DENISE BRODY, LCSW, ACSW, P.A.
7000 W Palmetto Park Rd., Ste. 210 • Boca Raton, FL 33433 • Ph: 561-477-4211 • Fax: 772-236-0215
1860 SW Fountainview Blvd, Suite 100 • Port St Lucie, FL 34986 • Ph: 772-236-0214 • Fax: 772-236-0215
Web: DeniseBrodyLCSW.net • Email: DeniseBrodyLCSW@att.net
Lic.#FL4482

WELCOME

At our first session we will discuss your history, current symptoms, problems, desired goals and begin to formulate a treatment plan. We will evaluate your progress periodically and revise the treatment plan as needed. Alternatives or adjuncts to therapy will be discussed when appropriate. Specific results cannot be guaranteed in psychotherapy, but I will make every effort to help you reach your goals.

RIGHTS AND RESPONSIBILITIES

You as a client have certain rights in regard to your treatment. You have the right to ask Denise about her credentials, training, experience and theoretical orientation. You are entitled to bring up any questions about diagnosis, duration of treatment, fees or any other aspect of treatment. You are entitled to honest and respectful answers. You have the right to terminate therapy at any time.

EMERGENCY PROCEDURES

Should a life threatening emergency arise, please call 911 or go to the nearest emergency room. If an urgent but non-life threatening emergency arises outside routine office hours, you can reach Denise Brody at 561-477-4211.

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LIFETIME AUTHORIZATION FOR INSURANCE

I authorize Denise Brody, LCSW to release any clinical information to my insurance company. I request that payment of authorized insurance benefits be made on my behalf to Denise Brody, LCSW, for services finished by its agents or providers. I also agree that any and all balances will be paid by me.

I understand that I am financially responsible for all charges whether or not paid by the insurance carrier. I have informed Denise Brody, LCSW and staff of my insurance coverage or lack thereof. I understand with insurance constantly changing, I need to verify with my insurance company, that I have mental health benefits. I understand that if I do not notify Denise Brody, LCSW that I am covered by insurance, that the Denise Brody, LCSW is a provider of, I am responsible for the fees of the practice. I also understand I am responsible for any fees that my insurance does not cover such as co-payments and deductibles. I understand that if I later inform the office that I am covered by insurance that Denise Brody, LCSW is a provider of, I will not be refunded or reimbursed for any fees that I paid prior to notifying the office. I am aware that if my insurance status changes, it is my responsibility to inform Denise Brody, LCSW. Failure to do so will result in my responsibility for the private fees that I paid prior to notifying Denise Brody, LCSW.

CANCELLATION POLICY

When an appointment is scheduled for my patients that time is reserved for only that patient. Therefore, it is not available for others who are awaiting services. If you are unable to make a scheduled appointment, 24 hours is requested to cancel and reschedule your appointment. Unless there is an emergency for last minute cancellations, you many be charged for the missed or late canceled pre-appointed time. Please be aware we can not bill your insurance company for missed appointments.

CONSENT OF TREATMENT

I (We) understand that counseling services are strictly confidential with the following exceptions:

*A legitimate subpoena by a court of law requires the release of information specified by the subpoena.
*Statements of intent to harm oneself or another may result in notification of the appropriate authorities and or intended victims.
*Information regarding treatment of a minor without parental consent may be shared with the parent(s) or legal guardian(s) with authority over the minor.

All information concerning all clients being seen at this office is to be kept strictly confidential. I request psychological services for myself (ourselves) and our children/family which have been fully explained to me (us).
I understand and agree to the above conditions.

_____ Date: _____
(Patient Name - Please Print)

_____ Date: _____
(Patient or Legal Guardian Signature)

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Authorization #: _____ Co Pay: _____ Number of Visits: _____

Patient name: _____ If Minor (check) _____

Spouse___Partner___Other___Name _____

Home Address: _____ City/State: _____ Zip _____

Employer: _____ Job/Title _____

Work Address: _____ City/State _____ Zip _____

Telephone: Home ( ) _____ Work ( ) _____

Cell ( ) _____ Email _____

Please send correspondence to my : _____ Home Address _____ Work Address

Please call me at: _____ Home _____ Work _____ Cell _____ Either

Emergency Contact: _____ Telephone: _____ Relationship: _____

Patient Date of Birth: _____ Sex: _____Female _____Male

Marital Status: _____

Insurance Information (please fill in all that applies)

Is this an EAP (Employee Assistance Program)? _____ EAP Name: _____

Name of Insurance Company: _____ Auth#: _____ No of Sessions Auth: _____

Address of Insurance Company: _____ City/State: _____ Zip _____

Telephone: ( ) _____ Group#: _____ ID#: _____

Name of Policy Holder: _____

Social Security # of Policy Holder: _____

Who may we thank for this referral? _____

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
ADMINISTRATIVE SIMPLIFICATION (HIPPAA-AS)

NOTICE OF PRIVACY PRACTICES1

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY IMPORTANT TO US.

