



Carrollwood Counseling

New Client Information Form

Live Life Well ©

Client: _____
First Name Middle Name Last Name

Date of Birth: _____ Relationship Status: Married Divorced Separated Widowed
(Month/Day/Year) Partnered Never Married None

Address: _____
Street Address/PO Box City State/Zip

By checking the box, I authorize a representative of Carrollwood Counseling to leave messages at these addresses: E-Mail Cell Phone Home Work DO NOT CONTACT

E-Mail Address: _____ @ _____

Telephone: (Cell) _____ (Home) _____ (Work) _____

Employer/School: _____ Full Time Part-time

Primary Care Physician: _____

Emergency Contact: _____
Name Relationship Telephone Number

Insurance Information

Name of Insurance/EAP: _____ Insurance EAP

Patient/Member ID#: _____ Group #: _____

Primary Insured (If Not Client): _____
First Name Middle Name Last Name

Date of Birth: _____ Relationship to Client: Spouse Parent Partner Other _____

Address (If Different Than Client): _____ Employer: _____
Street Address/PO Box City State/Zip

For Minors Only (17 years old and Younger)

Parent/Guardian Name: _____ Relationship to Client: _____

Address: _____
Street Address/PO Box City State/Zip

Informed Consent

I consent to psychotherapeutic evaluation and treatment. Additionally, I understand that psychotherapy is a shared effort and I agree to do my part to effect successful treatment. If at any time, I have questions about my treatment, I agree to discuss these with my therapist.

Client/Parent/Guardian _____ Date _____

Release of Information

I authorize the release of any information necessary to process my claim. _____
(Initials)

I authorize the release of any information to physicians providing treatment. _____
(Initials)

Client/Parent/Guardian _____ Date _____

How did you hear about us? Insurance Doctor Friend Former Client Internet Web Page Other: _____

Primary Therapist: Karol Jim Marta

3802 Ehrlich Road, Suite 101 ♦ Tampa, FL 33624-2330
813.908.2228 ♦ FAX 813.908.5551
CarrollwoodCounseling@verizon.net
www.CarrollwoodCounseling.com

Confidential

April 2017



Carrollwood Counseling

Financial Information Policy

The Therapists and Staff at **Carrollwood Counseling** would like to welcome you to our practice. We strive to provide you with excellent care and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- **It is your responsibility** to inform our office of any address or telephone number changes.
- **Fees**—all self-pay or insurance co-payment, co-insurances and deductibles will be collected at the time of service. Payable by **Cash, Check, VISA, Discover or MasterCard**.
- A **Returned Check** will result in a **\$ 25.00 service charge**, and all future payments must be in the form of cash or credit card.
- If you fail to cancel or reschedule your appointment with less than 24 hours notice, it will result in a **\$ 25.00 "NO SHOW" fee**.
- Since insurance/EAP do not pay for reports, a fee will be charged for reports and letters.
 - **Tell your therapist that you need a report at the beginning of the session.** Sometimes reports and letters can be completed during the counseling session.
 - If the report or letter requires additional time, there will be a charge, the amount determined by your therapist. **The minimum charge is \$25.00 to be paid at the time of request.**

If you have health insurance coverage:

- We will submit your claims; however, we must emphasize that as mental health providers, **our relationship is with you, not your insurance company.**
- Although we attempt to verify your mental health benefits with your insurance policy, this only an estimate of your coverage based on the information provided.

By signing below, you confirm:

- **It is your responsibility** to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If your insurance plan requires an authorization from your insurance company, **it is your responsibility** to have that referral faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans; it is **your responsibility** to be aware of the service(s) provided to you and if it is a covered benefit under your insurance policy.
- **You are responsible** for any non-covered charges not payable by your insurance policy.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to promptly contact us for assistance in the management of your account.

If you have any questions about the above information, please do not hesitate to ask us. **We are here to help you.**

Client Signature

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 IT CAREFULLY.

Carrollwood Counseling is required by law to maintain the privacy of certain health care information about our patients. The law requires that you be notified of these standards.

