NEW DIRECTIONS COUNSELING CENTER L.L.C.

5121 South Lakeland Dr. Lakeland, Fl. 33813
Phone (863) 606-5922 Fax (863) 606-5921

PATIENT INFORMATION					
Last Name	**First Name**	**M.I.**	**D.O.B.**	**Sex** M F	**Today's Date**
Address	**City**	**State**	**Zip**	**SSN**	
Home Phone	**Cell Phone**	**Marital Status** S, M, W, Div, Sep	**Employer (or School) Name**		
Primary Care Physician	**Psychiatrist**	**Referred by**			
Is it okay to confirm appt. by email? YES NO	**Please provide email address:**				

SPOUSE INFORMATION			
Last name	**First name**	**M.I.**	**D.O.B.**

I hereby give consent to New Directions Counseling Center (NDCC) to provide whatever treatment they may deem necessary to the patient above. I authorize NDCC and its staff to release my insurance carrier and its agents any information concerning health care advice, evaluation or treatment needed to determine those benefits or the benefits payable for related services. I hereby request payment of authorized benefits and/or any other, including supplemental insurance, benefits for me to be paid directly to New Directions Counseling Center for any services provided to me by NDCC. I authorize the office of NDCC to release or exchange information to staff and providers within NDCC. I understand personal information will not be provided to outside providers without my signature on a general release of information form. Confidentiality will be suspended if I am a danger to myself or others, if child or elder abuse is suspected, if issued a court order, or if otherwise prescribed by law. I understand I am responsible for charges incurred for services if they are not covered by my insurance and the co-pay is due before each session. Should it become necessary to collect the charges through an attorney or other collections processes, I shall be responsible for all court costs, attorney's fees and collections expenses. I understand I will be responsible for a $70.00 fee if I fail to show up at an appointment without at least 24 hours advance notice for each occurrence. Repeated occurrences might result in the termination of services.

Permission to Treat a Minor

I __________________ (parent/guardian) give permission to _____________________, to see my child _______________ for therapeutic services with or without me being present during sessions.

ALL PATIENTS PLEASE SIGN.

__________________________ __________ __________________________ __________

PATIENT SIGNATURE DATE SPOUSE /GUARDIAN SIGNATURE DATE

HIPAA Notice of Privacy Practices

This notice describes how Mental Health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information relating to your past, present, and future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your counselor, our staff and others beyond our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the counselor's practice, and any other use required by law.

We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed your protected health information in order to support the business activities of your counselor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of counseling students, licensing, arranging for other business activities. For example, we may disclose your PHI to counseling school students that see patients at out office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your appointment time. We may also call you by name in the waiting room when your counselor is ready to see you. We may also use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donations, research, criminal activity, military activity and national security, workers' compensation, inmates, required uses and disclosures, (under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and human Services to investigate or determine our compliance with the requirements of Section 164.500)

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing except to the extent that your counselor or the counselor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

1)You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.
2)You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your counselor is not required to agree to a restriction that you may request. If your counselor believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your counselor amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such a rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: ______________________________ Signature: _______________________________ Date:_____________

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Policies and Fees

Please initial each blank, indicating that you have read and understood each policy.

________ As a courtesy, our office verifies your insurance. **If the insurance company provides the wrong payment information, it is your responsibility for any additional payments.** Your payment is final once services are rendered. New Directions Counseling Center will not back date any past dates of service to your insurance.

________ We do not see clients involved in court proceedings pertaining to their counseling service.

________ If you "no show" or cancel in less than 24 hours before your appointment, you will be responsible for a **$70.00 fee.** This fee is included for clients who are on the cancellation list that take the place of someone else.

________ We bill for any additional professional services we provide beyond the office visit. Additional services include, but are not limited to written reports for third parties, filling out paperwork, e-mails between scheduled appointments, etc.

________ If you "no show" or cancel less than 24 hour notice twice in a row, we reserve the right to suspend services.

________ If your session is virtual/telehealth payment is due by the end of the week. If payment not received on Friday by noon, all future appointments will be canceled.

