FLORIDA
COUNSELING CENTERS
Family Services

PHONE: 321-259-1662
FAX: 321-259-1223

Patient

Last Name: _____ First Name: _____

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

Home Phone: ( ) _____ Work Phone: ( ) _____

May we leave a message? Yes or No (Circle One) May we leave a message? Yes or No (Circle One)

Cell Phone: ( ) _____ Cell Phone: ( ) _____

May we leave a message? Yes or No (Circle One) May we leave a message? Yes or No (Circle One)

Email Address: _____

May we contact you via email? Yes or No Would you like to be added to our newsletter mailing list? Yes or No

DOB: Sex: Marital Status:

Social Security Number: _____

Person Responsible for Payment: _____

Relationship to Insured: **Self** **Spouse** **Child** **Other**

Insured

Name of Insured: _____ DOB: _____

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

Home Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____ Work Phone: ( ) _____

Name of Primary Insurance Company: _____

Policy Number or ID Number: _____

Group Number: _____

Is there Secondary Insurance?: _____ Name of Secondary Insurance Company: _____

Policy Number or ID Number: _____

Group Number: _____

I authorize Florida Counseling Centers to bill the above insurance company on my behalf:

_____ _____

Signature Date

1299 BEDFORD DRIVE, SUITE A
MELBOURNE, FL 32940
WWW.FLORIDACOUNSELINGCENTERS.COM

FLORIDA
COUNSELING CENTERS
Family Services

PHONE: 321-259-1662
FAX: 321-259-1223

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ AUTHORIZE **FLORIDA COUNSELING CENTERS**
(Name of client)

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

O Information related to the scheduling of meetings or other appointments

O Information related to billing and payment
O Completed forms, including forms that may contain sensitive, confidential information
O Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
O My health record, in part or in whole, or summaries of material from my health record
O Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:
O Unsecured email.
O SMS text message (i.e. traditional text messaging) or other type of "text message."
O Other media. Describe: _____.

CONDITIONS REGARDING EMAIL AND TEXTING
· E-mail or texts should **not** be used for emergencies or issues that must be handled quickly.
· If you do not receive a response to an e-mail or text, you are responsible for calling your provider to follow up.
· If additional follow-up is needed, you must call and/or schedule an office visit.
You are in control of e-mails and texts sent to you by FCC. FCC is not responsible if you let others access your information.

TERMINATION
O This authorization will terminate _____ days after the date listed below. **OR**
O This authorization will terminate when the following event occurs: _____. **OR**
O This authorization will terminate when/if I provide a termination of this authorization in writing.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____
(Signature of client) Date

1299 BEDFORD DRIVE, SUITE A
MELBOURNE, FL 32940
WWW.FLORIDACOUNSELINGCENTERS.COM

FLORIDA
COUNSELING CENTERS
Family Services

PHONE: 321-259-1662
FAX: 321-259-1223

PRIMARY CARE PHYSICIAN (PCP) AUTHORIZATION FORM

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (Print): _____

By signing this form , I understand that I hereby request and authorize Florida Counseling Centers to release and receive verbally or in writing my protected health information, as needed for treatment, to the following primary care physician:

PCP Name: _____

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

I understand I may revoke this authorization at any time by providing written notice to Florida Counseling Centers. I also understand that such a revocation will have no effect on any information already used or disclosed by Florida Counseling Centers prior to receipt of such notice. Unless earlier revoked, I would like this authorization to expire as specified:

_____

I understand this authorization is voluntary and I may refuse to sign this form. I understand that I am not required to sign this form to receive treatment from Florida Counseling Centers. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described above with the primary care physician listed.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Patient or Representative Date

1299 BEDFORD DRIVE, SUITE A
MELBOURNE, FL 32940
WWW.FLORIDACOUNSELINGCENTERS.COM

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____
4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____
5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____
6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____
7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____
10. Did a household member go to prison
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

FLORIDA
COUNSELING CENTERS
Family Services

PHONE: 321-259-1662
FAX: 321-259-1223

To be completed by parent or guardian requesting services for a minor youth

*Note: Information requested on this questionnaire will be helpful in understanding your youth. Feel free to add as much information as you think is helpful in understanding the background and nature of the problem. We maintain the highest standards of professional confidentiality. Information about any particular individual can be released only with the written consent of that person, or in the case of a minor, his or her parent or guardian.

