TELECOUNSELING FLORIDA AT FAMILY COUNSELING CENTER

Diane HM Mandell MSSA, LISW, LCSW and Associates

Serving the Community Since 1993

CLIENT INTAKE FORM

General Information

Last Name: _____ First: _____ Middle: _____ Birth Date: ____/_____/_____

Preferred Name: _____ Preferred Pronoun: Him/He She/Her They/Them Other: ___

Address: _____ City: _____ State: _____ Zip: _____

Gender: _____ Marital Status: _____ Social Security #: _____ - _____ - _____

Employer: _____ Relationship to Insured: _____ Referred by: _____

Emergency Contact Name: _____ Relationship: _____ Phone #_____

Patient Contact Information: Email Address: _____

Cell Phone #: _____ May we leave a message? YES_____ NO_____

Work Phone #: _____ May we leave a message? YES_____ NO_____

Form of Counseling: Individual Couples/Marital Family

Financial Arrangements

Self-Paying Clients

Agreed Upon Self Pay Rate: _____ per session. _____
(Initial)

I agree to pay for services in the amount mentioned above. For services provided virtually (telephone or video therapy), I agree to be charged automatically for services to the credit card I authorize: _____
(client signature)

Insurance Information

Authorization #_____

Insured Last Name: _____ First: _____ Middle: _____Birth Date: ___/____/_____

Coinsurance Amount: _____ Deductible Amount: _____ Has your deductible been met? Yes No

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Social Security #_____ - _____ - _____ Employer: _____

Insurance Company: _____ Address: _____

City: _____ State: _____ Zip: _____ Insurance Phone #: _____

Policy/Subscriber Number: _____ Group Number: _____ Referral from Primary Care Required? Yes No

I agree to pay for any and all copayments and unmet deductibles for which I am responsible. For services provided virtually (telephone or video therapy), I agree to be charged automatically for services to the credit card I authorize:

_____
(client signature)

Employee Assistance Programs (EAP)

Employer: _____ EAP Service Provider: _____

Member's Last Name: _____ First: _____ Middle: _____Birth Date: ____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____Number of Visits Authorized: _____ Authorization Code: _____

Dates of Authorization: from ____/____/_____ to ____/____/_____ Authorized to: _____
(name of therapist)

Coordination of Care

It is important for your health care providers to speak to each other, so we may work together to help you. Please complete the information below and indicate your approval for us to coordinate care.

Primary Care Physician: _____ Phone #: _____Fax #: _____

Address: _____City: _____ State: _____ Zip _____

May we contact your physician? ____YES ____ NO ____ I do not have a physician

Psychiatrist: _____ Phone #: _____Fax #: _____

Address: _____City: _____ State: _____ Zip _____

May we contact your psychiatrist? ____YES ____ NO ____ I do not have a psychiatrist

Assignment & Release: I hereby assign my insurance benefits to be paid directly to the undersigned therapist. I am financially responsible for non-covered services. I also authorize the therapist to release any information requested.

_____ _____

Client Signature or Authorized Parent/Guardian **Date**

Patient Rights and Responsibilities

As a client of the Telecounseling Florida at Family Counseling Center, you have the following rights:

1. Services shall not be denied to any person on the grounds of race, ethnicity, age, color, religion, gender, nationality, sexual orientation, handicap, or developmental disability.
2. To be treated with courtesy and respect by all staff.
3. To receive appropriate mental health care or to be provided with a referral to another qualified provider, if necessary.
4. To participate in the planning of your treatment throughout the counseling process.
5. To ask questions and learn about the counseling process, and the qualifications of your provider(s).
6. As a competent individual, consent to or refuse treatment.
7. To confidentiality of your records and the right to inspect your records.
8. To be informed of your condition and to know the costs of services.

And the following responsibilities:

1. To make your payment at the time of service (whether self or co-payment).
2. To have your insurance company billed for covered services. You are responsible for all copayments, deductibles, and/or coinsurance payments as required by your insurance policy.
3. To schedule and keep appointments. Should you need to cancel or reschedule an appointment, we require a least 48 hours' notice when possible. Should you not provide notice, or not show for an appointment, you will be charged $55. We will automatically bill this to the credit card you list below.
   CC#_____ exp date_____
4. To not come to any appointment under the influence of any mood-altering substances, unless prescribed and only as prescribed by a physician. If you do, you will be asked to reschedule and charged $45.
5. To give your treatment provider the necessary information about you, and to be involved in the planning of your treatment.
6. To follow the recommendations of your treatment provider, including those for psychiatric evaluations for medication therapy and testing, and to follow the agreed upon treatment plan.

I have read, understand, and agree with my rights and responsibilities.

_____ _____

Client Signature Client Signature

TELECOUNSELING FLORIDA AT FAMILY COUNSELING CENTER
Diane HM Mandell MSSA, LISW, LCSW and Associates
We help people find balance in their lives everyday..

phone: (727) 254.9183 | fax: (888) 345.7010 | phcounseling1@gmail.com | intake@phcounseling.com

Serving all of Florida

Consent to Treatment

Informed consent: We ask that all clients sign the following general consent to treatment. You may at any time decline specific recommendations, with the understanding that you are responsible for your care as a client of the Telecounseling Florida at Family Counseling Center. You also have the right to know about the limits to confidentiality.

