SOLUTIONIST
COUNSELING SERVICES
WHERE PEOPLE DEVELOP HEALTHY SOLUTIONS FOR EVERYDAY LIVING

Informed Consent for Counseling and Psychotherapy

By signing the Informed Consent form, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment, or services at any time. By signing the Informed Consent form, you acknowledge that you have both read and understood all the terms set forth in the following forms: Intake, Limits of Confidentiality, Cancellation Policy, and Financial Agreement. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear.

By signing the Informed Consent and Privacy Practices Receipt, you are consenting for Solutionist Counseling Services to communicate with you by mail, e-mail, and phone (including text messaging) at the address and phone numbers provided at the initial appointment and you will immediately advise Solutionist Counseling Services in the event of any change. You agree to notify the Practice if you need to opt out of any form of communication.

_____

Client Signature

Today's Date:_____

9033 Glades Road Ste D, Boca Raton Florida 33434
Phone: 561-406-0636 Email: Info@solutionistcounseling.com
www.solutionistcounseling.com

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Intake Form

Please provide the following information and answer the questions below.
Please note: Information you provide here is protected as confidential information.

Name: _____ _____ _____
(Last) (First) (MI)

Date of Birth:_____

Name of parent / guardian (*if under 18 years):* _____

Marital Status:

- ☐ Never Married
- ☐ Domestic Partnership
- ☐ Married
- ☐ Separated
- ☐ Divorced Widowed

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____May we leave a message? Yes _____No _____

Cell Phone / Other: (_____)_____May we leave a message? Yes _____No_____

Email:
_____
Please note: *Email correspondence is not considered to be a confidential medium of communication.*

May we email you? Yes_____ No _____

Referred by (*If any)* _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc?)

- ☐ No
- ☐ Yes

If yes, previous therapist / practitioner

_____

Additional Information:

Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation?

Do you enjoy work? Is there anything stressful about your current work?

What brought you here today?

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

Do you own a gun?

- ☐ Yes
- ☐ No

License?

- ☐ Yes
- ☐ No

Are you currently taking any prescription medications?

- ☐ Yes
- ☐ No

Please list medications (*if any)*

Have you ever been prescribed psychiatric medication?

- ☐ Yes
- ☐ No

General Health and Mental Health

Information

How would you rate your current physical health?

- ☐ Very Good
- ☐ Good
- ☐ Satisfactory
- ☐ Unsatisfactory
- ☐ Poor

How would you rate your current sleeping habits?

Please list any specific sleep problems you are currently experiencing:

How many times a week do you generally exercise? _____

What types of exercise do you participate in?

Please list any difficulties you experience with your appetite or eating patterns.

Are you currently experiencing overwhelming sadness, grief or depression?

- ☐ Yes
- ☐ No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

☐ Yes ☐ No

If yes, when did you begin experiencing this? _____

Are you currently experiencing chronic pain?

☐ Yes ☐ No

If yes, please describe. _____

Do you drink alcohol more than once a week?

☐ Yes
☐ No

How often do you drink?

☐ Daily
☐ Weekly
☐ Monthly
☐ Infrequently
☐ Never

Are you currently in a romantic relationship?

☐ Yes
☐ No

What significant changes or stressful events have you experienced lately?

Have you experienced any traumas that you think we should address?

☐ Yes
☐ No

If yes, please explain briefly. _____

_____

Family Mental Health History

In the section below, please identify if there is a family history or any of the following. If yes, indicate the family member's relationship to you in the space provided. (*Father, Uncle, Mother, etc*)

	Self	Family Member
Alcohol/Substance abuse	Yes No	Yes No
Anxiety	Yes No	Yes No
Eating Disorders	Yes No	Yes No
Obsessive Compulsive Behavior	Yes No	Yes No
Schizophrenia	Yes No	Yes No
Suicide Attempts by self or other family member	Yes No	Yes No

End

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Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of a client with a client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client disclosures intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the healthcare professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abusive Children and Vulnerable Adults
If a client states or suggest that he or she is abusing a child (or vulnerable adult), or has recently abused a child (or vulnerable adult), or a child is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are giving information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairments, progress of therapy, case notes and summaries.