Today's date _____ Name of Youth _____

Age _____ Date of Birth _____

Parent's Name _____

Who referred you? _____

Describe the problem. If possible, list questions for which answers are sought _____

_____

_____

_____

Have there been any previous psychological, psychiatric or neurological evaluations? _____

if so, please list names, addresses and date of contact _____

_____

_____

_____

MEDICAL HISTORY: List all major illnesses, operations and injuries, past or present. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, or had convulsions, or was delirious, or head a very high fever

_____

_____

_____

Indicate any continuing medication treatment _____

_____

_____

Allergies? _____

How is child's vision? _____

Hearing? _____

Describe any difficulty pronouncing words or speaking _____

_____

Describe previous speech or hearing therapy, if any _____

_____

Describe any problems with awkwardness or clumsiness _____

_____

When did your child last have a physical examination? _____

Name of physician _____Address _____

_____

DEVELOPMENTAL HISTORY: While some of this information might seem "out of date," it may be helpful in evaluating your child comprehensively.

Did pregnancy with this child proceed typically? _____

Were there any complications during or immediately following the delivery? _____

How did the first year go? _____

Colic? _____ Feeding problems? _____

Please describe any difficulty with or concern about developmental milestones, such as walking, talking, toilet training or other _____

_____

CURRENT FUNCTIONING AND HABITS:

Describe your child's appetite and eating habits at present _____

_____

_____

Describe nervous habits such as thumb sucking, nail biting, etc. _____

_____

Describe any other unusual habits or behavior _____

_____

Describe child's sleeping pattern. Are there nightmares or night terrors now or in the past?

_____

_____

Describe child's level of activity and vigor _____

_____

Describe your method of discipline and how your child reacts to such discipline. Is there any

stubbornness?

_____

_____

How does your child get along with other children in the family? _____

_____

How does your child get along with others his/her age? Is he/she a leader, or a follower? How does your child associate with others who are older? Younger?

_____

_____

_____

Describe any moody periods _____

_____

Describe any problems in sitting still or paying attention _____

_____

Describe what your child likes to do for fun, special interests, hobbies, etc. _____

_____

Describe any concerns about sexual activity or identity _____

_____

EDUCATIONAL HISTORY

Name of School _____ Grade _____

Current School Teacher/Counselor/Principal _____

List previous schools attended, with dates _____

_____

Has your child repeated a grade? _____ If so, when? _____

If so, what was the problem? _____

What are your child's grades like now? _____

_____

Describe any difficulties in learning at home or in school _____

_____

Have there been any discipline problems or other behavior problems at school? _____

If so, please describe _____

_____

RELIGIOUS BACKGROUND: Describe child's experience (denomination, whether member of a church,

attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.)

_____

_____

HOUSEHOLD: List all people now living in the household; then draw a line and list others who have lived there during the child's lifetime.

Name	**Relationship to Youth**	**Age**	**Highest School Grade**	**Occupation**

1._____

2. _____

3. _____

4_____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Please describe if any children in the household were adopted, if there have been previous marriages, or if there have been any deaths in the immediate family _____

_____

_____

_____

In keeping with Florida state law, Florida Counseling Centers will report all suspected cases of child abuse. We very much appreciate the time you have spent in completing this form. Please feel free to add any additional comments below.

_____ _____

Parent or Guardian signature date

FLORIDA
COUNSELING CENTERS
Family Services

PHONE: 321-259-1662
FAX: 321-259-1223

OFFICE POLICIES & GENERAL INFORMATION
AGREEMENT TO PROVIDE PSYCHOTHERAPY SERVICES

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled. If your psychologist or counselor becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he will do whatever he can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care.

Health Insurance: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Your psychologist or counselor has no control or knowledge over what insurance companies do with the information he submits or who has access to this information.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc…), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your psychologist or counselor to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation: Your psychologist or counselor consults regularly with other professionals regarding his clients; however, client's name or other identifying information are never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

Your Right to Review Records: As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your psychologist or counselor assesses that releasing such information might be harmful in any way. In such a case, your psychologist or counselor will provide the records to an appropriate and legitimate mental health professional of your choice.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your psychologist or counselor between sessions, please leave a message with the office staff or on the voicemail at (321) 259-1662 and your call will be returned as soon as possible. Your psychologist or counselor picks up messages periodically throughout the day. If an emergency situation arises, please indicate it clearly in your message. If the emergency is life-threatening, please call 911 or go to your local emergency room.

