###### 5p Positive Counseling

###### Rhoda Donnelly, LCSW Phone (813) 922-8255; Fax (813) 818-4692 www.PositiveCounseling.net

##### **CLIENT INFORMATION**

##### Client/Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_/\_\_\_/\_\_\_\_

SS#: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Gender: □ Male, □ Female □ Other Date of Birth: \_\_\_/\_\_\_/\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to send you emails? □ Yes/□ No

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? □Yes/□No. OK to text? □Yes/□No

Secondary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? □Yes/□No. OK to text? □Yes/□No

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you learn about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician & Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### **IN CASE OF EMERGENCY**

Name of Local Friend/Relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### **INSURANCE INFORMATION** (if using insurance)

Primary Card Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Primary Card Holder SS#: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co. address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-pay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

X

Signature of Client (If client is minor child, parent must also sign) Date

Signature of Parent or Legal Guardian (if client is minor) Date  
FOR INTERNAL USE ONLY: □PTx? □ATx? PT/GT/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ fee \_\_\_\_\_\_\_\_

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#### **Informed Consent for Treatment & Notice of Information Practices**

##### Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am voluntarily seeking treatment for

(responsible party)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ from \_\_Rhoda Donnelly, LCSW.

(“myself” or child’s name) (therapist)

1. I understand that it is my responsibility to understand my mental health (aka behavioral health) insurance benefits and to notify Ms. Donnelly of any changes as soon as I am aware of such changes. It is the responsibility of Ms. Donnelly to bill for services provided. It is my responsibility to pay for services not covered by my insurance company unless restricted by contract. Co-payments are required by insurance companies to be collected at the time the service is rendered.
2. I understand that if I have a scheduled appointment and I need to cancel it, I will do so at least 24 hours in advance or more if possible. If I do not provide 24 hours’ notice, I will be billed for the appointment if it cannot be filled by another client.
3. My therapist will recommend a specific type of treatment for me and will explain the advantages and risks. It is my responsibility to ask questions if I am not clear about my treatment.
4. I understand that what I talk about in sessions with Ms. Donnelly is considered confidential and that my therapist will not disclose that information to anyone without a release of information except for the following as required by law: physical or sexual abuse of a minor child or a vulnerable adult, clear intent to harm oneself or someone else, court order from a judge.
5. I also understand that my therapist, in keeping with generally accepted standards of practice, may seek confidential clinical supervision regarding my treatment plan. The purpose of such consultation is to assure quality care. Every effort is made to protect my identity.
6. I understand that an on-call counselor is available for **crisis support** at 2-1-1 Tampa Bay Cares Inc. (immediate consultation needed to avert harm to self or others), as well as for emotional support and resources, 24 hours/7 days per week. If a situation is **urgent** within office hours of 8am to 8pm, and I would like to speak directly to Ms. Donnelly, I will leave a message at Ms. Donnelly’s office number and can expect a call within 12 hours. **I also understand that if I need medical help, physical safety or immediate help with an emergency situation, I will call 9-1-1 first.**
7. A copy of my clinical records will be maintained for seven years. Should I require a copy, I will submit a written request to release records to a person specified in the request.
8. I understand that I and my therapist alone are responsible for my treatment and that no other therapist sharing office space or in affiliation with my therapist will be responsible for any aspect of my on-going treatment.
9. I understand that mental health providers are required to submit a psychiatric diagnosis and a “treatment plan” including diagnosis, description of the problem, personal background information, treatment goals, and therapy methods to my mental health managed care company/insurance provider, if applicable. I permit the therapy staff to submit any information required to use my benefits.
10. I have read a copy of the “Notice of Information Practices” and I understand that I may request a hard copy of this document for my personal records.

Please check one: □ NO, I do not require a copy. □ YES, I received a copy on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Date)

X

Signature of Client (If client is minor child, parent must also sign) Date

Signature of Parent or Legal Guardian (if client is minor) Date