Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Sex: Male Female

Birthplace: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a voicemail? *YES* *NO*

Email: _____

Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

How were your introduced to us? _____

If you found us online what words did you search to find us? _____

* *Please complete below for additional client*

Name: _____

DOB: _____ Age: _____ Sex: Male Female

Birthplace: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

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8440 SW 21St.
Miami, FL 33155

Phone Number(s):

_____

Is it ok to leave a voicemail? *YES* *NO*

Email:

_____

Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

How Have We Come to Meet?

What are the 3 biggest concerns you have right now? How long have each been going on? Put them in order of importance:

1. _____
   _____
2. _____
   _____
3. _____
   _____

What do you think those that care about you would say their concern(s) is/are in regards to you?

_____
_____
_____
_____
_____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____
_____
_____
_____

Have you had therapy in the past? If so, with whom and when? What reasons did you attend therapy for? Please share with us about your experience. What was helpful? Unhelpful?

_____
_____
_____
_____
_____

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Change is Coming…

What are your expectations from therapy? What are your expectations of the therapist?

_____
_____
_____

Looking into the future, how will you know that our work and time together has been worth it? List concrete changes you will see:

_____
_____
_____

What other things would you like to see change in your life (family, career, health, relationships, etc.)?

_____
_____
_____

Do you foresee any obstacles to achieving your goals or the desired changes?

_____
_____
_____

How long do you think therapy will need to last to achieve your goals? Write down a target date:

_____
_____

List 5 strengths about yourself or that others say about you, give examples of each:

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

Is there anyone that you would like to be a part of your sessions or think may be helpful to be part of sessions either now or in the future?

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_____
_____

Medical & Wellness Information

What do you do for wellness (i.e. healthy food choices, exercise, limits on TV/electronics/work, managing stress, family time, leisure, etc.)? Give examples of each:

_____
_____
_____

How do you achieve balance in your life?

_____
_____
_____

Have you ever received psychiatric services before? YES NO
If yes, how long ago, with whom, for what, medications prescribed and results:

_____
_____
_____

Do you have any allergies (food, environmental, medicinal, animal, etc.)

_____
_____

Do you have any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, what?

_____
_____
_____

Is there a family history of the above medical issues/concerns?

_____
_____
_____

Are you presently under a physician's/psychiatrists care? If so, for what reason?

_____
_____
_____

Is there anyone in your life that is currently dealing with a medical issue that you are concerned about? If so, whom, for what?

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In the past year, have there been any changes in your life? (i.e.: moves, appetite, sleep, health, family, overall functioning)?

List any medications (over-the -counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons:

Important Questions We Must Ask

Have you ever had suicidal ideations? YES NO
If yes, please explain:

Have you ever planned to hurt yourself? YES NO
If yes, please explain:

Have you ever attempted to hurt yourself? YES NO
If yes, please explain:

Have you ever felt like you wanted to seriously hurt or harm someone else? YES NO
If yes, please explain:

Do you have weapons in your home or access to weapons? YES NO

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If yes, who has access to them and what are the safety protocols around them?

Is there any history past or present of abuse or violence? YES NO
If so, please explain:

Are you currently using any illegal drugs, or prescription medications in a way other than was prescribed, or is the reason you are seeking therapy services substance related?

Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful? If so, please explain:

Do you have currently legal issues or is the reason you are seeking therapy related to a court order? If so, please explain?

Career/Job, Recreation and Leisure

What is your current occupation? How would you describe your fulfillment of your job/career?

What is your highest level of education completed and field of study?

What do you enjoy doing during your free/leisure time?

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_____
_____
_____

Intimate Relationships

If you are currently in a relationship, describe your relationship:
_____
_____
_____

How would you describe your communication?
_____
_____
_____

How would you describe intimacy in your relationship?
_____
_____

* If you are in a relationship answer the following regarding your relationship:

1. Like _____
2. Dislike _____
3. Not enough of _____
4. Too much of _____
5. Ideal relationship _____

Understanding Your Family & Influences

* *Space left for therapist to draw family tree (genrogram)*

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Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

Please describe your relationship with your parents:

_____
_____
_____

How would you describe your upbringing?