The code of ethics for the American Psychological Association (APA), the state of Florida counselor, social worker, and marriage and family therapy board, and the health insurance portability and accountability act of 1996 (HIPPA), ensure that your records and conversations at the Telecounseling Florida at Family Counseling Center are to remain confidential and private, and not be discussed with anyone without your expressed written consent. However, there are certain limits and exceptions to your rights to confidentiality that we are required to uphold by the same codes of ethics, and state and federal laws. They are as follows:

1. The child and elder abuse reporting laws of the state of Florida require that any suspected abuse or neglect of any minor child under the age of 18, or any elder over the age of 60, be reported to the appropriate authorities, i.e. local police, department of children & family services. Child abuse/neglect may include, but is not limited to, inappropriate forms of punishment, physical and/or emotional neglect, abandonment, or sexual molestation. This also applies to the elderly.
2. Recent court decisions have mandated exceptions to the right to confidentiality when a client poses the imminent risk of harm to self or others. At any time during your treatment at the Telecounseling Florida at Family Counseling Center you threaten to harm yourself or others (suicide, homicide, or other acts of violence), we are required by law to notify the proper authorities and the intended victim(s). If at any time you disclose the intention to commit any felony, we will be required to notify the appropriate authorities.
3. If it is deemed in the best interest of your treatment, your treatment provider(s) here at the Telecounseling Florida at Family Counseling Center reserve the right to consult with other qualified professionals about you, but only as it relates to your care.
4. If you ask us to bill your insurance company to pay for your services, you are giving your insurance company the right to inquire about you and your treatment. Some insurance companies require specific information in order to process your claims, and your treatment provider(s) will be required to respond in order for you to maintain your benefits.

I give my consent for services to be provided by:_____, at the Telecounseling Florida at Family Counseling Center, and associated professional staff to include evaluation, psychotherapy, testing (if indicated), psychiatry (if indicated), and be involved in the treatment planning process.

_____		_____	
Client Signature	Date	Client Signature	Date
_____		_____	
Parent/Guardian (if client is a minor)	Date	Family Counseling Center Staff	Date

HIPAA NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have been given a copy of the HIPAA Notice of Privacy Practices. I also acknowledge that I understand the information contained in the notice and agree to the terms and conditions contained within, for services provided by_____ with Telecounseling Florida at the Family Counseling Center.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Parent/Guardian (if client is a minor) Date

_____ _____
Staff Date

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TELEMEDICINE / TELEHEALTH INFORMED CONSENT

I _____ [name of patient] hereby consent to engaging in telemedicine at Telecounseling Florida at Family Counseling Centers as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in the state of Florida.

Technology: I understand that I will need to have access to an email account to participate in telemedicine / telehealth. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Telecounseling Florida at Family Counseling Centers via phone to coordinate alternative methods of treatment.

Financial Obligations: Fees associated with telemedicine appointments are payable by credit or debit card only. If fees may be associated with my telemedicine services, I agree to have my credit/debit card information on file with Telecounseling Florida at Family Counseling Centers. My card will be billed the same day as my scheduled telemedicine appointment. If my card is declined, Telecounseling Florida at Family Counseling Centers will cancel my appointment and I will be charged in accordance with the cancelation policy. (Client Initial: _____)

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Family Counseling Centers and that Telecounseling Florida at Family Counseling Centers may release any information to my insurance provider required for processing my claims. (Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with Telecounseling Florida at Family Counseling Centers cancellation policy as documented by my signature on the Informed Consent. (Client Initial: _____)

I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted through Telecounseling Florida at Family Counseling Centers and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Video/Audio Recording: As a general practice Telecounseling Florida at Family Counseling Centers DOES NOT record Telemedicine sessions without prior permission.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. Telecounseling Florida at Family Counseling Centers' telehealth platform is HIPAA compliant to protect my privacy and confidentiality.

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withdraw my consent at any time.
2. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a counselor/therapist who can provide such services in my geographic area.
3. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured.
4. I understand that Telecounseling Florida at Family Counseling Centers may not provide telemedicine services to me if I am outside of the State of Florida, and I understand that I may access telemedicine services from Telecounseling Florida at Family Counseling Centers from within the State of Florida only.
5. I understand that I have a right to access my mental health information and copies of medical records in accordance with Florida state law.

I have read and understand the information provided above. I have discussed it with my counselor/therapist/clinical intern, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

_____ _____

Client Signature Date

_____ _____

Client Guardian's Signature Date

_____ _____

Provider's Name & Signature Date

Credit Card Authorization

I, _____ (print name) am authorizing Telecounseling Florida at Family Counseling Center, Diane Miller-Mandell & Associates, to charge my credit card in the event that I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 24 business hours in advance, as agreed to in the Office Policy Form. Furthermore, for outstanding payments of services rendered, I authorize Telecounseling Florida at Family Counseling Center, Diane Miller-Mandell & Associates to charge my credit card for the full amount due. I will not dispute for sessions I have received or that I have not cancelled less than 24 business hours in advance.

I further authorize Telecounseling Florida at Family Counseling Center, Diane Miller-Mandell & Associates, to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Type (circle one): Visa Mastercard American Express

Card #: _____

3-digit Security Code (4-digit for American Express): _____

Expiration date: _____

Name as printed on card: _____

Billing Address: _____
(Street, City, State, & Zip)

Signature: _____ Date: _____
(patient or financially responsible party)

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply:

- No-show for a schedule appointment
- Cancellation less than 24 business hours in advance
- Participation in treatment (eg. Appointment or phone session) without payment rendered

How to Access Virtual Appointment

The link that you will need to access at your scheduled appointment time is doxy.me/familycounseling. Once you arrive at the website, it will ask you to type in your name. After you have done so, you will be connected to your therapist. If you have any questions or concerns or need to reschedule this appointment please feel free to contact our administrator, Diane Mandell via email at phcounseling1@gmail.com or phone at (727)-254-9183.