*Considering all of the above exclusions, if it is still appropriate, upon your request, your psychologist or counselor will release information to any agency/person you specify unless your psychologist or counselor assess that releasing such information might be harmful in any way.

1299 BEDFORD DRIVE, SUITE A
MELBOURNE, FL 32940
WWW.FLORIDACOUNSELINGCENTERS.COM

FLORIDA
COUNSELING CENTERS
Family Services

PHONE: 321-259-1662
FAX: 321-259-1223

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of your psychologist or counselor and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Brevard County, Florida in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, your psychologist or counselor can use legal means (court, collection agency, etc…) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, that sum will be determined by the arbitrator.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your psychologist or counselor will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc...Or experiencing anxiety, depression, insomnia, etc… Your psychologist or counselor may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your psychologist or counselor is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational.

Dual Relationships: Therapy never involves sexual or business relationships or any other dual relationship that impairs your psychologist or counselor's objectivity, clinical judgment, therapeutic effectiveness or can be exploitative in nature.

Patient Bill of Rights: By signing this, you acknowledge that you have had access to Florida Counseling Centers' Patient Bill of Rights. If you have any questions about the Patient Bill of Rights, please don't hesitate to ask a professional staff member.

1299 BEDFORD DRIVE, SUITE A
MELBOURNE, FL 32940
WWW.FLORIDACOUNSELINGCENTERS.COM

FLORIDA
COUNSELING CENTERS
Family Services

PHONE: 321-259-1662
FAX: 321-259-1223

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, your psychologist or counselor will discuss with you (client) his/her working understanding of the problem, treatment plan, therapeutic objectives and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your psychologist or counselor's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your psychologist or counselor does not provide, he/she has an ethical obligation to assist you in obtaining those treatments.

Termination: As set forth above, after the first couple of meetings, your psychologist or counselor will assess if he can be of benefit to you. Your psychologist or counselor does not accept clients who, in his opinion, he cannot help. In such a case, he will give you a number of referrals whom you can contact. If at any point during psychotherapy your psychologist or counselor assesses that he is not effective in helping you reach the therapeutic goals, he is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, he would give you a numbers of referrals which may be of help to you. If you request it and authorize it in writing, your psychologist or counselor will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your psychologist or counselor will assist you in finding someone qualified, and if he has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, your psychologist or counselor will offer to provide you with names of other qualified professionals whose services you might prefer.

Electronic Communication: If you choose, during the course of treatment, to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with your therapist, there is a chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

· People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
· Your employer, if you use your work email to communicate with your therapist
· Third parties on the Internet such as server administrators and others who monitor Internet traffic

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a **minimum of 24 hours** (1 day) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I HAVE READ THE ABOVE OFFICE POLICIES AND GENERAL INFORMATION AGREEMENT CAREFULLY, I UNDERSTAND THEM AND AGREE TO COMPLY WITH THEM:

_____ _____
Client Name (print) Date Client Signature

_____ _____
Client Name (print) Date Client Signature

1299 BEDFORD DRIVE, SUITE A
MELBOURNE, FL 32940
WWW.FLORIDACOUNSELINGCENTERS.COM

FLORIDA
COUNSELING CENTERS
Family Services

PHONE: 321-259-1662
FAX: 321-259-1223

NOTICE OF PRIVACY PRACTICES EFFECTIVE JULY 15, 2004

Privacy is a very important concern for all consumers as they choose a healthcare provider. It is also a complicated issue because of federal and state laws governing the practice of psychology and the professional ethics that govern the practice of all psychologists and counselors at Florida Counseling Centers. In an effort to clarify your rights as a consumer of healthcare, Florida Counseling Centers has developed the following privacy statement in accordance with HIPAA (Health Insurance Portability and Accountability Act) requirements and guidelines. This statement will outline how Florida Counseling Centers handles your personal information and how we share your personal information with other professionals and organizations. If you have any questions about our privacy practices, please don't hesitate to ask your counselor for more precise details.