_____
_____
_____

Who lives with you currently?

_____
_____
_____

Do you have any pets? If yes, names, types and relationship to each pet:

_____
_____
_____

Describe your relationship with the following:
Mother:

_____
_____

Father:

_____
_____

Mother's Significant Other:

_____
_____

Father's Significant Other:

_____
_____

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Siblings: Age, Name and Sex:

a. Sibling 1

_____

_____

b. Sibling 2

_____

_____

c. Sibling 3

_____

_____

Children:

a. Child 1

_____

_____

b. Child 2

_____

_____

c. Child 3

_____

_____

Significant Other/Spouse:

_____

_____

Relationships

Describe your relationship with your friends:

_____

_____

_____

Who would you say your support system is (people, organizations, or affiliations)?

_____

_____

_____

Do you belong to any religious or spiritual groups? YES NO

If yes, what is your level of involvement?

_____

_____

How do your religious or spiritual beliefs/practices influence your life?

_____

_____

_____

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Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results:

_____
_____
_____
_____
_____
_____

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Charlene Lewis, LCSW, ASSECT CST, CSAT, CAP
Sound Mind Miami
8440 SW 21St.
Miami, FL 33155

I,_____
DOB:_____

hereby give my permission to **Charlene Lewis**, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under Florida law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or federal law.

This information will be released/requested upon request to the following:
To/From:

_____
_____
First and last name, phone, and address of person(s)

The type of information to be disclosed/requested is as follows:

To Be Released * *from **Charlene Lewis***	**To Be Requested** * *from third parties*
____Treatment Plans	____Treatment Plans
____Process Notes	____Process Notes
____Health/Medical Records (if applicable)	____Health/Medical/Academic Records
____Letter(s) of Progress	____Psychological/Psychiatric Evaluations/Assessments
____Bio Psychosocial Evaluation/Assessment (if applicable)	____Court Documents
__X Verbal Communication	__X Verbal Communication

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____Other (Specify): _____ ____Other (Specify): _____

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), we reserve the right to provide a report of examination or treatment in lieu of copies of the actual records, unless requested by/for a treating psychotherapist (Florida Statute 456.057 and HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **Charlene Lewis**.

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **Charlene Lewis**will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **Charlene Lewis**. **Charlene Lewis** will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **Charlene Lewis** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Release: **Request:**

_____ _____

Signature Client/Next of Kin/Guardian Date **Signature Client/Next of Kin/Guardian Date**

_____ _____

Clinician Signature/Credentials Date **Clinician Signature/Credentials Date**

Therapy Agreement, Policies & Consent

PART 1: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. (Florida statute 39.201). If you reveal information relative to child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect (Florida statute 415.1034). If you reveal information relative to vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself – I am permitted under such instances to take steps to protect your safety which may include the disclosure of confidential information. (Florida statute 491.0147 & Chapter 394).

