past <input type="checkbox"/> Present



## 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?

\_\_\_\_\_

## 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 counseling services for the client mentioned above:*

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





## Victimization History

### Abuse:

Physical:

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Sexual:

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---

Mental:

---



---

Neglect:

---



---

Domestic Violence:

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Past C.P.S. Involvement:

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Potentially Abusive Behavior:

Substance	Onset	Current	Highest	Most Recent	Tolerance/Withdrawal
Alcohol					
Marijuana					
Cocaine					
Depressants					
Amphetamines					
Hallucinogens					
Opiates					
Inhalants					
K2, Bath salts, spice					
Other					
Tobacco					
Caffeine					

## 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, Main Office at 1507 S. Hiawasse Road, Orlando, FL 32835 to:

Release information of: \_\_\_\_\_

Name of Client  _____	Date of Birth  _____/_____/_____
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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 \_\_\_\_\_





### Financial Policy

#### **Payment & Fee 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 : Clients are financially responsible for their counseling sessions. And there is a \$5 per hour cash or check discount effective September 1<sup>st</sup>, 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 Administrative 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.
- 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. The retainer is a minimum of 4 hours and we will need a credit card on file in the event the court hearing goes over.
- A cancellation fee is charged for appointments with **credit/debit only** that are no show or canceled without **2-business days** advance notice unless there is an emergency or illness. The no-show fee is equivalent to your normal session fee.
- Returned checks are subject to a \$42 fee
- If a patient's appointments are being covered by PIP, we must have a credit card on file in the event that your claims are denied or benefits are exhausted. Please note that any charges not covered by the third party will be the patient's responsibility.

#### **Disclosure:**

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

**To secure your appointments, please enter credit card information below. This is a different requirement from the card used to hold initial appointment.**

I authorize TLC to place my credit card information on file to charge for any applicable/outstanding fees.

(required) 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:

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.

By signing below I agree to the terms listed above.

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



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

Issues	Descriptions & Objectives	Interventions

Diagnostic Impressions:

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



## 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 Texas
  - a. **Licensed Mental Health Counselors:** Jada Jackson, Helena Davis
  - b. **Licensed Mental Health Counselor Associates:** Shermelia Drummer, Tracy Carey, Patricia Arps
  - a. **Clinical Hypnotist:** Marina Sbrochi
1. Certified Life Coaches operate under the supervision of Dr. Jada Jackson, LMHC, LPC
  - a. **Certified Life Coaches:** Natasha Gibson, Richard & Nancy Wallace, Stacye Bowers, Twyla Ellis
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 or coach 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.

All group members agree if the therapist is sued for breach of confidentiality, the client who breached confidentiality will hold the therapist harmless from any damages including attorney fees. Consequences of breaching confidentiality may result in pressed charges by another client. Although confidentiality agreements have been signed by all group members, this does not guarantee that confidentiality will not be breached by fellow group members.

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</p> <p>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.</li> </ul> <p>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.</p> <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. Hiawassee 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 Privacy Practices.

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

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

Client

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

Witnessed

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





Oak Lawn Blvd.  
Dragon Street

**OFFICE**  
1550 Dragon Street  
Suite 160

From Downtown Dallas:  
Access **Interstate 35** then  
exit **Oak Lawn Blvd** turning  
southbound. Make a left on  
**Dragon Street**. Our Office will  
be on your left. (See photo to  
right for visual appearance of our  
Building.)



Look for our **Dark Grey Building**  
(pictured above)  
and come to the front door for access.



**TLC Dallas | Office Locator** (Click link to open your GPS):

1500 Dragon Street, Suite 160, Dallas, Texas  
75207

Phone: 469.757.5215



# Thank You

Total Life. Totally Committed to  
your mental health & wellness.

Phone: 469.757.5215

