Richard P. White, MA, LMHC
wintergardencounselor.com
FL Lic. MH 4187
310 S. Dillard St. Suite 170
Winter Garden FL 34787
(407) 968-8055

CLIENT INFORMATION INTAKE FORM

Today's Date: _____

Name: _____Birthdate_____Age_____

Address_____Street___

_____ City_____ State_____ Zip_____

Home Phone (___) _____Work Phone ( ) _____

Can we leave a message? Yes No Best Place to Leave a Message ( ) _____

Who were you referred by? _____

May we acknowledge the referral? Yes ___ No___

Reasons for seeking counseling at this time? _____

_____

_____

_____

Level of Education: GED ___HS___College____Other___

Place/Type of Employment_____ Role/Title_____

How long? _____ If unemployed, how long: _____ what type of work did you do? _____

Marital Status (Parents if for a child) married____# of years____; divorced___# of years ___;

widowed____# of years____; single____;living with_____

Spouse's Name_____Spouse's Occupation_____

Spouse's Phone Number(s) _____

CHILDREN (SIBLINGS IF FOR A TEEN)

NAME	BIRTHDATE	GENDER

In Case of Emergency Notify:_____ Phone:_____

Relationship:_____

Have you ever been hospitalized for psychiatric reasons? Y N If yes, what were the circumstances?

Please include dates: _____

When was your last full physical exam? _____

Any physical issues? _____

Sleeping issues? Y N How many hours of sleep to you get each evening? _____

List any medications you are presently taking and dosage: _____

_____

Any family members (include parents, grandparents, aunts, or uncles with emotional issues (depression, anger, anxiety, etc)

_____

_____

List any problems with Alcohol?_____drugs?_____

How many drinks do you consumer per day? _____ Per week? _____

Do you have current thoughts of suicide? Yes No If so, do you have a plan? Yes No

Have you *ever* had thoughts about suicide Yes No

Have you ever attempted suicide? Yes No If yes, how many times? _____

How do you spend time relaxing? _____

Have you ever had concern about eating habits? Yes No

Have you ever been in counseling before? Y N For how long? _____

Who did you see previously for counseling?

Was it helpful? Y N Please explain: _____

What else would be helpful for your counselor to know about you? _____

_____

_____

_____

_____

Please Check Any of the Following Conditions That Currently Apply to You

___Headaches ___Nervousness ___Dizziness ___Fainting Spells

___Shyness ___Stomach Trouble ___Relaxation ___Stress

___Anxiety ___Fatigue ___Legal Matters ___Self Control

___No Appetite ___Anger ___Memory ___Making Decisions

___Insomnia ___Nightmares ___Separation ___Energy

___Inferiority ___Take Sedatives ___Drug Use ___Loneliness

___Bowel Troubles ___Marriage ___Use Alcohol ___Allergies

___Suicidal ___Sexual Problems ___Work ___Under eating

___Overeating ___Home Conditions ___Friends ___Concentration

___Temper ___Ambition ___Divorce ___My Thoughts

___Parenthood ___Health Problems ___Age ___Finances

___My appearance ___Future ___Sexual Abuse ___Children

___Career Choices ___Weight ___Unhappiness ___Depression

___Mood Swings ____Fears ___Self-esteem ___Physical Abuse

Other (s) _____

Circle everything that has happened to you in the past two years:

Death of a spouse/partner Marriage Problems Divorce

Death of a family member Family Issues (with children/parents/in-laws)

Major illness/injury of self Financial issues Move to another city or state

Major illness/injury of relative Legal Problems Bad break up

Job dissatisfaction Loss of job Other _____

Religious/Spiritual/ Faith Information:

How often do you attend Church, Synagogue or other religious services?_____

If so, where do you attend?_____

What is your perception of God?_____

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CONSENT FOR EVALUATION AND TREATMENT.

I hereby give consent for evaluation and treatment. It is agreed that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature:_____ Date: _____

In the case of a minor child, please specify the following:

Full name of minor _____ DOB ____ __ Relationship: _____

CANCELATION POLICY

Please give 24 hour notice if you need to cancel an appointment. Unless it is a verifiable emergency, a $75 charge will be incurred on your account for no-shows, or cancelations in less than 24 hours.

Signature:_____ Date: _____

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INFORMED CONSENT

It is the mission of Richard P. White, LMHC is to provide you with the highest quality counseling possible while keeping the content and records of therapy confidential. However, there are certain circumstances when your counselor is legally and ethically required to break confidentiality and make appropriate disclosures. These disclosures are strictly to protect you or someone else from potential harm. These circumstances include serious suicidal or homicidal threats, actions, or ideation of a degree severe enough to warrant medical care, HIV/Aids reporting requirements, Patriot Act reporting requirements, and/or child abuse/elder abuse (physical, sexual, emotional, or neglect). Disclosure in these circumstances is rare.

_____, understand the limits of confidentiality and am aware of and give consent that if any of the above situations are discussed in therapy, my counselor will be required to make the appropriate disclosures for the safety of myself and those around me. I understand that I am entering into a confidential therapeutic counseling relationship. I understand that I have the right to terminate this relationship at any time upon notice to my counselor.

Signature of Client: _____Date_____

Parent/Guardian:_____Date:_____

Witness: _____Date: _____

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NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of *treatment, payment, and health care operations*:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law.

You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that we restrict using and disclosing your PROTECTED HEALTH INFORMATION to family members and relatives, friends, or others you identify. We reserve the right to deny this request.
- You may request an amendment to your PROTECTED HEALTH INFORMATION.
- You may request alternative means or locations in which you receive confidential communications.
- You may request an accounting of disclosures of PROTECTED HEALTH INFORMATION beyond treatment, payment, and health care operations.

We are required by law to protect the privacy of your PROTECTED HEALTH INFORMATION and to abide by the terms of the Notice of Privacy Practices. We will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request.

You may file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information regarding our Privacy Practices, please contact:

- Privacy Officer : Richard P. White LMHC
  410 N Dillard ST.
  Winter Garden, FL 34787
  (407) 968-8055

For more information about HIPPA or to file a complaint, please contact:

- The U.S. Department of Health & Human Services
  Office of Civil Rights
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  (877) 696-6775 (TOLL FREE)

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

_____ have received a copy of Richard P. White, LMHC's Notice of Privacy Practices.

Name: _____

Street Address:_____

City:_____ State: _____ Zip: _____

Signature of Client: _____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

Signature of Witness: _____ Date: _____