Discovery Counseling

a non-profit corporation

Counselor: _____ Date: _____

www.discoverycounseling.org Location: _____

Confidential Client Information Form

GENERAL INFORMATION

Full Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Rev. _____

Nick Names: _____ Name you prefer: _____

Social Security Number: _____ Age: _____ Date of Birth: _____

Race: □ White □ Black □ Latino □ Asian □ Other: _____ Sex: □ Male □ Female

Referred by: _____

CONTACT INFORMATION

Street Address: _____ Suite or Apt. #: _____

City: _____ State: _____ Zip Code : _____ May we send mail here: □ Yes □ No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code : _____ May we send mail here: □ Yes □ No

Home Phone: (_____) _____ May we leave a message here: □ Yes □ No

Mobile Phone: (_____) _____ May we leave a message here: □ Yes □ No

Work Phone: (_____) _____ May we leave a message here: □ Yes □ No

Email Address: _____ May we send a message here: □ Yes □ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked per Week: _____

Annual Salary: □ $0 to $10,000 □ $20,001 to $40,000 □ $50,001 to $60,000 □ $80,001 to $100,000

□ $10,001 to $20,000 □ $40,001 to $50,000 □ $60,001 to $80,000 □ More than $100,000

EDUCATION INFORMATION

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ 1 □ 2 □ 3 □ 4 □ Other: _____

Are You Currently in School: □ Yes □ No. If Yes, What Level: _____ Degree Pursuing: _____

RELATIONAL INFORMATION

Current Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

Are You Content with Your Current Status: □ Yes □ No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Spouse: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

With Whom Do You Currently Live *(Check all that apply):* □ Alone □ Spouse □ Children

□ Parent(s) □ Sibling(s) □ Boyfriend □ Girlfriend □ Other: _____

PARTNER INFORMATION

Full Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Prefered Name: _____

Race: □ White □ Black □ Latino □ Asian □ Other: _____ Sex: □ Male □ Female

Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ 1 □ 2 □ 3 □ 4 □ Other: _____

What Words Would You Use to Describe this Person: _____

CHILDREN

List Your Children (Living or Deceased) as well as Children You Have Placed for Adoption

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Natural, Step, Adopted)	Living with You?	Describe Him/Her

Have You Ever Had a Miscarriage or Medical Abortion: □ Yes □ No. If yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected you Positively or Negatively

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Mom, Dad, Sibling, Step)	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____)_____

Address: _____ City: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are You Currently Receiving Medical Treatment: □ Yes □ No. If Yes, Please Specify: _____

List any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments you've had (Use Back if Necessary):

_____

MEDICATION INFORMATION

List All Current Medications You are Taking, Including those you Seldom Use or Take Only as Needed (Use Back if Necessary)

Medication	Dosage	Improves, Prevents or Controls	Treating

Are You Taking These Medication(s) According to Your Doctor's Recommendations: □ Yes □ No.

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to you Presently or in the Recent Past:

Headaches	□ Past	□ Present	Dizziness	□ Past	□ Present	Stomach Trouble	□ Past	□ Present
Visual Trouble	□ Past	□ Present	Sleep Trouble	□ Past	□ Present	Trouble Relaxing	□ Past	□ Present
Weakness	□ Past	□ Present	Tension	□ Past	□ Present	Rapid Heart Rate	□ Past	□ Present
Difficulty Breathing	□ Past	□ Present	Intestinal Trouble	□ Past	□ Present	Hearing Noises	□ Past	□ Present
Change in Appetite	□ Past	□ Present	Tiredness	□ Past	□ Present	Pain	□ Past	□ Present
Hearing Voices	□ Past	□ Present	Seeing Things	□ Past	□ Present	Other	□ Past	□ Present

Your Height: _____ Your Weight: _____ How has Your Weight Changed in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems that Apply to you and/or Your Family:

