Search for Strength Counseling

Open Doors Counseling
3586 Aloma Ave. Suite 11
Winter Park, FL 32792
www.searchforstrength.net

Dear Client,

Please take a minute to read the *Notice of Privacy Practices* attached to this letter. We are asking you to read this notice of procedures in compliance with the *Health Insurance Portability & Accountability Act of 1996 (HIPAA).* This Federal law requires that all health care professionals notify all patients how their information is protected and how it may be used.

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

Please review the enclosed document, complete and sign the *Acknowledgement of Receipt of Privacy Practices,* and return the acknowledgment form to your counselor.

Thank you for your cooperation in this matter

Sincerely,

Anthony Cravaritis, MA.
Director of Counseling

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.

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 to 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 heath 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.

Heath 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 HELTH 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 with the exception of information we released upon obtaining the written authorization and releasing information as required by law.

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.

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.

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 about HIPAA or to file a complaint, you may call at 877-696-6775 (Toll free) or write at:
The U.S. Department of Health & Human Services: Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

Search for Strength Counseling

Confidential Intake Form

GENERAL INFORMATION

Date: _____ Referred by: _____

Full name:_____Name you prefer: _____

Sex: □ Male □ Female Date of birth:_____ Age: _____

Ethnicity: □ White □ Black □ Hispanic □ Asian □ Other: _____

Street address:_____Suite/Apartment #: _____

City:_____State:_____ Zip code: _____
May we send you mail here: □ Yes □ No

Mailing address or Post Office Box: □ Same as above

Street address:_____Suite/Apartment #: _____

City:_____State:_____ Zip code: _____
May we send mail here: □ Yes □ No

Home Phone:_____Call you here? □ Yes □ No Message here? □ Yes □ No

Work Phone:_____Call you here? □ Yes □ No Message here? □ Yes □ No

Cell Phone:_____Call you here? □ Yes □ No Message here? □ Yes □ No

Email:_____Contact you here? □ Yes □ No

Employer:_____ How long have you been there? _____

Occupation:_____Average hours worked per week: _____

Highest level of education completed:_____Are you currently in school? □ Yes □ No

If Yes, what level?_____ Degree pursuing: _____

Do you regularly attend a place of worship? □ Yes □ No. If Yes, where? _____

In case of emergency, contact:

Name:_____Relationship: _____

Home phone:_____Cell phone: _____

RELATIONAL INFORMATION

Current marital status: □ Single □ Dating □ Engaged □ Married □ Separated □ Divorced □ Widowed

If dating, engaged, married, separated, or widowed, for how long? _____

Number of previous marriages for you?_____ For your partner/spouse? _____
Partner's/Spouse's name:_____Partner's/Spouse's age: _____

Is your partner/spouse supportive of you seeking counseling? ☐Yes ☐No ☐Unsure ☐They don't know

With whom do you currently live? (Check all that apply)
☐Alone ☐Spouse ☐Children ☐Parents ☐Siblings ☐Boyfriend ☐Girlfriend ☐Roommate
Other: _____

List your children (including step, adopted, foster) below:

Name	Sex	Age or year of death	Relationship to you	Living with whom?

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? _____

List your mother, father, sisters, step-family relations or any other family member who had a significant effect (positive or negative) upon your life.

Name	Age or year of death	Relationship to you (mother, father, sibling, step-relation)	Give 2-3 words to describe this person

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: (use the back if necessary)

Therapist name or program	Major issue	Dates

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries:

_____

Your height_____ Your weight_____

How has your weight changed in the last 2-3 months: ☐little or no change ☐up_____lbs. ☐down_____lbs.

List all current medications you are taking, including those you seldom use or take only as needed: (use back if necessary)

Name of medication	Dose	Reason for taking medication

Are you presently 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?_____
Are you experiencing any thoughts of harming another person? ☐Yes ☐No

PRESENT ISSUES

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Present	Past	
☐	☐	Stress
☐	☐	Anxiety or worry
☐	☐	Panic
☐	☐	Depression
☐	☐	Crying all the time
☐	☐	Lack of motivation
☐	☐	Fatigue/Lack of energy
☐	☐	Poor appetite or overeating
☐	☐	Trouble sleeping
☐	☐	Poor concentration
☐	☐	Feeling worthless or inferior
☐	☐	Feeling hopeless
☐	☐	Guilt
☐	☐	Death of friend/loved one
☐	☐	Grief
☐	☐	Chronic pain
☐	☐	Physical disability
☐	☐	Terminal illness
☐	☐	Loneliness

