Client Information

To make our first meeting more productive, please provide complete and accurate responses to the following. All information will be treated confidentially. If you have a question about an area, put a check mark by it and your counselor will discuss it with you during the session.

Date: ______________ Client's Full Name ____ Sex _____

Nickname __________________________ Age _____ Birthdate ________________

Home Phone: ( ) ____________________ Other Phone (cell, pager, etc.): ( ) ____________________

Address ____ City/Zip ____________________

Parents'/Guardian's Names (if under 18) ____

Employer ____ How long? ________ Type of work ________________

Work phone: ( ) ________________ Ext. _______ OK to call at work? _________

Circle last year of school completed: 6 7 8 9 10 11 12 GED College: 1 2 3 4 Other: ____________________

Person not living with you to contact in case of emergency: Name: ________________________________

Phone: ( ) ____________________ Relationship: ____________________

Marital Status: (circle current status)

Never married Engaged Living with someone Separated Divorced Widow(er) Married

How long in current status? ______________

Spouse/partner name __________________________ Age______ Occupation ____________________

How long married or living with this partner? __________ Are you happy in this relationship? ________

Number of prior marriages for you ______ For your partner ______

Household Members Names	Relationship to You	Age

If you have minor children from a previous relationship not living with you, give first names, ages, location: ________________

____

Does anyone else in your household have any major medical or emotional problems? _____ If yes explain: ________________

____

Describe your general health: Excellent ___ Good ___ Average ___ Poor ___

List all doctors that you see: ______________________________

List any ongoing medical conditions (high blood pressure, diabetes, etc.): ______________________________

List any medications you are currently taking (include dosage and purpose): ______________________________

Have you ever been hospitalized in a mental health or substance abuse treatment facility? ______ If so, give reason, dates, and name of facility: ______________________________

If you have been to counseling before, list reason, dates, and name of counselor: ______________________________

If you are currently involved in any type of counseling or support groups, please specify: ______________________________

Circle your current use of alcoholic beverages: Never Occasionally Once per week Several times per week Daily

Describe any other current drug use ______________________________

Circle any losses you have experienced within the last 18 months:

Death of: Spouse Child Parent Sibling Grandparent Friend Pet

Divorce Separation Broken engagement Change of school Suicide of loved one Miscarriage Abortion

Infertility Bankruptcy Homelessness Career or job loss Other ______________________________

Circle any of the following that you have experienced:

Child abuse: physical, sexual, emotional. Spouse abuse: physical, sexual, emotional. Abandonement Rape Robbery

Assault Suicide attempt Major accident Major surgery Other ______________________________

Circle any of the following that concern you now:

Relationship with: Spouse Boyfriend/Girlfriend Children Parents In-laws Co-workers Friends Teachers

Alcohol Drugs Eating habits Shopping Overwork Weight Procrastination Sleep Sex Anger Depression

Grief Anxiety Loneliness Low self-esteem Stress Fear Mood swings Spirituality Suicidal thoughts

Other ______________________________

______________________________ ____________

Client signature Date

HELEN CHOATE, M.S., LMHC

HIPAA PATIENT CONSENT
FOR
NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my **protected health information** (PHI) to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of this practice.

You have the right to:

- Request restrictions on the disclosure of your PHI as provided by law, however, the practice is not obligated to agree to any requested restrictions. If there is agreement, the practice is then obligated to abide by the agreed restrictions.
- Inspect a copy of your PHI. Your PHI does not include the therapist's "psychotherapy notes." "Psychotherapy notes" means notes recorded by the therapist during a private counseling session and that are separated from the rest of the individual's medical record.
- Amend your PHI in our practice records.
- Receive confidential communications of your PHI from the practice by alternative means or at alternative locations.

PLEASE NOTE: The practice asks if you wish to exercise any of the rights enumerated above that you put your request in writing and deliver it to the practice location. If you have any questions about this information, please contact the Compliance Officer, Helen Choate, and she will entertain your request.

I have also been informed of, and given the right to review and secure a copy of Helen Choate's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and I may contact you at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at anytime. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ___________ day of ______________________, 20________.

Print Patient Name: ____

Signature of Patient: ____

Relationship to Patient: ____

CONSENT FOR SERVICES

I the undersigned client AND/OR I a parent or guardian of the client hereby authorize Helen Choate, LMHC to administer mental health and/or substance abuse treatment to the below named client.

