**Emotional Wellness Center**

PO Box 100319

Palm Bay, FL 32910

321-288-0692

**CLIENT INFORMATION** Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Client Returning Client (Use “Returning” if it has been more than 3 months since your last visit)

Name :(L,F,MI)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (State) \_\_\_\_\_\_\_\_ (Zip)\_\_\_\_\_\_\_\_\_\_\_

Phone Numbers: *Okay to call you here Okay to leave a message*

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No Emergency Only Yes No Emergency Only

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No Emergency Only Yes No Emergency Only

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No Emergency Only Yes No Emergency Only

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Sex: Female Male

SSN: \_\_\_\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_\_\_\_

Marital Status: Single Married Divorced Legally Separated Widowed

Student: Yes No School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who Referred You To Us? Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friend Other

Is condition for which you are seeking treatment related to: Employment Auto Accident Other Accident

**RESPONSIBLE PARTY (**Complete if primary client is under eighteen and you must also sign the financial agreement)

Name: (L, F, MI.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: (if different than client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: *Okay to call you here Okay to leave a message*

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No Emergency Only Yes No Emergency Only

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No Emergency Only Yes No Emergency Only

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No Emergency Only Yes No

 Emergency Only

Sex: Female Male Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*PRIMARY INSURANCE COMPANY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber or ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group/File #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address if different than client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible: \_\_\_\_\_\_\_\_\_\_\_ Co-Payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Health Coverage Limits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is referral/pre-authorization required**: Yes No **Has pre-authorization been obtained**: Yes No

**Terms of the referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*SECONDARY INSURANCE COMPANY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber or ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group/File #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address if different than client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible: \_\_\_\_\_\_\_\_\_\_\_ Co-Payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Health Coverage Limits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is referral/pre-authorization required**: Yes No **Has pre-authorization been obtained**: Yes No

Terms of the referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**-INFORMATION FORM CONTINUED –**

**Other Persons in Household:** Sex Birth date Relationship to

Name (M/F) (mo/day/yr) Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**SUMMARY OF THE CONTENTS OF THE FLORIDA NOTICE FORM**

Your protected health information (PHI) may be used or disclosed with your consent for purposes of Payment, and Health Care Operations. Your signature on our patient registration indicates your consent for the release of information, for the above underlined purposes **ONLY**.

The use or disclosure for purpose of Treatment or for purposes outside those underlined above is permitted ONLY with your written authorization on a separate form designated for this purpose.

The Emotional Wellness Center, may disclose information without your consent or authorization under circumstances of Child Abuse, Adult and Domestic Abuse, Health Oversight, Judicial or Administrative Proceedings, Serious Threat to Health or Safety, or Worker’s Compensation.

Your rights and my duties are summarized in this document.

You have received and reviewed the following policy: HIPPA POLICY

**SUMMARY OF THE CONTENTS OF THE BILL OF RIGHTS**

**I acknowledge that:**

I have been informed of my rights as a client of **The Emotional Wellness Center** as outlined in the Client Bill of Rights.

I have received and reviewed the Client Bill of Rights and Client Information Form.

I consent to treatment as outlined by my therapist and in accordance with the Client Bill of Rights.

I have been informed of the cost of treatment.

Unless otherwise Specified, I give permission to contact my primary care physician, as well as to communicate with my insurance company and/or managed care provider for the purpose of billing and/or treatment.

I understand that I am responsible for obtaining current referral on HMO policies. I understand that I am responsible for co-pay portions of benefits, for cost incurred during any period in which you do not have a current referral, and for services which are not covered by insurance, such as school consultation, telephone therapy, correspondence, report writing, marital counseling, psychological testing, and case management.

***Ultimately* – *I am responsible for my entire bill.***

My signature gives the insurance company permission to make payment directly to my account at The Emotional Wellness Center. Any payment received will be applied directly to my account. The Emotional Wellness Center reserves the right to seek legal means to secure reimbursement. This may include releasing names and information to collection agencies, attorneys or the Court.

I have read and understand the missed appointment and bad check fees/policies of the **Emotional Wellness Center.**

CLIENT NAME : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PLEASE PRINT)

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness – Therapist Signature

**CONSENT TO TREAT A MINOR AUTHORIZATION** I give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ permission (Therapist) to give psychiatric treatment to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Client)

**Because client is** Minor Incompetent **Legal Authority** Parent of Minor Legal Guardian

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

**Notice of Mental Health Providers’ Policies and Practices to Protect the Privacy of Your Health Information**

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

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

“*PHI”* refers to information in your health record that could identify you.

