Tina Saunders, LMHC, CAP
600 S.W. 3rd Street, Suite 6121C
Pompano Beach, FL 33060
(954) 347-0651

POLICY AND PROCEDURES

Consent for Treatment, Authorization for Payment, Cancellation Policy

I hereby consent to psychological treatment therapy (individual/family/group) with Tina Saunders, LMHC (MH8071).

As with any powerful treatment, there are some risks, as well as benefits, involved with therapy. I acknowledge that I have been thoroughly informed about these benefits and risks (like, recalling unpleasant memories, experiencing feelings of sadness, guilt, or anger, etc.). These and other risks are to be expected when people are making considerable changes in their lives and I understand that it is my responsibility to cooperate with the treatment to the best of my ability. I understand Florida State, Federal law and professional ethical standards provide for the confidentiality of psychotherapist, including records. {This therapist and office will not disclose or confirm your use of services at this office. Lawful and legally required exceptions to this privilege of confidentiality are stated in the Limits of Confidentiality form.

Initial _______

I understand that payment in full is **due and payable at the time services** are rendered. Initial _______

A copy of the HIPAA Notice of Privacy Practices has been made available to me. Initial ________

A copy of Limits of Confidentiality has been made available to me. Initial ________

Because time has been reserved for me and/or members of my family, I understand that, except in a true emergency, I am expected to provide at least 24 hours advanced notice if I am unable to keep a previously scheduled appointment. ***IN THE EVENT THAT I DO NOT PROVIDE NOTICE AT LEAST 24 HOURS PRIOR TO CANCELING AN APPOINTMENT, I UNDERSTAND THAT I WILL BE CHARGED THE NORMAL FEE.***

Initial ________

I have had all my questions answered fully about the therapy and its fees. I do hereby seek and consent to take an active role in this therapeutic intervention and acknowledge that there have been no promises made to me as to the results of the therapy or of any procedures provided.

I hereby understand and agree with the above statements.

Client Name: (print) ___________________________________ Date: __________________

Signature: ____

I, Tina Saunders, LMHC, have thoroughly discussed the above issues with my client. My observation of this person's behavior and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent.

Therapist: ____ Date: ________________
Tina Saunders, LMHC

This is a strictly confidential medical record. Law expressly prohibits re-disclosure or transfer.

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____________________________________ ____________________
Client's Signature Date

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CLIENT INFORMATION

Name: ___________________________________ Date of Birth: __________________

Address: _________________________________ City: ________________________

State: _________________ Zip Code: _________________

Home Phone: ________________________ Cell Phone: __________________________

E-mail Address: _______________________________

Emergency Contact: __________________________ Relationship: __________________

Phone Number: __________________________

Referred by: ____

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Client: ___________________________________ Date of Birth: _________________

BIO-PSYCHOSOCIAL ASSESSMENT

Gender: ❑M ❑F Age: ____________ Marital Status: ___________________

Reason for therapy: ____

____

____

The presenting problem has affected which of the following area's in your life: ❑Relationships with self and/or family ❑Work or school performances ❑Legal problems ❑Other: (specify) ______________________________	**Have you had previous therapy?** ❑Yes ❑No If yes, when and how long? ______________________ ____ ____

Do you have any substance abuse history? ❑Yes ❑No If yes, please answer the following questions:

What was your drug(s) of choice? ____

When was the last time you used? ____

Medical Conditions & Complications

Do you have any major medical problems (past and/or present)? Have you ever been hospitalized for medical problems (what year and what for)? ____

____

List any medications you are currently taking: ____

____

Have you ever been hospitalized for psychiatric problems? ❑Yes ❑No If yes, when, what for and how long?

____

____

Have you ever had...

❑ suicidal thoughts? (when and how long) ____

❑ suicide attempts? (when and how) ____

❑ a suicide plan? (explain) ____

How would you rate your current physical health? ❑Poor ❑Unsatisfactory ❑Satisfactory ❑Good ❑Very good

How would you rate your current sleeping habits? ❑Poor ❑Unsatisfactory ❑Satisfactory ❑Good ❑Very good

Are you experiencing any abnormal appetite or eating patterns? ❑Yes ❑No If yes, please specify.