I understand that this consent can be revoked orally or in writing prior to or during the treatment period at which point treatment would cease and an appropriate referral would be provided to me. I acknowledge that no guarantees or assurances as to the results of treatment are made or implied.

I understand that I am personally responsible for the costs of all therapy services rendered and the costs of treatment will be discussed with me. I also understand that payment for services is expected at the time services are rendered.

I have read and/or fully understand the above consent for services.

Date of Consent ______________

Client Name ________________________________ Client Signature ____________________________________

Parent/Guardian Signature (for minors) ____________________________________

Please answer the following to help us serve you better:

How did you learn about our center or who referred you here? ______________________________________

____

Briefly explain why you are pursuing counseling: ____

____

What do you want to gain from counseling? ____

____

Helen Choate, LMHC

Important Information for Clients

As a client, you have the right to be treated with respect and dignity, to be treated by qualified professionals and to be treated in privacy. You have the right to have answers to your questions and to know about the treatment process. You have the right to have your written records and all information about you known by your therapist held in strictest confidence. However, your therapist may reveal confidential information about you under any of the following conditions:

a. If you sign a Release of Information Form, information can be shared with the person or agency that is designated on the form.
b. Even without a release, a court may order your therapist to reveal information about you.
c. By law, all suspected cases of the abuse and neglect of a child, elderly person or handicapped person must be reported to the Department of Children and Families.
d. If you threaten to harm yourself or another person, your therapist may reveal information as necessary to protect you or the other person.
e. Your therapist will gladly discuss their background and qualification with you. Furthermore, all therapists licensed in Florida are under the supervision of the Department of Health. To verify their licensure or register a complaint which you cannot resolve with your therapist, you may contact:

Florida Department of Health
Board of Clinical Social Work, Marriage and Family Therapy,
and Mental Health Counseling
4052 Bald Cypress Way, Bin #C08
Tallahassee, Florida 32399-3258 Phone: (850) 245-4474

As a Client, you will be expected to:

a. Arrive on time for your scheduled appointments. If you arrive late, your session may still need to end at the appointed time so others can begin their time. In that case, you would still be responsible for the cost of your entire session. Therapy sessions are usually 50 to 60 minutes.
b. To provide at least 24 notice if you need to cancel or reschedule. There will be a $25.00 no show fee if you miss your appointment unless indicated by your therapist.
c. Call and stay home if you are ill or have a cold or fever or are in quarantine.
d. To pay for services at the end of each session. If we are billing your insurance company, you still are expected to pay co-pays. You are responsible for any fees the insurance company doesn't pay.
e. All paperwork is to be filled out as required by the therapist. If you refuse to do so, the therapist has the right to not accept you as a client.
f. Pay your co-pay over the phone by credit card if you have a Virtual Appointment scheduled.

I understand and have read the above:

____

Client Signature Date: Parent/Guardian

INSURANCE CONSENT

I understand that I am personally responsible for the costs of services not covered by my insurai including but not limited to unmet deductibles, co-payments, and any fees or portions of fees not paid b insurance carrier. I understand that these fees are due at the time of service.

I hereby choose to have my insurance company billed for these services. Benefits due to me un below policy are hereby assigned to Helen Choate, LMHC **I understand that specific diagnostic and treatment information will be required by my insurance company. I consent to the release of all requested confidential information to billing services and insurance companies for the purpose o processing my claims.** I understand that Helen Choate, LMHC cannot be responsible for confidential information once it is released to others.

Client Name ____

Client Signature ______________________________________ Date ____________

Signature of person responsible if other than client ______________________________

Insurance Co. _________________________________ Phone (_____) ____________

Policy # ______________________________________ Group # ______________

Please allow the office manager to make a copy of your insurance card

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Many managed care insurance companies request that we inform your primary care physician (I about your treatment here. We will not release this confidential information without your consent. Ple know of your preference by checking 1 or 2 and signing below.

1. ___ I choose to have confidential information released to my PCP. My PCP's name and address are:

   ____

2. ___ I choose not to have confidential information released to my PCP because: (check all that apply)

   ___ I do not have a PCP or do not see him regularly

   ___ I do not want my PCP informed about my treatment here

   ___ I am concerned about the security of information released to my doctor's office

   ___ I would rather have my treatment information released to another doctor (e.g. my psychiatri instead of my PCP. The doctor's name and address are: ______________________

   ____

Client Signature ______________________________________ Date ____________

Signature of person responsible if other than client ______________________________

HELEN CHOATE, LMHC