Present	Past	
☐	☐	Fears
☐	☐	Shyness
☐	☐	Low self-esteem
☐	☐	Don't like myself
☐	☐	Marital problems
☐	☐	Relational problems
☐	☐	Parenting problems
☐	☐	Physical abuse
☐	☐	Emotional abuse
☐	☐	Verbal abuse
☐	☐	Sexual abuse
☐	☐	Sexual problems
☐	☐	Gender identity
☐	☐	Anger
☐	☐	Aggressive behavior
☐	☐	Bad dreams
☐	☐	Unwanted memories
☐	☐	Loss of control
☐	☐	Impulsive behavior
☐	☐	Controlling
☐	☐	Controlled by others

Present	Past	
☐	☐	Obsessive thoughts
☐	☐	Seeing things others don't see
☐	☐	Hearing voices
☐	☐	Racing thoughts
☐	☐	Eating problems
☐	☐	Drug use
☐	☐	Alcohol use
☐	☐	Pregnancy
☐	☐	Abortion
☐	☐	Legal matters
☐	☐	Work stress
☐	☐	Career choices
☐	☐	Indecisiveness
☐	☐	Lack of discipline
☐	☐	Financial problems
☐	☐	Spiritual apathy
☐	☐	Other_____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

[_____]
Minimally Distressing — Moderately Distressing — Extremely Distressing

Please describe why you are coming to counseling (What are your problems, issues?)

_____

Why have you decided to come for counseling now?

_____

What do you hope to gain or change by coming for counseling?_____

_____

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: _____

Search for Strength Counseling

STATEMENT OF COUNSELING POLICIES AND PROCEDURES

COUNSELING SESSIONS

Search for Strength Counseling counselor is available weekly. Sessions are scheduled to begin on the hour and are 50 minutes in length. Therefore, it will be to your advantage to arrive on time so that you can benefit from a full-length session.

FEES

We charge $140 fee per session in order to help cover our administrative costs. Payment is due at the beginning of each session; either by cash, or by check, made payable to Search for Strength Counseling. We are committed to providing affordable counseling to those in need so please fill out a scholarship form so that we can assess your financial situation to lower the cost per session.

RESCHEDULING APPOINTMENTS

It is our policy to schedule you for a "standing appointment". Your counselor will confirm, at the end of each session that you intend to come at the same time for your next scheduled appointment.
If you occasionally need to come at a different time, please ask your counselor, who will see if an alternative appointment time is available. **Please be aware that repeated cancellations or no-shows will result in the loss of your standing appointment.**

CANCELLATIONS

If you must cancel your appointment, please call your counselor at least 24 hours in advance of your scheduled time. Their confidential voice mail is available 24 hours a day. Failure to do so will result in you being charged the $25 cancellation fee, payable your next visit. Your counselor has reserved a room for your session and has made himself/herself available for you at this time.
Advance cancellations allow us to make the most efficient use of counselor time and office space.

NO SHOWS

If you fail to show for an appointment and have not notified your counselor 24 hours in advance, you will be considered to have been a "no-show" and are obligated to pay the full fee for that session. It is your responsibility to contact your counselor before your next session to confirm your next appointment.

I have read and understand the policies regarding payment, cancellations, "no-shows", and fees.

Signature _____ Date _____

Search for Strength Counseling

Informed Consent and Release of Liability

Search for Strength Counseling (SSC) provides counseling with a distinctively Christian framework to the community of Baldwin Park and surrounding areas as needed.

The completion of the intake questionnaire and an informed consent and release of liability are required for counseling services to begin.

In order to initiate counseling please read and complete the following agreement. Your signature attests that you both understand and agree to the terms contained herein:

1. I _____ understand that my counselor is a licensed mental health counselor (MH 11400) with the state of Florida.

2. I understand that my counseling records are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession (e.g. child abuse/elder abuse reporting requirements, serious threat of harm to self or others).

3. In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Search for Strength Counseling Center or employees of the aforesaid from any and all claims, demands, actions, or causes of action of whatsoever kind and nature related to the counseling process.

4. The clinical records are the property of SSC and as such, are deemed confidential sessions between counselor and counselee.

(Initial)	*I have read and understood the preceding information and agree with the policies of SSC as stated, I understand that these comments are prerequisite to my receiving and continuing counseling through this center, Search for Strength Counseling.*
(Initial)	*I have received and reviewed a copy of Search for Strength Counseling Notice of Privacy Practices. (HIPPA)*

Signed:_____Date:_____

Parent/Guardian:_____Date:_____

Witness:_____Date: __

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