*“Treatment, Payment and Health Care Operations”*

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another Mental Health Provider.

– *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

– *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

“*Use*” applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

“*Disclosure*” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

**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 disclosures. 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.

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 nor Authorization**

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

**Child Abuse:** If I have reasonable cause to suspect that a child seen in the course of my professional duties has been abused or neglected, or have reason to believe that a child seen in the course of my professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, I must report this to the relevant county department, child welfare agency, police, or sheriff’s department.

**Adult and Domestic Abuse:** If I believe that an elder person has been abused, or neglected, I may report such information to the relevant county department or state official of the long-term care ombudsman.

**Health Oversight:** If the Florida Board/Licensing requests that I release records to them in order for the Psychology Examining Board to investigate a complaint, I must comply with such a request.

**Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release the information without written authorization from you or your personal or legally-appointed representative, 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, if this is the case**.**

**Serious Threat to Health or Safety:** If I have reason to believe, exercising my professional care and skill, that you may cause harm to yourself or another, I must warn the third party and/or take steps to protect you, which may include instituting commitment proceedings.

**Worker’s Compensation:** If you file a worker's compensation claim, I may be required to release records relevant to that claim to your employer or its insurer and may be required to testify.

**IV. Patient's Rights and Mental Health Provider's Duties**

**Patient’s Rights:**

*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. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

*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. On your request, I will discuss with you the details of the request process.

*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 will discuss with you the details of the amendment process.

*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 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.

**Discharge Policy:**

Clients may be discharged if there is no contact for at least three (3) months and/or client and clinician agree to terminate. Involuntary discharge from service may occur due to unsafe client behavior in the clinic, repeated missed appointments, lack of cooperation in working out a payment plan, or lack of cooperation with recommended treatment that is significantly interfering with safety or treatment.

**Mental Health Provider’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 required to abide by the terms currently in effect.

If I revise my policies and procedures, I will notify you either by mail or in person.

**V. 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 at 321-288-0692. You may also send a written complaint to Department of Health, **Board *of* Mental Health Professions**, 4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

**VI. Effective Date, Restrictions and Changes to Privacy Policy-**This notice will go into effect on October 21, 2017.

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 either mail, by posting in the waiting room, or in person.

**VI. Emergency Services**

Current clients can obtain emergency mental health services after hours by calling (321) 288-0692. If there is a life-threatening emergency call 911.

**Emotional Wellness Center**

PO Box 100319

Palm Bay, FL 32910

321-288-0692

**INVESTMENTS/FEES**

**Individual Therapy Service (50 minutes) $95.00**

**Family/ Couples Therapy Services 90 minutes $125.00**

**Money, Relationship, and Life Coaching Services- 50 minutes $95.00**

 **(15% discount for package of min 3 prepaid services) Prepaid packages are non-refundable**

**Hypnotherapy and EFT (Emotional Freedom Technique) 90 minutes $95.00**

**Telephone/Web Counseling $85 for first 50 minutes; $2 per each additional minutes**

**Completion of outside forms including FMLA, disability, summaries, letters regarding treatment, etc. $50 per item requested**

**Confidential Copying (Records Release) Administrative $35 plus 50cents per page**

**Court appearances or other court related work $700 minimum daily rate plus an additional $125 per each additional administrative hour spent on the case. Fee is to be paid up front. Additional out of pocket expenses to be covered at cost.**

**Returned payments $40 per item returned**

**Missed appointments/Late Cancellation (24 hour notice required) $50**

**\*\*\*\*\*If you do not have insurance and would like to continue counseling we provide a Mental Health Wellness Plan for you. Please contact me to discuss.**

***\*\*\*\*\*\*Individual and Couples intensives are arranged by request. Intensives are half a day to two days according to your needs and goals. Prices are all inclusive…excluding transportation, however transportation can be arrange by request. Insurance does not cover intensives.***

**Payment/Co-Pay/Deductibles are due at the time of the session unless other arrangements are made with your therapist. We reserve the right to charge interest on unpaid accounts over 60 days old at the rate of 1.5% or 18% annually. If you have any questions about your account, contact my business account manager.**