Life Transformation Counseling

Client Information

Client Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ OK to leave message: yes or no (circle one)

Cell Phone: _____ OK to leave message: yes or no (circle one)

Date of Birth: _____ Sex: Male or Female (circle one)

OK to send mail to home address: yes or no (circle one)

Employer: _____

Marital Status:_____ Anniversary:_____

Email Address: _____OK to Email: yes or no (circle one)

****If counseling is for a child/teen under the age of 18 both parents/all guardians must sign all paperwork.***

How did you hear about the counseling center? _____
Referred By: _____

Guardian /Responsible Party Information and Emergency Contact

Guardian/Emergency Contact Name: _____
Relationship to client: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ OK to leave message: yes or no (circle one)
Date of Birth: _____ Sex: Male or Female (circle one)
Email Address:_____ OK to Email yes or no (circle one)
Marital Status: _____

**** If divorced, do you have legal custody or shared custody? (circle one) Please supply Court Documentation for the file supporting your answer.***

FOR GUARDIANS REGARDING TEENAGE CLIENTS:
Is your teenager authorized to schedule and attend counseling appointments without your confirmation and/or acknowledgement? yes or no (circle one)

In a few words, please describe your main concern or reason for seeking Counseling:

_____
_____
_____
_____
_____

Please list below all past and present counselors, therapists, psychologists, psychiatrists, social workers or any other mental health specialists you have seen in the past 10 years for any type of treatment.

Name:_____Phone:_____Dates:_____

Name:_____Phone:_____Dates:_____

Name:_____Phone:_____Dates:_____

Please also list any additional physicians you are currently seeing.

Physician Name and Phone Number	**Reason**

By signing below I attest that previous written information is correct to the best of my knowledge.

_____ _____

Client Signature Date

Life Transformation Counseling

We require all clients to keep a credit card on file.

The credit card will **only** be used in instances where an appointment is cancelled or no-showed outside the parameters of the **24 hour cancellation policy**. Please note, reminder calls are a courtesy and keeping appointment times is the responsibility of the client. If an appointment is missed the client will be billed for that session.
Your credit card is part of your file and is therefore handled with **complete confidentiality**.

We thank you for your understanding in this matter. If you have any questions, please feel free to speak with Director Natalie Southward.

By signing below you understand the cancellation policy:

_____ _____
Client Signature Date

Credit Card Number: _____Exp._____

CVV Code (3-4 digits on back of card): _____

Billing Address (including zip):
_____

Payment in full is due prior to going into session with the counselor. Please note, our accepted forms of payment are: cash, credit/debit cards, and checks. We regret that we cannot hold payment or post date checks, payment is due at the time services are rendered.
Thank you!

Life Transformation Counseling

3036 W. Bearss Ave
Tampa, FL 33618

Consent to Treatment

This form is to document that I, _____, give my permission and consent to Life Transformation Counseling/Natalie Southward to provide counseling to me and/or _____ who is/are my spouse/child(ren)/_____.

While I expect benefits from this treatment I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed. I understand that because of the counseling or therapy, I/he/she/we may experience emotional strains, feel worse during treatment, and make life changes which could be distressing. _____ **Initial**

I understand that this therapist is not providing an emergency service and I have been informed of whom to call upon in an emergency or during weekend and evening hours. I understand the counselor is a consultant and a professional resource only, Intervention may be freely accepted or rejected by the client, therefore, decisions made during and after counseling are the responsibility of the client. I understand that regular attendance will produce the maximum benefits but that I/we the client am/are free to discontinue treatment services at any time. _____**Initial**

I understand that conversations with the therapist will be confidential except as allowed by the Privacy Policy of Life Transformation Counseling. *However*, I understand there are limits to confidentiality based on payment methods, wireless and electronic communication that I elect to utilize. I *further understand* that Florida law requires any therapist who has reasonable cause to suspect child or elder abuse, neglect and abandonment/exploitation to report such knowledge to the appropriate authorities. I *also understand* that Florida law allows the confidentiality between the therapist and client to be waived when there is a clear and immediate probability of physical harm to the client, to other individuals, or to society and the therapist communicates the information only to the potential victim, appropriate family members, law enforcement or other appropriate authorities. _____**Initial**

