REDEEMER Counseling

Phone: 407.405.7677
Web: redeemercounselingcenter.com

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—Minor Client

GENERAL INFORMATION

Date: _____ Referred by: _____ May we thank them? _____

Full Name of Child/Adolescent: _____

Name of Parent/Guardian: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Rev. _____

Name You Prefer: _____ Name Child Prefers: _____

Relationship to Child: _____

Your Age and Date of Birth: _____ Child's Age and Date of Birth: _____

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

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 (other than adult filling out form)

Name: _____ Relationship: _____

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

EMPLOYMENT INFORMATION OF ADULT/PARENT

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

RELATIONAL INFORMATION OF ADULT/PARENT

Current Relational Status: □ Single □ Dating □ Engaged □ Married □ Separated □ Divorced □ Widowed

Are You Content with Your Current Relational 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: _____ Partner's Sex: □ Male □ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

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

FAMILY OF ORIGIN FOR CHILD

List Your Children, Parents, and Grandparents (Living or Deceased):

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

MEDICAL INFORMATION OF CHILD

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty *(e.g. Family Practice, Pediatrician, Internal Medicine)*: _____

Is Child Currently Receiving Medical Treatment: □ Yes □ No. If Yes, Please Specify:
_____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments Child Has Had *(Use Back if Necessary):* _____

_____

CHILD'S MEDICATIONS

List All Current Medications Child is Taking, Including those Seldom Used or Take Only as Needed (*Use Back if Necessary*):

Medication: _____ Dosage: _____ □ Improves □ Prevents □ Controls: _____

Medication: _____ Dosage: _____ □ Improves □ Prevents □ Controls:_____

Is Child Taking these Medication(s) According to Doctor's Recommendations: □ Yes □ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS NOTED CONCERNING CHILD

Please Check Any of the Following Physiological Symptoms/Sensations that Apply 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

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

CURRENT STATUS OF CHILD

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

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

Is Child Currently Experiencing Any Suicidal Thoughts: □ Yes □ No. Has Child Experienced Them in the Past: □ Yes □ No

Has Child Ever Attempted Suicide: □ Yes □ No. If Yes, When and How: _____

Have Any of Child's Friends or Family Ever Committed or Attempted Suicide: □ Yes □ No

If Yes, When and Who: _____

PEOPLE LIVING WITHIN HOME OF CHILD/ADOLESCENT

How many times has your family moved in the past year? _____

Has an adult besides yourself moved into or out of your home in the last year? □ Yes □ No

If Yes, please explain: _____

Describe how well you get along with your spouse/significant other: _____

Does the child/adolescent's grandparents live in the home? □ Yes □ No

How many of the child/adolescent's siblings live in the home?_____

Do any of the siblings provide support/advice to the child when he/she needs it? □ Yes □ No

Has a psychological or psychiatric evaluation ever been done on your child? □ Yes □ No

Results: _____

Has your family ever been investigated by Department of Children and Family Services? □ Yes □ No

If Yes, Please Explain:_____

FAMILY ACTIVITIES

How often does your family have dinner together?_____ Do activities together? _____

If you do activities with your family, what are they?_____

What time is your child's curfew on school nights?_____ Weekend Nights? _____

Do you give your child specific chores around the house? □ No □ Yes (please specify) _____

If your child does not follow the rules or disobeys, what are the consequences for his/her behavior?_____

_____

CHILD'S SCHOOL INVOLVEMENT

Is your child in any advanced classes this year? □ No □ Yes _____

What grades did your child get on his/her last report card?_____

If your child is failing classes, how many classes and which ones? This Year_____ Last Year:_____

Has your child had a discipline problem at school? This Year_____ Last Year: _____

Does your child like school? □ Yes □ No

How regularly does your child attend school? □ Every day □ Most days □ Some days □ Never

Does your child/adolescent have friends?
□ Yes, I have met most of them □ Yes, but I have never met them
□ My child does not talk about his/friends □ No friends at all

Is your child involved in any extracurricular activities?
□ Yes □ No □ I don't know

If Yes, what: _____

CRIMINAL INVOLVEMENT AND SUBSTANCE USE OF CHILD AND FAMILY

Has your child or any family members ever been arrested? □ No □ Yes (please explain) _____

Does your child use alcohol or drugs?
□ Never □ Has experimented once or twice □ Uses every weekend
□ Uses several times a week □ Uses Daily □ I don't know

Do the adults in your home use alcohol or drugs? □ Yes □ No □ I don't know

Do other children in the home use alcohol or drugs? □ Yes □ No □ I don't know

CURRENT ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e. What Are Child's 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

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 fee.

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.

Guardian's Signature	Date
Print Guardian's Name	Print Client Name

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Informed Consent and Release of Liability to Treat a Minor Client (Pages 1 of 2)

Legal Guardian Name(s): _____

Minor's Name: _____ DOB: _____

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 Statues.

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 for my child from treatment, I fully understand that such benefits and particular outcomes cannot be guaranteed. I understand that because of the treatment, my child 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 for my child 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 for my child can be implemented.

I understand that contents of all my child's 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 child's counseling 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

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Informed Consent and Release of Liability to Treat a Minor Client (Pages 2 of 2)

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 understand that once my child reaches the age of majority my consent for treatment is no longer required.

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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Minor Child Not Living With Both Legal and/or Biological Parents

Please complete this form only in cases where a minor child does not live with both legal and/or biological parents. Please be aware that Redeemer Counseling must contact the other parent via mail or telephone if both parties are not present during the initial intake session.

Contact Information

Mother's Name: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Living and Medical Arrangements

What is the living arrangement of the minor client? _____
_____

Primary Residence of the minor client: □ Mother □ Father

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____

Secondary Residence of the minor client: □ Mother □ Father

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____

What is the arrangement for seeking medical services on behalf of the minor client? _____
_____

What document type has determined these arrangements (e.g. divorce decree, separation order, temporary order, etc.)?
_____

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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
(Full Name)
Notice of Privacy Practices.

Print Name of Client: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____