



Phone: 407.405.7677

Web: redeemercounselingcenter.com

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Thank you for taking this important step to pursue counseling for you and/or your family. Please find in this packet several important documents to ensure you receive the best professional treatment possible. This includes the **Confidential Client Information Form, Statement of Counseling Policies and Procedures, and Informed Consent and Release of Liability.**

In addition, this packet includes a copy of our **Notice of Privacy Practices**. This is in compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPPA). This Federal law requires that all health care professionals notify patients of how their health information is protected and how it may be used.

Florida law regarding psychotherapy is much stricter than Federal guidelines. HIPPA allows stricter state laws to prevail where conflict between the two may exist.

To best serve you, please take the time to review the attached documents, complete the necessary information, and sign the **Acknowledgement of Receipt of Privacy Practices, Statement of Counseling Policies and Procedures, and Informed Consent and Release of Liability.**

If you have questions regarding HIPPA or our privacy practices, please do not hesitate to contact us.



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## Confidential Client Information Form

### GENERAL INFORMATION

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_ May we thank them? \_\_\_\_\_

Full Name:  Mr.  Mrs.  Ms.  Miss  Dr.  Rev. \_\_\_\_\_

Nick Name: \_\_\_\_\_ Name You Prefer: \_\_\_\_\_

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

Race:  White  Black  Hispanic  Asian  Other: \_\_\_\_\_ Sex:  Male  Female

### CONTACT INFORMATION

Street Address: \_\_\_\_\_ Suite/Apartment Number: \_\_\_\_\_

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 Email Here:  Yes  No

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Mobile Phone: (\_\_\_\_\_) \_\_\_\_\_

### EMPLOYMENT INFORMATION

Employer: \_\_\_\_\_ Length of Employment: \_\_\_\_\_

Occupation: \_\_\_\_\_ Average Hours Worked Per Week: \_\_\_\_\_

Average 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 Relational Status:  Single  Dating  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 Your Partner: \_\_\_\_\_

If Separated or Divorced, How Long: \_\_\_\_\_ If Widowed, How Long: \_\_\_\_\_

Partner's Name:  Mr.  Mrs.  Ms.  Miss  Dr.  Rev. \_\_\_\_\_

How Long Have You Known Your Partner: \_\_\_\_\_ Age: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Partner's Race:  White  Black  Hispanic  Asian  Other: \_\_\_\_\_ Partner's Sex:  Male  Female

Partner's Occupation: \_\_\_\_\_ Average Hours Worked Per Week: \_\_\_\_\_

Last Year of School Partner Completed:  9  10  11  12  GED College:  1  2  3  4  Other: \_\_\_\_\_

What Words Would You Use to Describe Your Partner: \_\_\_\_\_

Is Your Partner Supportive of You Seeking Counseling:  Yes  No  Unsure  Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*):  Alone  Spouse  Children  Parent(s)  Sibling(s)  
 Boyfriend  Girlfriend  Roommate  Other: \_\_\_\_\_

## CHILDREN

List Your Children (Living or Deceased):

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

Have You Ever Placed a Child for Adoption:  Yes  No. If Yes, When: \_\_\_\_\_

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 <i>(e.g. Mom, Dad, Sibling, Step)</i>	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 Have Had (Use Back if Necessary): \_\_\_\_\_

## MEDICATIONS

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  Controls: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  Improves  Prevents  Controls: \_\_\_\_\_

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.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Dizziness.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Stomach Trouble....	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Visual Trouble.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Sleep Trouble.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Trouble Relaxing....	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Weakness.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Tension.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Rapid Heart Rate...	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Difficulty Breathing..	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Intestinal Trouble....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Hearing Noises.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Change in Appetite.	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Tiredness.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Pain.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Hearing Voices.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Seeing Things.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Other.....	<input type="checkbox"/> Past	<input type="checkbox"/> Present

Your Height: \_\_\_\_\_ Your Weight: \_\_\_\_\_ How has Your Weight Change in the Last 2-3 Months: \_\_\_\_\_

## CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

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

## 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 and 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: \_\_\_\_\_

## 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 it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.*

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

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



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## **Statement of Counseling Policies and Procedures**

### **COUNSELING SESSIONS**

Counseling sessions at Redeemer Counseling are available weekly. Sessions are scheduled to begin on the hour and are 50 minutes in duration. Please arrive on time so that you can benefit from a full-length session. Because of other scheduled clients, your session will end at 50 minutes pass the hour regardless of your arrival time.