MEDICAL INFORMATION

Each time you visit a healthcare facility or provider, information is collected about you and your physical or mental health. It may be information about your past, present, or future health or about the treatment or services you received from a healthcare provider. Health information also includes billing and payment data. This healthcare information is called Protected Health Information, or PHI. Your PHI is considered a part of your medical or healthcare record and is stored on site in a file at Florida Counseling Centers. Protected Health Information included in your Florida Counseling Centers file likely includes:

- Relevant history
- Presenting problems
- Diagnosis
- Treatment plan
- Progress notes
- Records from other providers
- Psychological testing raw data and final reports
- Information about medications
- Legal matters
- Billing and insurance information

Protected Health Information is used for many reasons, including:

- Treatment planning
- Treatment evaluation
- Coordination of care with other providers
- Insurance billing

PRIVACY AND THE LAW

HIPAA laws require Florida Counseling Centers to keep your PHI private and to provide you with notice of the legal duties and policies of this clinic (Notice of Privacy Practices). The guidelines outlined in this notice are subject to change. In the event of a change in policy, the new guidelines will apply to all PHI stored at Florida Counseling Centers. The new guidelines will also be posted in our offices and available upon request.

HOW YOUR INFORMATION IS USED AND SHARED

Protected Health Information is disclosed by Florida Counseling Centers to other professionals for the purposes of treatment, payment, and health care operations.

· Treatment - PHI is used to provide clients with psychological treatment or services. These services might include individual therapy, group therapy, family therapy, psychological testing, education, or treatment planning. Your PHI will be disclosed to other professionals for the purpose of treatment only if a release of information is signed. For example, if a client would like their counselor to speak with their general practitioner about medication, they would be required to sign the necessary release of information. Otherwise, the client's personal health information would not be released to the general practitioner. On occasion, your counselor might secure a consultation from another provider about your treatment plan. In these situations, your counselor will not disclose any identifying information about you to the other provider.

· Payment - PHI is also used to secure payment from insurance companies for services rendered. Information typically shared with insurance companies might include: diagnosis, treatment plan, dates of services rendered, and client progress.

· Health Care Operations - PHI is used to enable the offices of Florida Counseling Centers to conduct standard and customary business practices. For instance, your information might be used and disclosed by office personnel for the purpose of appointment setting or reminders. Occasionally, Florida Counseling Centers contracts with other business associates that help us conduct our business. These business associates might answer phones, complete billing, etc. To protect your privacy, all business associates have agreed in contract to safeguard your personal health information.

RELEASE OF INFORMATION WITH CONSENT

When a client requests that Florida Counseling Centers share information with others for any purpose other than treatment, payment, or health care operations, they are required to sign a release of information form that includes the other party's name, address, phone number, and the nature of the information to be disclosed. Releases of Information may be revoked (cancelled) at any time.

RELEASE OF INFORMATION WITHOUT CONSENT

There are times when Florida Counseling Centers will disclose your personal health information without your consent or authorization.

· When required by law to report suspected child abuse

· When you are involved in a legal proceeding or lawsuit and your counselor received a subpoena, discovery request, or other lawful process. In these situations, your counselor will only release information after they attempt to contact you about the request, consult with your lawyer, or attempt to obtain a court order to protect the information requested.

· When government agencies request proof that Florida Counseling Centers are HIPAA compliant.

· To prevent a serious threat to your health or safety (including suicide) or to the safety of some other person(s).

In the event that personal health information is disclosed without your consent, Florida Counseling Centers keeps records of the specific information released, the recipient of your PHI, and the date it was released.

QUESTIONS OR PROBLEMS

For more information about the privacy practices of Florida Counseling Centers, please contact your counselor or psychologist. If you have a grievance about how this office handled your private information, please don't hesitate to contact the office personnel or your counselor. You have the right to file a complaint with the Secretary of the Federal Department of Health and Human Services. Please be assured that if you have a grievance or file a complaint about our policies, this will in no way limit your care at Florida Counseling Centers.

CONSENT: I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES OF FLORIDA COUNSELING CENTERS

_____	_____	_____
Client Name (print)	Date	Client Signature
_____	_____	_____
Client Name (print)	Date	Client Signature