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- **Harm to Others**: Threats regarding harm to another person (Florida statute 491.0147). If you threaten bodily harm or death to another person, I am permitted by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone and send you an email or letter (if I cannot get in touch with you by phone). If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Court Ordered Therapy**: If you are in therapy ordered by the court, and the court requests records or documentation of your participation in services, the information/documentation that will be discussed/sent on your behalf will be discussed with you prior to information being sent to the court.
- **Written Request**: Your specific request, in writing, to disclose information regarding your psychotherapy to you or to a third party. In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), I reserve the right to provide to you or the authorized third party a report of examination or treatment in lieu of copies of the actual records, unless the third party is a treating psychotherapist (Florida Statute 456.057 & HIPAA Privacy Rule). If therapy sessions involve more than 1 party, ALL parties over the age of 18 MUST consent to release of requested information prior to information being released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the needed and adequate documentation i.e. your signature on the "Therapy Agreements and Consent" that covers the cancellation policy to your Bank or Credit Card Company should you dispute a charge that you are financially responsible for. If you have a financial balance, you will be sent a bill to the home address on the intake form unless you advise me otherwise.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that no separate party of the couple attempt to triangulate me into keeping a "secret" that is detrimental to the goal of therapy for the couple. If one party of the couple requests that I keep a "secret" in confidence, I may choose to end the therapy and give you referrals for other therapists as our work and your goals then become counter-productive.
- **Dual Relationships & Public**: My relationship with you is strictly professional. In order to preserve this relationship, it is imperative that we do not have any relationship outside the counseling relationship such as a friendship, business, or social relationship. If we have contact in a public setting, I will not acknowledge you in any way that would jeopardize your confidentiality. Should you choose to acknowledge me, I may not be able to protect your confidentiality.
- **Social Media**: If you choose to connect with me on any of my professional (not personal) social media outlets such as Facebook, LinkedIn, Pinterest, Instagram, or Twitter, you do so at your own risk. I will do my best to protect your identity. However, if you choose to comment on my pages or posts, you do so at your own risk and I cannot be held liable if someone identifies you as a client.
- **Electronic Communication:** Email offers an easy and convenient way for therapist and client to communicate, but can also introduce unique challenges into the therapist–client relationship. Below are some guidelines for contacting me using e-mail. **Do not use e-mail for emergencies**. If it's an emergency, consult with an emergency room. E-mail is not a substitute for seeing me. If you think that you might need to be seen, please call and book an appointment. E-mails should not be used to communicate sensitive medical or mental health information. **E-mail is not confidential**. Be aware that if you send e-mails from your work, your employer has the legal right to read your e-mail. E-mail is a part of your record. Further, texting also introduces some of the same challenges. Like e-mail, it is not a substitute for seeing me or making an appointment. **Texting is not confidential**. Because phones can be lost or stolen, it is imperative that you do not communicate information of a sensitive nature over a text. Further, I cannot know the person who is texting is actually you, rather than another person who has possession of your phone.
- **Sessions Outside the Office:** From time to time, the people we work with would like to meet in an alternate location i.e. their home, in public, or somewhere more conducive for them. We are more than happy to accommodate your request, but please know that you may be taking a risk in regards to your confidentiality. I cannot fully protect your confidentiality if we meet in a location other than my office.

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PART II: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: Participating in therapy can result in numerous benefits, including improving intrapersonal and interpersonal relationships, resolving the concerns that led you to therapy. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific complaint(s). A major benefit that may be gained from participating in therapy includes a reduction in distress and a better ability to handle or cope with personal, relational, family, work, and other problems as well as stress. Another possible benefit may be a greater understanding of personal and relational goals and values; this may lead to greater maturity and happiness as an individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy. I will do my best to assess progress on a regular basis and solicit your feedback regarding the therapeutic process to help provide you with the most effective therapeutic services. I can make no guarantees as to the ultimate outcome of therapy.

EXPECTATIONS: Work outside of the counseling sessions is an essential aspect of change. I may assign tasks between sessions related to your goals. My commitment is to work as efficiently as possible, but at the same time, therapy may move more slowly than you anticipated. We will collaborate to identify your therapeutic goals and periodically review your progress toward them.

RISKS: In working to achieve these potential benefits, the therapeutic process requires that actions be made to change and may involve experiencing discomfort. Therapeutically resolving unpleasant events and relationship patterns may arouse intense, unexpected feelings. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work together for a desirable outcome; however, there is a possibility that the goals of therapy will not be met. We will review your progress at regular intervals and modify our treatment plan as needed.

