OHANA THERAPY CENTER
CELIA QUINTAS Ph.D., L.M.H.C., L.M.F.T., M.S., M.ED., GAL Certified
AAMFT Qualified Supervisor
12555 Orange Drive Suite 224 – Davie, FL 33331
954-862 3681
www.ohanatherapycenter.com

TODAY'S DATE: _____/_____/_____

Name of client(s): _____ Date of Birth: _____

In case of a minor, parents' names: _____

Address: _____

City: _____Zip Code: _____

Telephone: Home: ( )_____Other ( )_____

Is it ok to leave a message? ( ) Yes ( )No

- Therapy sessions last 50 minutes. If you need more time, please let me know and I can try to accommodate your needs.
- Payment is expected at the time of service or before. You can pay using Venmo, Zelle, or cash.
- Please note that if you need to cancel your appointment let me know at least 24 hours before your session as you may be subject to a no show/cancellation fee of $75. Also, charges will be applied on top of your session fee for services such as court appearances, clinical summary reports and/or letters, and telephone consultations.
- The privacy of your information is very important. Confidentiality is key for building trust and collaboration. However, there are limitations to keep the privacy of your therapy sessions such as disclosure of any kind of abuse and/or dangerous situations for you and/or others or court subpoenas. Therapy notes will not be shared. If needed, I may provide a clinical summary report. Also, limitations apply in case your session is via online, due to the risks of the privacy of the session to be intercepted by unknown parties. I will try my best to avoid such situations, yet at times this is unavoidable. A unique code will be given to you if we use Zoom (HIPAA) platform for your session.
- Please notify the names of people and your relationships with them to whom you authorize the release of your information. Also, by doing so, you authorize the use of this form and release of your information to different providers involved in your care, such as your physician, teachers, attorneys as per your request below.

Names	Relationship to you	Phone number
_____	_____	_____
_____	_____	_____

- You allow for the recording of the session to be used for clinical consultation/supervision, when needed. These consultations serve to further benefit your therapeutic process.
- You (or minor under your guardianship) voluntarily consent to enter this therapeutic treatment. You may withdraw your consent at any time.
- Please do not hesitate to ask any questions you may have. Let's start working together.
  Thank you.

NAME: (please print) _____

SIGNATURE: _____