Stress	□ You	□ Family	Nervousness	□ You	□ Family	Anxiety	□ You	□ Family
Panic	□ You	□ Family	Unhappiness	□ You	□ Family	Depression	□ You	□ Family
Guilt	□ You	□ Family	Apathy	□ You	□ Family	Terminal Illness	□ You	□ Family
Recent Death	□ You	□ Family	Grief	□ You	□ Family	Hopelessness	□ You	□ Family
Inferiority Feelings	□ You	□ Family	Defective Feelings	□ You	□ Family	Loneliness	□ You	□ Family
Shyness	□ You	□ Family	Fears	□ You	□ Family	Friends	□ You	□ Family
Marriage	□ You	□ Family	Communication	□ You	□ Family	Physical Abuse	□ You	□ Family
Emotional Abuse	□ You	□ Family	Verbal Abuse	□ You	□ Family	Sexual Abuse	□ You	□ Family
Temper	□ You	□ Family	Anger	□ You	□ Family	Aggressiveness	□ You	□ Family
Bad Dreams	□ You	□ Family	Concentration	□ You	□ Family	Racing Thoughts	□ You	□ Family
Unwanted Thoughts	□ You	□ Family	Memory	□ You	□ Family	Loss of Control	□ You	□ Family
Impulsive Behavior	□ You	□ Family	Self-Control	□ You	□ Family	Compulsivity	□ You	□ Family
Sexual Problems	□ You	□ Family	Pregnancy	□ You	□ Family	Abortion	□ You	□ Family
Legal Matters	□ You	□ Family	Trauma	□ You	□ Family	Eating Problems	□ You	□ Family
Drug Use	□ You	□ Family	Alcohol Use	□ You	□ Family	Trouble with Job	□ You	□ Family
Career Choices	□ You	□ Family	Ambition	□ You	□ Family	Making Decisions	□ You	□ Family
Children	□ You	□ Family	Being a Parent	□ You	□ Family	Finances	□ You	□ Family
Recent Loss	□ You	□ Family	Disaster	□ You	□ Family	Other	□ You	□ Family

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1= Very Little Distress; 10=Extreme Distress)*

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: □ Yes □ No. Have You Experienced Them in the Past: □ Yes □ No

Have You Ever Attempted Suicide: □ Yes □ No. If Yes, When & How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: □ Yes □ No.

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e. What Are Your Issues, Problems?)*: _____

Why Have You Decided to Come for Counseling Now: _____

What Do You Hope to Gain or Change by Coming for Counseling: _____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back if Necessary)

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself: _____

If God Were to Describe You, What Would He Say: _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: _____

Complete the Following Thought: God is _____

Do You Regularly Attend a Place of Worship: □ Yes □ No. If Yes, Where: _____

What is the Name of your Pastor, Priest, Rabbi or Other Spiritual Leader: _____

Do You Have a Personal Support System: □ Yes □ No. If Yes, Who: _____

TERMS OF SERVICE

I understand that payment for professional services is due when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that if an appointment is not cancelled 24 hours or more in advance of the scheduled appointment, I will be charged the full fee for the session.

Signed: _____ 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 THIS DOCUMENT 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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

·The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

·The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

·The right to request an amendment to your PROTECTED HEALTH INFORMATION.

·The right to receive an accounting of disclosures or PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

·The right to obtain a paper copy of this notice for us upon request.
We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

The Privacy Officer
Cheryl Eastlund Gowin
Discovery Counseling
3806 6th Avenue.
Holmes Beach, Fl 34217
(407) 222-7923

For more information about HIPAA or to file a complaint:

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)

Discovery Counseling
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www.discoverycounseling.org
Administration Phone Number 407-222-7923
Email contact@discoverycounseling.org

Acknowledgment of Receipt of Privacy Practice Notice

I, _____ (Full Name)

have received a copy of Discovery Counseling, A Non profit Corporation Notice of Privacy Practices.

