Theresa Stiteler, LMHC

161 S Boyd Street Suite #120
Winter Garden, FL 34787
407-399-5372

Confidential Client Information

Personal Information: **Today's Date: _____**

Last Name: _____ First _____ Middle Initial _____

Address: _____

City: _____ State_____ Zip _____

E-Mail Address: _____

Occupation _____ Highest Level of Education _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Please check if it is okay to leave a message for you at: Home _____ Work _____ Cell _____

Birth Date: _____ Age: _____ Sex: Male _____ Female _____

Marital Status: Single ____ Married ____ Partnered ____ Divorced ____ Separated ____ Engaged ____

How long _____ If married/partnered, spouse/partner's name: _____

Is your spouse/partner supportive of you seeking counseling?_____

Do you have children? _____ Ages: _____

Does anyone else live with you? _____

In case of emergency please notify: _____

Couseling History:

If you have previously seen a counselor/therapist/psychologist/psychiatrist, please list the names and dates:

Name	Major issue	Dates

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? ___ Yes ___ No

If yes, please describe: _____

Are you currently experiencing any suicidal thoughts? _____

Have you experienced suicidal thoughts or attempted suicide in the past? _____

Have any friends or family members attempted suicide? _____

If yes, who and when? _____

In your own words, write why you are seeking counseling: _____

_____

_____

How long have these concerns been causing you distress? _____

How do you hope counseling will help? _____

_____

Is there anything else you feel that is important for me to know: _____

_____

Medical History:

Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling: _____

Please list all current medications you are taking and the reason for taking them.

Name	Dose	Reason for taking medication

Are you taking these medications according to doctor's recommendation? ___ Yes ___ No

If no, please explain: _____

Date and outcome of last physical exam:

_____

How many hours of sleep do you average each night? _____

How many servings of fruits and veggies do you eat a day? _____

Tell me about your exercise. _____

Notice of Privacy Practices

This Notice describes the confidentiality of your medical information, and the limited ways that medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to confidentiality of your medical information, and we are required by law to maintain the privacy of that protected information. We are required to abide by the terms of this Notice of Privacy Practices, and to provide you with notice of our legal duties and privacy practices with respect to protected health information you provide to us. If you have any questions about this Notice, please contact the privacy officer, Theresa Stiteler, at this office.

Who Will Follow This Notice

Your counselor and all business associates who share your personal health information, such as insurance or managed care companies, must follow these same privacy practices. When personal health information is shared, only the minimum necessary information needed to accomplish this task will be disclosed.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

In most cases, Theresa Stiteler, LMHC may not use or disclose information in your health records that could identify you (Protected Health Information) without your written authorization except for the reasons described below. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

How We May Use and Disclose Medical Information Without Your Authorization

There are limited circumstances where an authorization is not needed for disclosure of personal information. Most, but not every possible use or disclosure category are listed below. This Notice applies primarily to information contained in your medical and billing records. More detailed and personal information contained in provider's "psychotherapy notes" are kept separately, and are given an even greater degree of privacy and protection than the personal health information contained in your medical and billing records. As such, these would require written authorization even for the standard disclosure exceptions listed below.

For Payment. We may use and disclose medical information about you without specific authorization so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may release your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment. In most cases, insurance companies may review your medical record to verify services were rendered and were medically necessary in accordance with your contract.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- To avert a serious threat to health or safety
- Child abuse or neglect
- Abuse of elderly or incapacitated adults
- Court ordered evaluations or information

- Health oversight activities, such as for federal enforcement of these privacy practices

We may, at our discretion, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you without your specific release.

Your Rights Regarding Complaints Concerning Use or Disclosure of Your Health Information. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services, whose address will be provided to you by the Privacy Officer, at your request. All complaints must be submitted in writing.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Theresa Stiteler, LMHC is not required to automatically agree to a restriction you request if the provider is otherwise obligated to release that information. Your request must be in writing and specifically state what information you wish to limit.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of private health information by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a provider at this practice. Upon your request, this practice will send your bills to another address, or arrange to call you only at work instead of home.)

Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of private health information in this practice's mental health and billing records used to make decisions about you for as long as the information is maintained in the records. On your request, your provider or the privacy officer will discuss with you the details of the request process.

Right to Amend. You have the right to request an amendment of private health information as it is maintained in the record. Your provider may deny your request if, in his or her opinion, it would compromise the accuracy of your medical information.

Right to an Accounting. You generally have the right to receive an accounting of any disclosures of medical information. On your request, your provider or the privacy officer will discuss with you the details of the accounting process.

Right to a Paper Copy. You have the right to obtain a paper copy of this notice from your provider or the practice upon request, even if you have agreed to receive the notice electronically.

Changes To This Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

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Policies, Informed Consent, and Release of Liability

Welcome! I have listed below my various policies for your information. Please read through these, ask any questions, and sign at the bottom. You may call 407-399-5372 regarding any questions you may have. This is not a 24 hour counseling center. In an emergency, please call 911.

I have been trained in a variety of specific counseling methods and will determine what approaches and techniques might be most effective for your particular needs. You may, at any time, seek a second opinion from another therapist and/or may terminate my services at any time without penalty.

SESSIONS

Sessions are typically scheduled for 50 minutes at a frequency to be determined by the counselor and client.

PAYMENT POLICY

I see clients on a fee-for-service basis only. The client/parent is responsible for payment in full at the time of each session. I charge $125 for a (50) minute session. Scholarships are available for those with financial need. My policy is for each person receiving counseling to pay for such service at the time they are rendered. Any other arrangements must be made in advance. A $25 administrative fee will be charged on all checks that are returned for non-sufficient funds. Payments can be made by cash or check. Charges for testing services are at an additional fee.

CANCELLATIONS

I understand that it may, at times, be necessary to cancel an appointment. I ask that changes / cancellations be made 24 hours in advance. Any changed, cancelled, or missed appointment with less than 24-hour notice will be charged the normal rate.

CONFIDENTIALITY

The confidentiality of the services provided is protected by law. Unless you grant permission to do so in writing, I will neither inform anyone that you are a client, nor will I disclose the content of any session. The only circumstances under such professional confidentiality may be broken is if one or more of the following conditions apply:

- If you pose a serious physical danger to yourself or to another person.
- If you disclose that you or another person has physically or sexually abused or molested a child, an incompetent or disabled person.
- If you disclose that a child, an incompetent or a disabled person is suffering because of neglect.

If such abuse or neglect is disclosed, I am mandated by Florida law to report such information to an appropriate state agency.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I have read the preceding information and agree to it. I authorize treatment of the person named below and agree to pay all fees. I have received a copy of our HIPAA Notice of Privacy Rights.

_____
Signature of Client or Legal Guardian

_____
Signature of Spouse (when in joint therapy)

_____
Date

_____
Date