### **PROFESSIONAL SERVICE FEES**

The professional service fee per 50 minute session is \$135. Payment is due at the time of service. You may pay by cash, credit card, or check made payable to "Redeemer Counseling." A \$25.00 service charge will be levied on all checks returned by a financial institution for insufficient funds. If you be unable to pay for all or part of a session, please speak with your counselor.

### **INSURANCE**

Redeemer Counseling will provide you with a receipt should you choose to pursue personal reimbursement from your insurance company. We do not accept or file any insurance on your behalf.

### **OFFICE HOURS**

Redeemer Counseling's office hours are by appointment. Please call and leave a message with your therapist should you need to talk outside of your regularly scheduled appointment time.

### **RESCHEDULING APPOINTMENTS**

It is our policy to schedule you for a regular "standing appointment." This will be confirmed at each session that you intend to come at the same time for your next appointment. If you occasionally need to come at a different time you can ask your counselor to determine if an alternative appointment time is available. Please be aware that two or more cancellations or "no-shows" will result in the loss of your standing appointment.

### **CANCELLATIONS AND MISSED APPOINTMENTS**

A 24-hour notice should be given to cancel a previously scheduled appointment. Advance cancellations allow us to make the most efficient use of counselor time and office space. Failure to give a 24-hour notice will result in you being charged the full professional service fee, payable on your next visit. A *mutually agreed upon* emergency will result in rescheduling with no charge.

### **CONTACTING YOUR COUNSELOR**

You may leave a confidential voice mail message for your counselor 24 hours a day, 7 days a week. Telephone calls will be returned within 24 hours, between 8:00 a.m. and 5:00 p.m. Monday through Friday, unless otherwise arranged. Email and text messaging may be used for periodic business communication; including confirmation of appointments and to inform you of educational opportunities provided by Redeemer Counseling. Email or text messaging will not be used as a means of counseling or therapeutic exchange. In the case of an emergency, please call 911. Our office is not a crisis center and is not staffed 24 hours.

**I understand and agree to the policies and procedures as written above.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Client Name



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### ***Informed Consent and Release of Liability***

While sensitive to other faiths, Redeemer Counseling is operated to provide counseling with a distinctively Christian framework to the local community. Counseling services are provided by independent Christian professionals who have earned a Master's Degree, or higher, from an accredited graduate program, and who have been licensed by the State of Florida or provisionally licensed by the State of Florida as registered interns as defined in and governed by Chapter 491, Florida Statutes.

To begin counseling services, the completion of an intake questionnaire and the signing of an Informed Consent and Release of Liability form are required. While I expect benefits from treatment, I fully understand that such benefits and particular outcomes cannot be guaranteed. I understand that because of the treatment, I may experience emotional strain, feel worse during treatment, and make life changes, which could be distressing. I also understand regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so I will notify the provider at least two weeks in advance so that effective discharge planning can be implemented.

I understand that contents of all therapy sessions are considered confidential. Both verbal information and written information about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

- When a client discloses intentions or a plan to harm self or another person, the mental health professional is required to notify legal authorities and those people who may be impacted.
- If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
- When a mental health professional is made aware of prenatal exposure to controlled substances that are potentially harmful, a report must be made to the appropriate authorities.
- Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.
- Insurance companies (when applicable) and other third-party payers are given information that they request regarding services to clients, such as types of service, dates/times of service, diagnosis, treatment plan, progress of therapy, case notes, and summaries.

The clinical records are the property of the mental health professionals of Redeemer 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 Redeemer Counseling.

I waive any right I may have otherwise to seek to use my counselor records with Redeemer Counseling, except as may otherwise be agreed upon in writing, in any judicial proceeding or to compel the testimony of any mental health professional outlined in Chapter 491, Florida Statutes or supervisors providing counseling with Redeemer Counseling. 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.

In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release and forever discharge and covenant not to sue or hold legally liable Redeemer Counseling; the licensed counselors; the licensed therapists; the registered interns; the supervisors; or the staff from any and all claims, demands, damages, actions or causes whatsoever related to the counseling process.

I have read and understood the preceding information and agree to the terms and conditions of Redeemer Counseling as stated. I understand that this agreement is a prerequisite to receiving and continuing counseling services through Redeemer Counseling.

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

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

Witnessed: \_\_\_\_\_

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, except to the extent that we have already taken actions relying on your authorization.

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. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- 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.
- The right to obtain a paper copy of this notice from us upon request.

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:

J. Michael Blackston, M.A.  
Licensed Mental Health Counselor MH9621  
Redeemer Counseling  
2562 Rouse Road  
Orlando, FL 32817  
(407) 405-7677

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***

I, \_\_\_\_\_ have received a copy of Redeemer Counseling's Notice of Privacy  
(Full Name)

Practices.

Print Name of Client: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

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