____

Abuse History / Issues

Have you ever been a victim of the following abuse(s)?	Have you ever been a perpetrator of the following abuse(s)?
❑No ❑Yes (check all that apply)	❑No ❑Yes (check all that apply)
❑Physical	❑Physical
❑Sexual	❑Sexual
❑Emotional / Verbal	❑Emotional / Verbal
❑Spiritual	❑Spiritual
❑Neglect	❑Neglect
❑Exploitation (financial or other)	❑Exploitation (financial or other)

Have you ever had counseling in reference to the abuse you experienced? ❑Y ❑N

Has there been any domestic violence in your family growing up? ❑Y ❑N

Do you have any history of domestic violence either as a victim or as the abuser? ______________________

____

Family History & Environment

Home Environment: (check all that apply) ❑Live alone ❑Live with spouse / partner ❑Live with children ❑Live with parents ❑Other: (please specify) ______________	Who has been the most important adult in your childhood: ______________________ Are there any crucial family issues? ______________________ ______________________
Birth Order: ❑Youngest child ❑Middle child ❑Oldest child **Number of siblings:** ❑Brother(s): -age- ______________ ❑Sister(s): -age- ______________	**Significant losses:** (death, divorce, job, etc.) ______________________ ______________________ ______________________ ______________________ ______________________

Family History

	Father / Stepfather	Mother / Caretaker	Siblings	Spouse / Partner
Alcohol / Drug Abuse				
Mental Illness				
Major Medical Issue				

Do you have any children? ❑Y ❑N If yes, how many, what gender, and what ages?

____

____

Relationships

Martial Status:	Current Relationship:	What is your perception of your current relationship?
❑Married # of times: _______ ❑Single ❑Committed relationship ❑Divorced ❑Separated ❑Widowed	How long? _________	______________________ ______________________ ______________________

Describe how you and your partner generally resolve arguments: ______________________________

____

Educational & Vocational

What is your highest level of education?	Do you have any learning disabilities? (If yes, specify)
❑Below high school ❑High school or GED (circle one) ❑Some college ❑Bachelor's Degree (major): ____________________ ______________________ ❑Master's Degree (major): ____________________ ______________________ ❑Other: ______________________	❑Y ❑N ______________________ **What is your work status?** ❑Employed ❑Homemaker ❑Employed part-time ❑Student ❑Not in labor force ❑Disabled (nature of disability): ____________________

Military Service: ❑Y ❑N What type and how long? ______________________________

Employment History

(last 2 jobs)

Job Title	Company	Length of Employment	Reason No longer Working There

Do you enjoy your work? ❑Yes ❑No

Is there anything stressful about your current work? ______________________________

____

Sexual History

Current sexual activity: ❑Active ❑Abstinent ❑Active, not interested ❑Interested, but not active **Recent change in interest or behaviors:** ❑None ❑Increased ❑Decreased **Orientation:** ❑Heterosexual ❑Homosexual ❑Bisexual	**Are there any problems related to sexual functioning or sexuality?** ____________________ ____________________ ____________________

Name three strengths you believe you have: ____

____

Name three weaknesses you believe you have: ____

____

What type of coping skills do you use if you are depressed, anxious, fearful, etc.?

____

____

Religious and Cultural Interests

Do you have any religious/spiritual preference? ❑Yes ❑No If yes, please describe: ____________________

____

Is a religious belief a source of hope and strength for you?

❑Always ❑Most of the time ❑Sometimes ❑Not at all

Do you attend religious services? ❑Weekly ❑Major holidays only ❑Whenever possible ❑Never

What culture do you identify with? ____

Do you feel your cultural practices have an impact on your life? ❑Yes ❑No If yes, please describe:

____

____

How often do you pray? ❑Daily ❑Never ❑Occasionally

Do you feel life has meaning and purpose?