Telephone & Emergency Procedures: I am aware that if I need to contact the center, the offices answering system will receive my call 7 days a week, 24 hours a day. When calling, I will leave my name and telephone number where I can be reached for a return phone call. I understand that phone calls will be returned within a 24-hour business day period. If an emergency arises, I will hang up and call 9-1-1 or 2-1-1 for further assistance. _____**Initial**

I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by third parties. I also understand that I am expected to pay for the counseling fees at the time of the visit and any arrangement for payments by third parties will be made before the counseling session. I understand that receipts will be provided for at each request. I understand that Life Transformation Counseling requires a credit card to be kept on file. _____**Initial**

I understand that the appointment with a counselor is, in a sense, a contract whereby the client has exclusive use of the counselor's time for the scheduled appointment. I also understand that the client is held responsible for the fee for all cancelled appointments; to avoid paying for cancelled appointments, The credit card that is kept on file will be charged for the cancelled appointment. The undersigned agrees to call Life Transformation Counseling 24 hours before the date of the appointment. If the cancellation is done at least *24 hours in advance* of the appointment, there will be no charge for the cancellation. Appointments are *50 minutes* in length unless otherwise agreed upon with the counselor. _____ **Initial**

Missed Appointments- If you do not attend you scheduled appointment, it is considered a "no show." No Shows will result in a full service charge fee. The credit card that is kept on file will be charged for the "no show." _____ **Initial**

I know of no reasons I/he/she/we should not undertake this therapy and I/he/she/we agree to participate fully and voluntarily.

I _____ **(Initial)** have received the Notice of Privacy Practices of Life Transformation Counseling and I agree to read it and discuss any questions I may have with my therapist. I understand and agree that this consent form will remain valid subsequent to my reading the notice unless I advise otherwise.

Signature: _____ Date: _____
(Of client or person authorized to consent for client)

Signature: _____ Date: _____
(Of client or person authorized to consent for client)

Life Transformation Counseling

Acknowledgement of Notice of Privacy Practices

Client Name: _____

Date: _____

I acknowledge receiving a copy of the HIPAA Notice of Privacy Practices for Life Transformation Counseling, which was effective on July 1, 2013.

_____
Client Signature

_____
Client's Legal Representative

_____
Relationship/Authority to sign for Client
(attach a copy of authority document if not already in Client chart)

This acknowledgment is to be retained in client record.

Internal Use Only

Staff: If this acknowledgment is not signed, provide a description of your efforts to obtain client's signature, and the reason(s) why a signed acknowledgement was not obtained:

_____

_____

_____

_____

Staff Name: _____

NOTICE OF PRIVACY PRACTICES
FOR LIFE TRANSFORMATION COUNSELING

PLEASE REVIEW IT CAREFULLY. THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

THIS NOTICE IS EFFECTIVE ON JULY 1, 2013

This Notice describes the privacy policies of Life Transformation Counseling, and applies to counselors, employees, staff and other personnel who provide services at Life Transformation Counseling. The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by the terms of this notice. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

This notice applies to any information in our possession that would allow someone to identify you and learn something about your physical or mental health. It is intended to describe the policies that protect information relating to your past, present and future physical or mental conditions, counseling, and payment for that counseling (Protected Health Information or "PHI"). It does not apply to information that contains nothing that could reasonably be used to identify you.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your PHI.
- We are required to provide this notice of our privacy practices to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

HOW WE MAY USE OR DISCLOSE YOUR PHI.

We may use your PHI, or give it out to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. Any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

Treatment. We will use your PHI to provide you with counseling and related services. This means that our employees and staff and others who work under our direct control may read or discuss your PHI to learn about your physical or mental condition and use it to make decisions about your counseling plan or other care. For instance, a counselor may read your chart in order to counsel you properly, or may discuss your situation with other counselors to better our counseling to all clients. We will also give your information to others who need it in order to provide you with physical or mental treatment or services. For instance, we may share your PHI with your mental health providers.

Payment. We will use your PHI, and disclose it to others, as necessary to obtain payment for the services we provide to you. For instance, an employee in our business office may use your PHI to prepare a bill. And we may send that bill, and any PHI it contains, to your insurance company. We may also disclose some of your PHI to companies with whom we contract for payment-related services. We may give information about you to a health plan that pays for your benefits. We will not use or disclose more information for payment purposes than is necessary.