STRUCTURE OF THERAPY:

- **Intake Phase** – During this phase, we will discuss the process, structure, policies and procedures of therapy. This occurs during the 1st session. We will need to spend some time (usually brief) exploring your experiences both surrounding the presenting complaint(s) and outside the realm of your complaint(s).
- **Assessment Phase** – An initial evaluation may last from 2-4 sessions. During the assessment phase, I am getting to know and understand you, your worldview, strengths, concerns, needs, family and relationship dynamics, etc. During this phase I am gathering a lot of information. During this phase it may not feel like we are moving forward quickly, but it is imperative for me to gather this information to assist you the best I can. During this time, we both decide if I am the best person to provide therapeutic services for your specific needs. If you or I determine that I am not the best person to address your needs and treatment plan, then referrals will be made for a more appropriate treatment provider.
- **Goal Development/Treatment Planning** – After we have explored and developed sufficient background to proceed, we will collaboratively identify specific goals for therapy. Therapy is best concluded through mutual agreement among the participants, including myself as therapist, and will be directly tied to sufficient progress toward and/or the achievement of the goals we set together. If you are court ordered, we encompass both what is important to you and what the court is requiring of you into the goal. If you are court ordered, it is important to provide copies of documents from the court that states what needs to be addressed during our counseling sessions. After the goal is completed we will both sign the goal and you will receive a copy.
- **Intervention Phase** – This occurs anywhere from session 2 until graduation/discharge/termination. This phase requires effort both in session and completing any agreed upon assignments outside of session. You will maximize therapy by implementing solutions discussed during session. During this phase we will review your progress and make any adjustments to your goals as needed. If at any time you have questions about what I am attempting to do or where we are headed, please do not hesitate to ask.
- **Graduation/Discharge/Termination** – As you progress and get close to completing your goals we will collectively discuss your progress, make a transition plan and decide on the date of graduation/discharge/termination.

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LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 60 minutes depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed, but we will collaboratively determine from session to session how much longer therapy is recommended.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment you agreed upon. You agree to adhere to the following policy: ***If you are prevented from keeping a scheduled appointment, you MUST notify me 24 hours in advance. If I do not receive a 24-hour advance notice, you will be responsible for paying the full fee for the session you missed.*** Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I will, from time to time, take time off for vacation, to attend seminars, and/or become ill. I will attempt to give you adequate notice in advance and will arrange coverage for any emergencies by a colleague. If I am unable to contact you directly due to circumstances out of my control, I will have a colleague contact you to cancel or reschedule an appointment.

FEES: My fee for each session is $200 Payment is due at the time of the session in the form of exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus $30 for any returned check), or credit/debit card. In the event that you miss your scheduled appointment time or cancel less than 24 hours, your credit card or debit card on file will be automatically charged. By signing this document, you agree to such cancellation and returned check fees.

I reserve the right to terminate our counseling relationship if more than 3 sessions are missed without proper notification.

I charge my hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed to your credit/debit card on file.

In-home/On-site therapy services offer people comfort and flexibility. In-home/ On-site services are offered at an hourly rate of $300. Cost for travel is based on the regularly hourly rate and is determined by time it takes for the therapist to travel from the office to your home or requested place of session and back. Travel time is configured by the therapist tracking and logging actual driving time or using Internet sites such as Google, Bing, Mapquest, etc. to determine travel time.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. Please know if I get called into court by you or your attorney, which I strongly suggest not being involved in court in order to protect your confidentiality, you will be charged $250/hour which will include travel to and from the courthouse, time in court, waiting for the court hearing, preparation for documents, etc. A proposed invoice will be drawn up and you will be required to pay prior to the appearance. Any amount that is due to Charlene Lewis or needs to be returned to you after the appearance will be due/returned within 2 calendar weeks.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records they will be dispensed at $1.00 per page. Payment for your medical records will be due prior or upon receipt of them and can be picked up at our office please allow at least 2 weeks to prepare your records. You will also need to sign a release for medical records to be dispensed to either you or designated party, and I reserve the right to provide a summary of process notes, in lieu of the actual notes, a described above.