I agree to the above limits of confidentiality and understand their meetings and ramifications.

_____

Client signature (*Client's parent/ guardian if under 18*)

Today's date: _____

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Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the **entire cost** of your missed appointment.

A full session fee ($_____) is charged for missed appointments or cancellations with less than a 24 hour notice unless it is due to illness or an emergency. A credit card on file will be charged or a bill will be mailed directly to all clients who do not show up for, or do not cancel an appointment.

No Call No Show: If you fail to arrive by 15 minutes past the session start time, the session will be considered cancelled and a full session fee will be charged.

Thank you for your consideration regarding this important matter.

Client Signature (*Client's Parent/Guardian if under 18)*

Today's Date: _____

Credit Card:_____ Exp:_____ CVV: _____

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Financial Agreement

At Solutionist Counseling Services, we help coordinate your expenses by filing to insurance companies we are listed as in-network with. To fully understand your individual policy, it is your responsibility to contact your insurance company to discuss your benefits before your appointment. Your health insurance contract is between you and your insurance company. Any complaints regarding your coverage should be directed to your carrier. Unless arrangements have been made in advance, co-payments, co-insurance and any outstanding balances are expected at the time of service. Patients will be financially responsible for any services not covered or denied payment by insurance. Patient accounts not paid promptly are subject to third party collections and/or legal procedures.

(If Applicable)

Insurance Company:_____ Policy Number:_____

Policy Holder Name:_____ Group Number:_____

Policy Holder D.O.B:_____

******ATTENTION: PLEASE INITIAL EACH LINE BELOW******

_____ You must provide your insurance card at the time of service.

_____ If your insurance should change, it is **your responsibility** to provide updated information.

_____ If your insurance changes to a non-network company or is no longer valid, you are responsible for the full cash pay rate of $_____ for each session provided.

_____ You must pay any reimbursements sent directly to you for services received if not prepaid to Solutionist Counseling Services.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING:
By signing below I acknowledge that I have read and understand the policy.

Client Signature (*Client's Parent/Guardian if under 18)*

Today's Date: _____

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HIPAA

WHAT IS HIPAA: HIPAA is an abbreviation that stands for the Health Insurance Portability and Accountability Act of 1996. A major component of HIPAA addresses the privacy of individual health information by establishing a nation-wide federal standard concerning the privacy of health information and how it can be used and disclosed. This federal standard will generally preempt all state privacy laws except for those that establish stronger protections. The HIPAA privacy laws are effective April 14, 2003 with noted addendums thereafter.

Generally, HIPAA "covered entities" are required to comply with HIPAA rules for any health or medical information of identifiable individuals, including their medical records, medical billing records, any clinical or research databases, and tissue bank samples. Covered entities are health care providers, health plans, and healthcare clearing houses. The covered units will, generally, not be able to communicate or transfer protected health information to the non-covered units without violating HIPAA. Clients must give authorization to release protected health information.

Essentially, a HIPAA covered entity cannot use or disclose protected health information for any purpose other than treatment, payment, or healthcare operations without either the authorization of the individual or under an exception in the HIPAA regulations.

WE PLEDGE TO PROTECT YOUR PRIVACY.

Clients with Substance Use Disorders: It is the policy of Solutionist Counseling Services to comply with Title 42, Code of Federal Regulations, Part 2, titled "Confidentiality of Alcohol and Drug Abuse Client Records," and with subsections 397.419(7) and 397.501(7), F.S., paragraphs 397.6751(2)(a) and (c), F.S., and Section 397.752, F.S., regarding confidential Client information.

It is the policy of Solutionist Counseling Services to have you sign a "Consent for Release of Information" form, for each individual you wish to have information released to with specific identified information to be disclosed. Each Release of Information shall contain the purpose of the release of information and the timeframe for which the information can released. You have the right to revoke a Release of Information, at any time, and document the revocation in writing.

_____

Client signature (*Client's parent/guardian if under 18*)

Today's date _____