Operations. We may use your PHI for activities that are necessary to operate this organization. This includes reading your PHI to review the performance of our counselors or staff. We may also use your information and the information of other patients to plan what services we need to provide, expand, or reduce. For example, we may disclose your PHI to a company that assists us with quality assurance. We may disclose your PHI as

necessary to others who we contract with to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants, for instance.

To Business Associates. We may hire third parties that may need your PHI to perform certain services on behalf of Life Transformation Counseling. These third parties are "Business Associates" of Life Transformation Counseling. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, Life Transformation Counseling.

Family and Friends. We may disclose your PHI to a member of your family or to someone else who is involved in your counseling or payment for counseling. We may notify family or friends if you are in the hospital, and tell them your general condition. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to such family or friends that you object to in writing. We may also disclose to your personal representatives who have authority to act on your behalf (for example, to parents of unemancipated minors or to someone with a power of attorney).

Public Health Oversight. We may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; licensure or disciplinary actions (for example, to investigate complaints against health care providers); inspections; and other activities necessary for appropriate oversight of government programs (for example, to investigate Medicaid fraud).

To Report Abuse. We may disclose your PHI when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your PHI, and the information of others, if we are audited by Medicare or Medicaid.

Law Enforcement. We may disclose your PHI for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your PHI to a federal or state agency investigating our compliance with applicable privacy regulations.

For Lawsuits and Disputes. We may disclose PHI in response to an order of a court or administrative agency, but only to the extent expressly authorized in the order. We may also disclose PHI in response to a subpoena, a lawsuit discovery request, or other lawful process, but only if we have received adequate assurances that the information to be disclosed will be protected.

Specialized Purposes. We may disclose your PHI for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security and intelligence purposes. We may disclose the PHI of members of the armed forces as authorized by military command authorities. We also may disclose PHI about an inmate to a correctional institution or to law enforcement officials to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your PHI to your employer for purposes of workers' compensation and work site safety laws (OSHA, for instance). We may disclose PHI to organizations engaged in emergency and disaster relief efforts.

To Avert a Serious Threat. We may disclose your PHI if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Research. We may disclose your PHI in connection with medical research projects if allowed under federal and state laws and rules. Life Transformation Counseling may disclose PHI for use in a limited data set for purposes of research, public health or health care operations, but only if a data use agreement has been signed.

Information to Patients. We may use your PHI to provide you with additional information. This may include sending you appointment reminders via phone or e-mail/internet. This may also include giving you information about treatment options or other services that we provide.

YOUR RIGHTS

Authorization. We will ask for your written authorization if we plan to use or disclose your PHI for reasons not covered in this notice. If you authorize us to use or disclose your PHI, you have the right to revoke the authorization at any time. If you want to revoke an authorization, send a written notice to the Privacy Official listed at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have already given out your information or taken other action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

Request Restrictions. You have the right to ask us to restrict how we use or disclose your PHI. We will consider your request, but we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

Confidential Communication. You have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send mail to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your PHI by mail. We will not ask you to explain why you are making the request. We will agree to reasonable requests.

Access to and Copies of PHI. You have a right to access the PHI about you that we have in our records. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes counseling summary and billing records. We may charge a fee for the cost of copying and mailing the records, to the extent allowed by state and federal law. To ask to inspect your records, or to receive a copy, send a written request to the Privacy Official listed at the end of this notice. Your request should specifically list the information you want copied. We will respond to your request within a reasonable time, but no later than 30 days. We may deny you access to certain information, including certain psychotherapy notes; If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

Amend PHI. You have the right to ask us to amend PHI about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your PHI to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must request this list in writing. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before July 1, 2013. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or operations; disclosures for national security purposes; certain disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed at the end of this notice.

Complaints. You have a right to complain if you think your privacy has been violated. We encourage you to contact our Privacy Official. You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

OUR RIGHT TO CHANGE THIS NOTICE.

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any PHI which we already have, as well as to PHI we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. We will post the new notice in our reception area. The new notice will include an effective date.

CONTACT THE PRIVACY OFFICER FOR MORE INFORMATION

If you have any questions regarding this Notice or if you wish to exercise any of your rights described in this Notice, you may contact the Privacy Official at:

Natalie Southward
Life Transformation Counseling
3036 W Bearss Ave
Tampa Fl 33618

Copies of this notice are also available at the front reception desk.