________ We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, we are not part of that contract.

________ Your insurance will be billed for a 45 minute session. If you are more than 15 minutes late you may not be seen.

Print Name__________________________ Sign Name____________________________

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AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Patient:____ DOB:_________________

Information to be released by or exchanged with:

Name:____

Address:____

Information To Be Released By Or Exchanged:

___Discharge Summary
___Mental Status
___Treatment Plans
___Psychological Test Results
___Therapist Orders
___Psychosocial Report

___ Court/ Agency Documents
___ Psychiatric Evaluation
___ Consultation Reports
___ Progress Notes
___ Diagnoses
___ Crisis Intervention Reports
Other:___________________________

Parent/ Patient Signature:_______________________________________
Date:______________

Treatment Goals: Check all that apply.

1. Reducing a fear.
2. Having more pleasurable activities.
3. Improving communications with my: (circle)
   Spouse/ Children/ Friends/ Coworkers/ Others
4. Expressing myself more assertively.
5. Learning how to relax.
6. Better managing my health.
7. Better tolerating my mistakes.
8. Better tolerating others' mistakes.
9. Feeling less guilt.
10. Feeling less depressed.
11. Better accepting a loss/ death.
12. Increasing my conversational skills.
13. Learning how I come across to others.
14. Not taking disappointments so hard.
15. Doubting myself less.
16. Thinking more positively.
17. Improving my sexual relationship.
18. Controlling my eating or weight.
19. Controlling my alcohol use.
20. Changing a habit.
21. Controlling my drug use.
22. Better managing my pain.
23. Learning how to improve friendships.
24. Reducing uncomfortable thoughts.
25. Learning more effective parenting skills.
26. Improving my sleep.
27. Reducing my sensitivity to possible criticism.
28. Talking out a pending decision.
29. Problem-solving/ decision making techniques.
30. Reducing panic attacks.
31. Increasing self-esteem.
32. Reducing family difficulties.
33. Reducing job difficulties.
34. Better managing my temper.
35. Taking initiative more often.
36. Receiving medication help.
37. Decreasing procrastination.
38. Better managing time.
39. Decreasing trying to be perfect.
40. Not reacting so emotionally.
41. Allowing myself to express feelings more.
42. Building self-confidence.
43. Discussing self- harm thoughts.
44. Discussing thoughts of harming others.
45. Adjusting better to recent change/ incident.
46. Adjusting better to a past change/ incident.
47. Becoming more optimistic.
48. Improving my self-awareness.
49. Adopting a healthier attitude.
50. Worrying less.

51. Other (specify):

Now, please review your list and decide which 3 goals you wish to discuss/ change at this time.

MY 3 most important goals are (write in the goal numbers):

First:__ Second:__ Third__

Symptom Checklist

Adults (check all that apply)

__Depressed Mood
__Restlessness
__Loss in pleasurable activities
__Racing thoughts
__Lack of motivation
__Behaviors that have to be repeated
__Recurrent thoughts of death
__Withdrawing from others
__Irritable
__Sexual Issues
__Auditory/ Visual Hallucinations
__Muscle tension
__ Fatigue
__Increase/loss of appetite
__Elevated/ High Mood
__Increase in Crying
__Problems concentrating
__Drug use
__Recurrent, intrusive thoughts
__Low self esteem
__Suicidal thoughts
__ Anxiety
__Easily distracted
__Excessive worrying
__Alcohol Abuse
__No energy
__Sleep problems
__Panic Attacks
__ Experiencing/ Witnessing a traumatic event
__Weight loss/gain

Other problems not in the checklist:

____

____

Please list any medications:

____

____

Children (Check all that apply)

__Sadness
__Impulsivity
__Developmental Delays
__ Academic Problems
__Anger
__Inattentive
__Separation Issues
__Fear/Scared
__Behavior Problems
__Attention Problems

Other problems not in the checklist:

____

____

Please list any medications:

____

____