❑Always ❑Most of the time ❑Sometimes ❑Not anymore ❑Never

Do you feel God has treated you unfairly? ❑Never ❑Occasionally ❑Most of the time ❑Always

How often do you think about death? ❑Never ❑Occasionally ❑Daily

Are you currently experiencing overwhelming sadness, grief or depression? ❑Y ❑N If yes, for approximately how long?

____

Are you currently experiencing anxiety, panic attacks or have any phobias? ❑Y ❑N If yes, when did you begin experiencing this? ____

DIAGNOSIS

AXIS I ____

____

____

AXIS II ____

AXIS III ____

AXIS IV ____

AXIS V **GAF:** ____________

FLORIDA HIPPA POLICY

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health care information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, the following are some definitions.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization' is written permission above and beyond the general consent that permits only specific disclosure. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes, "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent and Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse. If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.

Adult and Domestic Abuse. If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

Health Oversight. If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, The Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings. If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization or you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance in this case.

Serious Threat to Health or Safety. When you present a clear and immediate probability or physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

Worker's Compensation. If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

1. *Right to Request Restrictions*. You have the right to restrictions on certain uses and Disclosures or protected health information about you. However, I am not required to agree to a restriction you requested.
2. *Right to Receive Confidential Communications by Alternative Means and at Alternative Means and* at *Alternative Locations*. You have the right to request and receive confidential communications of **PHI** by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a psychologist. Upon your request, I shall send any mailings to another address.)
3. *Right to Inspect and Copy*. You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the request process.
4. *Right to Amend*. You have the right to request an Amendment of PHI for as long as the **PHI** is maintained in the record. I may deny your request. On your request, I shall discuss with you the details of the amendment process.
5. *Right to an Accounting*. You generally have the right to receive an accounting of disclosures of **PHI** regarding you. On your request, I shall discuss with you the details of the accounting process.
6. *Right to a Paper Copy*. You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

1. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to **PHI.**
2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently I effect.
3. If I revise my policies and procedures, I shall provide individuals with a revised notice during their session or by mail within 60 days, and subsequent to any request made by you when you are no longer in treatment with me pertaining to the release of any information or consultation with an outside person or agency.

V. Business Associates

I may rely, depending on the circumstances, on certain persons or entities, who are not my employees, to provide services on my behalf. These persons might include lawyers, billing services, collection agencies and credit card companies. Where these persons or entities perform services, which require the disclosure of individually identifiable health information, they are considered under the Privacy Rule to be my business associates. I enter into a written agreement with each of my business associates to obtain satisfactory assurance that the business associate will safeguard the privacy of the PHI of my patients I rely on my business associates to abide by the contract, but will take reasonable steps to remedy any breach of the agreement that I become aware of. If my attempt to remedy the breach is not successful, then 1 will terminate the contract, or if termination is not feasible, I will report the problem to the Department of Health and Human Services.

VI. Complaints

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me (as above). You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed at the outset can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VII. Effective Date Restrictions and Changes to Privacy Policy

I will limit, i.e., deny, the disclosures that I make when your request to access copies of either your or your child's psychotherapy notes may, in my professional opinion, pose harm to you or you child's mental health. Such denials to access may be considered final and not reviewable by another licensed health care professional typically designated as a reviewing official with respect to other conditions (see below). I may also deny access to records when information is compiled in reasonable anticipation of, or for use, in a legal or administration action of proceeding, and when someone other than a health provider provides information about you or your child under a promise of confidentiality and the access to the requested information would be reasonably likely to reveal the source of the

information. However, you may request and are entitled to a review of my denial by another licensed health care professional for access to other information contained in your medical records when I deny access if: 1) in the exercise of my professional judgment I determine that access to the record is "reasonably likely to endanger the life or physical safety" of you, the patient, or another person: 2) the requested information makes reference to another person (other than another health care provider) and in the exercise of professional judgment I determine that access is 'reasonably likely to cause substantial harm" to this person; or 3) a personal representative for you or the patent has requested access to the record and in the exercise of professional judgment I determine that such access is "reasonably likely to cause substantial harm" to the you, the patient or another person.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by face-to-face verbal explanation and written notice in person or via mail within 60 days.