As a part of our day-to-day activities, **Carrollwood Counseling** may need to use and disclose (share) your protected health care information for several purposes without first getting your written approval. Those purposes include:

- **Carrollwood Counseling** operations. For example, appropriate Carrollwood Counseling staff must discuss your condition to provide you proper treatment.
- **Carrollwood Counseling** may contact you based upon your protected health care information. For example, **Carrollwood Counseling** may call to arrange your appointments, provide you with information about treatments, benefits, and services that are available to you.
- **Carrollwood Counseling** may provide information to government officials who oversee health care or threats to public safety.

No other uses and disclosures of your protected health care information will occur without your written authorization. Moreover, if you sign such an authorization, you have the right to cancel it at any time.

Your Rights Regarding Your Protected Health Care Information. Under the law, you have several rights that **Carrollwood Counseling** is committed to upholding. Those rights include:

- The right to request restrictions on some of the ways Carrollwood Counseling uses and discloses your information. **Carrollwood Counseling** may not always agree to implement these additional restrictions.
- The right to receive confidential communications. While **Carrollwood Counseling** cannot promise to communicate in every possible way requested, we will work with you to find an acceptable way to communicate confidentially.
- The right to inspect and get copies of your health care information held by **Carrollwood Counseling** by making a request in writing. **Carrollwood Counseling**, however, may charge a reasonable fee to cover only the cost of providing this information.
- The right to request that **Carrollwood Counseling** amend or correct information about you. To make a change, you will be required to request in writing including the reason you want your record changed. **Carrollwood Counseling** may not always agree to such requests.
- The right to a list of **Carrollwood Counseling** disclosures that were not authorized by you and the disclosures that were unrelated to treatment, or operations.

If you have any questions or complaints about the way **Carrollwood Counseling** handles your protected health care information or if you believe your privacy rights have been violated, contact the **Carrollwood Counseling** Privacy Officer (M. Jim Teixeira, LMHC) at 813.908.2228 or in person. You can also contact the Secretary of the U.S. Department of Health and Human Services. Please note that there will be no retaliation against you for filing a complaint or making requests regarding your health care information, or for disagreeing with **Carrollwood Counseling**-related decisions.

Anyone has a right to get a paper copy of the latest version of this Notice by asking any of the persons associated with **Carrollwood Counseling**.

Notice of Privacy Practices Acknowledgement of Receipt

I received a copy of Carrollwood Counseling's Notice of a Privacy Practices. I understand that if **Carrollwood Counseling** uses my personal health information in a manner that is different than described by the Notice, **Carrollwood Counseling** must first get my permission in writing.

I am accepting this Notice on behalf of:

Myself Another person as his or her personal representative (parent, guardian, family member, etc.)

Print Name of Patient: _____

Print Name of Personal Representative (if applicable): _____

Signature of Patient/Personal Representative: _____ Date: _____

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General Information of Interest

Appointments

- ✦ Counseling Sessions are 45 minutes long
- ✦ It is YOUR responsibility to inform your Therapist of any address, telephone, e-mail or insurance changes.
- ✦ If you fail to cancel or reschedule your appointment with less than 24 hours' notice, it will result in a \$25.00 'No Show' fee.

Messages and Phone Services

- ✦ Appointment Reminders are done automatically by E-Mail from by the scheduling program.
- ✦ Phone calls are returned during the week between appointments or at the end of the day; or the next business day.
- ✦ We do not leave messages without prior approval to protect your right of confidentiality.

Emergencies

- ✦ In the case of an emergency, CALL 911 or 211 Hillsborough County Crisis Line.

Confidentiality

- ✦ Information shared as part of the counseling process is protected by law and will not be disclosed without your written permission. Your insurance company or Employee Assistance Program—if you are using them require some information to process claims.
- ✦ There are legal exceptions to the rules of confidentiality and they are:
 - When there is reported abuse against a child, elder or disabled person;
 - When there is a suspected danger to yourself or others; and
 - In certain legal and emergency situations.

Dependent Children

- ✦ As a parent/guardian, it is appropriate to question and understand the nature of the therapeutic interventions as well as the progress of your child's therapy, however, Florida law provides for the confidentiality of ***Children 12 years and older.***
- ✦ Specific information may be shared with the permission of the child.
- ✦ The Therapist will use their discretion as to what other information is shared.
- ✦ The Therapist may disclose progress of your child's therapy, any dangerous or threatening situation, and suggestions as to how you can best participate.
- ✦ There may be times that you may be asked to participate in sessions with or without your child.
- ✦ Our goal is to strengthen the bonds between parents/guardians and the child.

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