I. Our Legal Responsibility

The confidentiality and privacy of your personal health information is extremely important to me. Your health information includes records that I create and obtain when I provide you with mental health care, such as a record of your symptoms, evaluation and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that I must maintain related to your care. I want you to be aware of my privacy practices, my legal duties, and your rights concerning your health information.

This Notice describes how I handle your health information and your rights regarding this information. Generally speaking, I am required to:

1. Maintain the privacy and confidentiality of your health information as required by law;
2. Provide you with this Notice of my duties and privacy practices regarding the health information about you that I collect and maintain;
3. Follow the terms of my Notice currently in effect, until a revised notice is issued. A revised notice may be sent because; I modify my business practices. I reserve the right to change my privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. I reserve the right to make the changes in my privacy practices and the new terms of my notice effective for all health information that I maintain, including health information I created or received before I made the changes. If I make a significant change in our privacy practices, I will change this notice and send the new notice to my clients at the time of the change.
4. You may request a copy of our Privacy notice at any time. For more information about my privacy practices, or for additional copies of this notice, please contact me using the information listed at the end of this notice.

II. Contact Information

After reviewing this Notice, if you need further information or want to contact me for any reason regarding the handling of your health information, please direct any communications to the following contact person:

DENISE BRODY, LCSW, P.A.
7000 W Palmetto Park Rd., Ste. 210
Boca Raton, Florida 33433
561-477-4211 / Fax: 772-236-0215
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Example of using or disclosing health information for payment:

Submit a bill to your health care insurer to receive payment for your care; the insurer asks for health information (for example, your diagnosis and what care I provided) in order to pay me. In such situations, I will disclose only the minimum amount of information necessary for this purpose.

Child/Elder Abuse, Neglect, or Domestic Violence

As **required** by Florida law, I **must disclose (mandatory reporting** of child or elder abuse or neglect) health information about you to a state or federal agency to report suspected child or elder abuse, neglect, or domestic violence. I may disclose your health information to the appropriate legal authorities as required by Florida law, if I reasonably believe that you yourself are a possible victim of abuse, neglect, domestic violence, or other crimes.

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Denise Brody, LCSW, ACSW, P.A., is ethically and legally required to maintain the privacy of protected health information. I must provide individuals with notice of my legal duties and private policies with respect to protected health information. I must abide by the terms of our Notice of Privacy Practices currently in effect. I reserve the right to change my privacy practices that are described in the notice. I may obtain a revised notice by forwarding a written request to Denise Brody, LCSW, ACSW, P.A., 7000 W Palmetto Park Rd., Ste. 210, Boca Raton, FL 33433.

My signature below indicates I have read the HIPPA handout given to me by Denise Brody, LCSW, ACSW, P.A., and I understand my rights in regard to disclosure of my private information.

LIFETIME HIPPA CONSENT

Printed Name:_____

Signature:_____

Date:_____

For further information, please contact Denise Brody, LCSW, ACSW, P.A. or view the information provided by the Office of Civil Rights at http://www.hhs.gov/ocr/hipaa/.

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TO: ALL NEW PATIENTS

RE: CANCELLATION POLICY

IT IS THE POLICY OF THIS OFFICE THAT 24 HOURS NOTICE MUST BE GIVEN FOR ALL CANCELED SESSIONS. IF YOU DO NOT GIVE SUCH NOTICE, YOU WILL BE CHARGED $50.00.

THANK YOU FOR YOUR COOPERATION IN MAINTAINING THIS POLICY.

I have read the above policy and understand that I must give 24 hours notice for a cancellation and understand I will be assessed a charge of $50.00

_____ _____

Patient Name Date

CONFIDENTIAL AND PRIVILEGED INFORMATION
For Professional Purposes Only, Not for Publication

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CLIENT SELF ASSESSMENT FORM

(Adult and Adolescents over 14)

CLIENT NAME:	DATE:

PERSON COMPLETING (IF OTHER THAN CLIENT): _____

Completion of the following information will help me better serve you and meet your needs. Please complete each question as completely as possible.

1. Please state in your own words why you are seeking help:

   _____

   _____

   _____

2. Please describe how long you feel you have had problems and what you have attempted to do about them thus far:

   _____

   _____

   _____

3. Please check any of the following that apply to you

Strengths	**Areas to Work On**
Creative	Increase Anger Management Skills
Independent	Decrease Depression
Considerate	Decrease Substance Abuse
Confident	Decrease Anxiety
Sympathetic	Decrease Self Harm
Insight Into Illness	Increase Social Skills
Intelligent	Resolve Economic Issues
Trustworthy	Decrease Psychotic Thoughts
Helpful	Secure Housing
Friendly	Increase Social Support
Logical	Unable to relax
Healthy	Improve Coping Skills
Sense of Humor	Increase Self Sufficiency
Dependable	
Positive work history	
Artistic	
Uses Support Groups	
Goal Oriented	
Problem Solving Skills	

Please check any of the following that apply to you:

	Were a good student		Had many friends		Liked school
	Dropped out		Liked teachers		Sent to principal's
	Did poorly		Had few friends		Disliked school
	Was expelled		Disliked teachers		Never sent to principal