Life Counseling
43 Barkley Circle, Suite 102
Ft Myers, FL 33907
PH: 239-939-4566 FAX: 239-936-4413

Office Policy

WELCOME. We appreciate your coming to us. It is our desire to help you according to your needs. However, please keep in mind that we are not an emergency mental health service – should you ever require emergency assistance, be sure to call the Ruth Cooper Center at 239-275-4242. The following information presented here is intended to familiarize you with our policies. If you have any further questions, please feel free to discuss them with your therapist.

THE THERAPY PROCESS
We view the therapy process as a process in which a person interacts with a trained, licensed professional in an attempt to bring about positive change. Since most life problems develop over time, it usually takes time to find relief.

TIME FRAME
The length of each session is approximately 45-50 minutes. Should you be late for a session, your therapist will see you for the remainder of your scheduled session. Since another person is usually scheduled for the next hour, it is not possible to extend to or beyond the next session.

FEE STRUCTURE
Our fee is $130 for the initial visit and $100 for subsequent sessions. Many insurance plans cover our service. If you have insurance, we will assist you in processing your claim; however, the final responsibility for payment is yours. You are responsible for securing any necessary pre-authorization from your insurance carrier prior to the initial date of service as well as remitting any co-pays due at the time of your session.

MISSED APPOINTMENTS
Cancellations need to be made at least 24 hours in advance. Cancellations made less than 24 hours in advance will be charged the full fee. Messages can be left on our voice mail at any time at 239-939-4566.

_______________________________ __________________
CLIENT SIGNATURE DATE

CLIENT PROFILE

First Appointment Date ________________________________

Last Name ________________________ First Name __________________MI_______

If under 18, Parents' Names ____
(Mother) (Occupation)

____
(Father) (Occupation)

Address ____

____

Home Phone ________________________ Cell Phone _________________________

Birth Date ____/____/____ Sex M______ F ______Social Security #______________

Married___ Co-habitating____ Separated ____ Divorced ___Widowed____ Single_____

Occupation ________________________________ Work Phone __________________

Employer ____

Insurance Carrier __________________________ Insurance #___________________

Student Yes______ If Yes, Where?____

Referred by ____

Person Responsible for Bill Patient ______ Other ____________________________

Do you have health insurance that covers mental health counseling? Yes____ No ____

Does your health insurance require pre-authorization? Yes__ No__
Authorization No. _____________________________

If insurance is in another person's name, please provide the following
Insured's Name _______________________ Social Security #____________________
Birth Date ____/____/____ Employer _______________________________________

WE MUST HAVE A COPY OF YOUR INSURANCE CARD AND HAVE YOU SIGN AN INSURANCE FORM PRIOR TO THE FIRST SESSION.

Office use only below this line____

Fee __________ Co-pay __________ Diagnosis Code _______________

AREAS OF CONCERN

Which of the following are concerns for you? (Please circle)

Stress	Legal Problems	Parenting
Gambling	Caring for Someone	Grief
Anger	Alcohol/Drug Use	My Thoughts
Depression	Bad Habits	Emotions
Suicidal Thoughts	Tiredness	Friends
Medical	Loneliness	Smoking
Physical Pain	Weight Gain	Career Decisions
Family	Weight Loss	Self Control
Relationships	Financial Problems	Marital/Divorce
Trouble Sleeping	Spiritual Needs	Nightmares
Worries About Children	Sexual Difficulties	Physical/Sexual Abuse
Concentration	Memory	Eating Problems/Appetite

What else concerns you?____

____

List of Members of your family/others in your home?

Name	Age/Birthdate	Relationship

Has anyone in your family ever had an alcohol/drug problem? Yes____ No ____

Has anyone in your family ever had a mental health problem? Yes ____ No ____

Have you ever been to counseling before? Yes ___ No ___ Did it help? Yes ____No ____

When were you last examined by a physician and what is his/her name? _______________

____

List any major health problems for which you currently receive treatment: ______________

____

List any medications which you are now taking. Please include dose, frequency, and supervising physician.

____

____

Have you used drugs other than for prescribed medical purposes? Yes ____ No ____

If so, what drugs? ____

If alcohol is one of your areas of concern, what and how much do you drink each week?

____

Thank you for completing this questionnaire.

____
Signature

Notice of Privacy Practices – Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP and you may have a copy of this to read and refer to it for more information. However, we can't cover all possible situations, so please talk to your therapist (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purpose, we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it., For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires to do so.

4. For Workers Compensation and similar benefit programs.

Your rights regarding your health information:

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information we have about you such as your client and billing records. You can even get a copy of these records but we may charge you. Contact your therapist to arrange how to see your records.

4. If you believe the information in your record is incorrect or missing important information, you can ask us to make some changes (called amending) to your health information. You have to make this request in writing and send it to your therapist including the reasons you want to make the changes.

5. You have the right to a copy of this Notice. If we change this Notice of Privacy Practice, we will post the new version in our waiting area and you can always get a copy from your therapist.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with your therapist as well as with the Secretary of the Department of Health and Human Services., All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this Notice of our Health Information Privacy Practices, please contact your therapist at 239-939-4566. You may also have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. We will be happy to discuss these situations with you now or as they may arise.

PRIVACY NOTICE ACKNOWLEDGEMENT

I understand that Life Counseling may share my health information for treatment, billing and healthcare services. I have reviewed a copy of the office's Notice of Privacy Practices that describes how my health information is used and shared. I understand Life Counseling has the right to change this notice at any time. I may obtain a current copy by contacting Life Counseling at 239-939-4566.

My signature below constitutes my knowledge of the Notice of Privacy Practices.

______________________________________ _________________________

Signature of Client/Legal Representative Date

If signed by Legal Representative, please describe relationship to client: _______________

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