Name: _____

Street Address: _____ Suite / Apt. #: _____

City: _____ State: _____ ZIP Code: _____

Client
Signed: _____ Date: _____

Parent/Guardian
Signed: _____ Date: _____

Witnessed
Signed: _____ Date: _____

Discovery Counseling

a non-profit corporation

Counselor: _____

www.discoverycounseling.org
Administration Phone Number **407-222-7923**
Email **Contact@discoverycounseling.org**

Informed Consent & Release of Liability

Discovery Counseling is operated to provide counseling with a distinctively Christian framework to the community of believers, and non-believers, at various churches and to the local community, as a whole. Counseling services are provided by practitioners who have earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and who have been licensed by the state of Florida as Mental Health Counselors, Registered Mental Health Counselor Interns, or Registered Clinical Social Work Interns, or are Student Interns under the supervision of a licensed mental health counselor (hereafter referred to as Counselors).

The completion of an intake questionnaire and an informed consent and release of liability are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent.

In order to initiate counseling, please read the following agreement. Your signature attests that you both understand and agree to the terms and conditions contained herein.

1. I _____ understand that my counselor is a registered intern, a mental health counselor, or a student intern, working under the laws and rules specified by the state of Florida and/or the Federal Government where applicable.
2. I understand that my counseling records (files) are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession (e.g. child, elder, disabled abuse/neglect reporting requirements, serious threat of harm to self or others, etc.) The clinical records are the property of Discovery Counseling and as such, are deemed records of confidential sessions between counselors and clients. Other than as required by law these records will only be released subject to the following paragraph and with the advanced written consent of the client and Discovery Counseling.
3. In consideration of the benefits to be derived from the counseling, the receipt of which is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable the ministry of Discovery Counseling, the Counselors, and the supervisors, if applicable, from any and all claims, demands, damages, actions, or causes of action whatsoever related to the counseling process.
4. I waive any right I may have otherwise have to seek to use my counseling records with Discovery Counseling, except as may otherwise be agreed upon in writing, in any judicial proceeding or to compel the testimony of any Counselor or supervisor associated herewith. If testimony is required, I agree to pay twice the normal hourly rate for any, and all, of these individuals for their testimony, and preparation therefore.

I have read and understood the preceding information and agree to the terms and conditions of Discovery Counseling as stated herein. I understand that these comments are prerequisite to my receiving and continuing counseling services through this ministry.

Date: _____ Signed: _____

Signed: _____

Witness: _____

Discovery Counseling

a non-profit corporation

Counselor: _____

www.discoverycounseling.org
Administration Phone Number **407-222-7923**
Email: **contact@discoverycounseling.org**

INSURANCE BILLING AUTHORIZATION

RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

I, _____hereby authorize Dennis Gowin of Discovery Counseling to disclose to my Primary Care Physician,

_____ _____
(Primary Care Physician Name) (Address)

all clinical information about me as may be necessary to permit my Primary Care Physician to monitor the continuity of my care and to inform my Primary Care Physician of health status.

This authorization may be revoked by me in writing at any time, with the exception of any actions already taken to coordinate my care. I understand this authorization does not extend to the release of any AIDS/HIV information unless I also place my initials here. _____

I further understand that the information authorized by this release will be released to the authorized representative only, for purposes noted above. I understand I am entitled to a copy of this authorization form for my records.

NOTE TO RECEIPIENT: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and /or state law. In accordance with federal and state law requirements, this information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

RESPONSIBILTY FOR PAYMENT INFORMATION TO INSURANCE CARRIER

I authorize Discovery Counseling to release information or copies of mental health counseling records contained in my patient file to any third party payer or the representative for the purpose of obtaining payment for the services rendered by Discovery Counseling. I understand I am responsible for my bills including any portion of my bill not covered or reimbursed by my insurance company. I authorize Discovery to act as my agent to help assure payment from my insurance company and request and assign payments directly to Discovery by all insurance carries with whom I have coverage. If collection action is necessary, I agree to pay all costs of collection, including reasonable attorney's fees, court costs and collection agency fees associated with the collection process.

Plan Coverage **Insurance Company** _____ **Group Number** _____

Member ID Number _____ **Customer Service Phone Number** _____

Covered under additional Insurance Company Plan Yes / No **Name of Plan** _____

_____ _____
Signature of Participant or Legal Guardian Date

_____ _____
Name of Participant Witness