PHONE CONTACTS AND EMERGENCIES: Office hours are from 7:30AM to 7:30PM, Sunday through Monday. If you need to contact me for any reason please call 786-290-0935, leave a voicemail, and I will get back to you within 24 hours. In emergency situations, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255 or simply dial 911 if either you or someone else is in danger of being harmed. For residents living in Broward Florida you can call, First Call for Help of Broward 954-537-0211, Henderson Mobile Crisis Unit for adults at 954-463-0911 or for children at 954 677-3113 ext 3, or simply dial 911 if

either you or someone else is in danger of being harmed.

PART III: REASONS WHY I DON'T ACCEPT INSURANCE

I would like to share with you my position on why I don't accept health insurance.

- **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require "preauthorization" before you can receive services. This means you or I must call the company and justify why you are seeking therapeutic services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company's list (who offer truncated and reduced-fee services in order to be placed on this list). Reimbursement is sharply reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.
- **Pre-Authorization and Reduced Confidentiality:** When visits are authorized, usually only a few sessions are granted at a time. When these sessions are finished, your therapist must justify the need for continued service causing a delay in treatment. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if you do not feel you have achieved your therapeutic goals. Your insurance company may request or require additional clinical information that is confidential in order to approve or justify a continuation of services. The information they may request may include: treatment plans, progress notes, and at times the entire medical record is requested. I cannot assure or guarantee your confidentiality when an insurance company requires this information. Even if the therapist justifies the need for ongoing services your insurance company may decline services regardless if you think you need continued therapy or not. You are at the mercy of your insurance company to decide your care. You should be aware that some of your personal information might be added to national medical information data banks. For these and other reasons, many therapists openly talk about "the myth of confidentiality" whenever insurance companies become part of the therapeutic process.
- **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies require the therapist to give you a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") in order to get reimbursed. Most therapists do not inform their clients of this process and place a mental health disorder diagnosis on their record without consulting or informing them of this process. Psychiatric diagnoses may come back to negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations that require revealing that you have a mental health disorder diagnosis. This includes but is not limited to applying for job applications, applying for financial aid, and concealed weapons permits.

It is also important to note that some psychiatric diagnoses are not even eligible for reimbursement. This is often true for marriage/couples and family therapy as well.

Why I Don't Take Insurance: These involve enhanced quality of care and other resulting advantages such as:

1. You determine and are in control of your care. You may see whomever you wish, whenever you wish, and for as long as you feel is necessary. You and your therapist make treatment decisions jointly – not someone you have never met.
2. Increased privacy and confidentiality. I hope to create a sense of safety within therapy so you can talk freely about what concerns you most, within your informed consent and federal and state laws.
3. Not carrying a mental health disorder diagnosis on your medical record. You may wish to consult with me on many non-psychiatric issues, such as finding skills to cope with life changes, learning more effective

communication techniques for your relationships, or gaining personal insight and developing new, healthy skills.

4. Utilizing your therapy for things that are important to you - you may want your therapy to revolve around things that are important to you such as career counseling, finding your ideal mate, improving communication, gaining personal insights, or developing ways to have a healthier lifestyle. Insurance will not reimburse for these types of sessions.

After reading my position on why I don't accept health insurance, you still may decide to use your health insurance. If you provide me with a list of therapists on your insurance provider list, I will do my best to recommend a therapist for you.

PART IV: EMERGENCY CONTACT:

It is necessary that **Charlene Lewis** has someone to contact on your behalf. In case of an emergency who should we contact?

_____

_____Full Name Relationship

Phone

Number(s)Please check here that you agree and sign below.

□ I agree to allow **Charlene Lewis** to contact my emergency contact on my behalf in the case of emergency

_____

_____ Signature Date

PART V: CONSENT

1. I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with **Charlene Lewis**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Charlene Lewis** to provide counseling services that are considered necessary and advisable.

2. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Charlene Lewis to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Charlene Lewis** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name of Minor Child	DOB	Date

***** *Your signature also signifies that you have received a copy of the "Therapy Agreement and Consent" for your records. If you initially received this paperwork through email it will be considered that you have an electronic copy. If you did not receive this through email you can be provided a copy per your request.*

Printed Name	Signature	Date

Charlene Lewis, LCSW,ASSECT CST, CSAT, CAP
Sound Mind Miami
8440 SW 21St.
Miami, FL 33155

Witness – ***Charlene Lewis, LCSW, ASSECT CST, CSAT, CAP*** *Date*

CLIENT COPY

1. I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with **Charlene Lewis** . My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Charlene Lewis** to provide counseling services that are considered necessary and advisable.

2. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Charlene Lewis to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Charlene Lewis** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session. If you are enrolling a minor in therapy (under age 18), please review my "minor therapy agreement" for more specific information and to address best practice standards when working with a minor.

Printed Name of Minor Child	DOB	Date

***** *Your signature also signifies that you have received a copy of the "Therapy Agreement and Consent" for your records. If you initially received this paperwork through email it will be considered that you have an electronic copy. If you did not receive this through email you can be provided a copy per your request.*

Printed Name	Signature	Date

Charlene Lewis, LCSW,ASSECT CST, CSAT, CAP
Sound Mind Miami
8440 SW 21St.
Miami, FL 33155

Witness ***Charlene Lewis****, LCSW, AASECT CST, CSAT, CAP* *Date*

Credit/Charge/Debit Card Preauthorization

Please note that this form will be securely stored in your clinical file.

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I authorize Charlene Lewis to keep my signature and card information on file and to charge therapy session fees when delivering a check/cash is not possible; this includes individual, group, couples, family or other), or partial fees, and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials, and or fees), or for any appointments with the therapists at Sound Mind Miami, that are not cancelled by the stated client within 24 hours of the scheduled appointment time to be charged to my credit, charge, or debit card or flex spending account as filled out below for therapy services provided to:

_____

(Therapy Client's Name: Please Print)

I understand that this authorization is valid until canceled in writing. I understand that charges for on-going services or materials will normally be posted to my credit/debit card account within 72 hours of each session date and **my session fee will be charged at the start of the day of my session.**

I understand that the fee per 60-minute session is $200.00 and is payable via check or cash unless another fee is agreed upon between Charlene Lewis and I the client. Initial _____

Additionally, I agree that the card listed below may be charged by Charlene Lewis in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials [i.e. books, CD's, DVD's] that I have not returned within one week of termination. I understand that if a charge back fee of $30 is incurred (i.e. incorrect card information was provided below and request that the fee be charged back), or a retrieval fee of $30 is incurred (i.e. choose to dispute the charges), I am responsible for these fees. Initial _____

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Charlene Lewis, Licensed Clinical Social (SW 9306) in the state of Florida for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Charlene Lewis (L.C.S.W. SW9306) and those attempts have failed. Initial _____

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by contact Charlene Lewis Initial _____

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I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Name (print) _____ Date _____

Relationship to client _____

Signature _____

CREDIT CARD INFORMATION

Cardholder Name (please print):
_____

Relationship to client listed on page 1
_____

Billing Address (where statements are mailed):

_____-
_____

City: _____ State: ____ Zip: _____

Card Type (circle one):

1. Visa 2. Mastercard 3. American Express

Acct. Number: _____

Exp. Date: _____

Security Code _____

Cardholder Signature:

_____Date: _____

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Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I

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can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.

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- ***For Payment*** – We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.
- ***For Operations*** – We may use and disclose your health information within The Family Institute as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Patient's Rights:

- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by 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.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.
- ***Right to a copy of this notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- 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. 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

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required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Charlene Lewis, LCSW, ASSECT CST, CSAT, CAP Date

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