Client Information Form (Youth)

First Name: ______________________ **Last** Name: ______________________

DOB: ______________________ Age: __________ Gender: ______________________

Home Address: ____

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Youth's School: ______________________ Current Grade: ______________________

Guardian Information:

Name: ______________________ Relationship: ______________________

Cell Phone #: ______________________ Alternate Phone #/Type: ______________________

Is it OK to contact you at these numbers? *(please check)* ☐ Yes ☐ No

Identify at which number(s) voicemail messages can be left: ______________________

Is it OK to email you regarding upcoming appointments or with therapy resources? *(please check)* ☐ Yes ☐ No

If Yes, email address: ____

Occupation: ______________________ Employer (optional): ______________________

Relationship status: ____

Name of spouse or partner, if applicable: ____

Additional Guardian Information:

Name: ______________________ Relationship: ______________________

Cell Phone #: ______________________ Alternate Phone #/Type: ______________________

Is it OK to contact you at these numbers? *(please check)* ☐ Yes ☐ No

Identify at which number(s) voicemail messages can be left: ______________________

Is it OK to email you regarding upcoming appointments or with therapy resources? *(please check)* ☐ Yes ☐ No

If Yes, email address: ______________________________

Occupation: ______________________ Employer (optional): ______________________

Relationship status: ______________________________

Name of spouse or partner, if applicable: ______________________________

Referral Source (Psychology Today, Emerge Therapy Services Inc. website, other, please indicate):

____

PCP Name/location: ______________________________

Youth'd health problems, if applicable: ______________________________

List any medications: ______________________________

Has your child been in therapy before? *(please check)* ☐ Yes ☐ No

If so, dates? ______________________________

For what issues? ______________________________

Emergency Contact Person: ______________________________

Relationship to Emergency Contact Person: ______________________________

Cell Phone #: ______________________ Alternate Phone #/Type: ______________________

Please let me know in your own words what issues you would like addressed in therapy. You may include any symptoms your teen is experiencing, recent life transitions, current struggles, other areas areas you would like to see strengthened, etc.:

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____

____

(please continue on next page if needed)

Signature of Guardian

Date

Printed Name of Guardian

Signature of Client

Date

Printed Name of Client

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the currently effective HIPAA Notice of Privacy Practices. A copy of this signed and dated acknowledgment shall be as effective as the original.

Signature of Legal Guardian ______________________ Date ______________

Print Name of Legal Guardian (Relationship/authority to client) ______________________

Signature of Client ______________________ Date ______________

Print Name of Client ______________________

Thank you. If you have any questions about this form, or the attached notice, please contact **Steve Davis, LMHC**.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

FOR TREATMENT. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

FOR PAYMENT. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

FOR HEALTH CARE OPERATIONS. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

REQUIRED BY LAW. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

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WITHOUT AUTHORIZATION. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

CHILD ABUSE OR NEGLECT. We may disclose your PHI to a state or local agency (Department of Children and Families) that is authorized by law to receive reports of child abuse or neglect.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

DECEASED PATIENTS. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

MEDICAL EMERGENCIES. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

FAMILY INVOLVEMENT IN CARE. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

HEALTH OVERSIGHT. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

LAW ENFORCEMENT. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

SPECIALIZED GOVERNMENT FUNCTIONS. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

PUBLIC HEALTH. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

PUBLIC SAFETY. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

RESEARCH. PHI may only be disclosed after a special approval process or with your authorization.

FUNDRAISING. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

VERBAL PERMISSION. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

WITH AUTHORIZATION. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Steve Davis LMHC/Emerge Therapy Services, Inc.:

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you

with a copy. Please contact Steve Davis LMHC/Emerge Therapy Services, Inc. if you have any questions.

- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to Emerge Therapy Services, Inc. or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 1, 2013.

Consent for Treatment

Welcome to Emerge Therapy Services, Inc. . This document contains information about the professional services and policies which are an integral part of our work together. Please read this document carefully, and feel free to discuss any questions you may have.

SESSIONS – Sessions are 50 minutes long and are generally scheduled on a weekly basis. Coming to scheduled sessions consistently and on time will provide you with the most benefit of working toward reaching your goals. Additional or less frequent sessions can sometimes be arranged.

FEES – My standard rate for a 50-minute session is **$ ________ /session**. I may offer a sliding fee schedule on an individual basis based on income. This fee may be revised with prior notice. I do not accept insurance, but may provide a receipt for Out-of-Network benefits. It will be your responsibility to confirm benefits prior.

I accept payments in the form of cash, debit card, or credit card. **The agreed-upon fee per session will be indicated on next page of this agreement.**

CANCELLATIONS – Your session time is reserved specifically to address your needs. I request that you contact me with no less than 24 hours notice. You will be responsible for the full session fee if you do not reschedule or cancel within this 24 hour timeframe. Any outstanding fees must be paid at the beginning of the next scheduled session. If you must cancel, please leave me a phone message with as much advance notice as possible.

CONTACTING ME – You may leave confidential phone messages at any time. It helps if you leave a few specific times when I can reach you. I will do my best to return your call on the same day, or on the next business day. Other than phone calls to schedule and confirm appointments, any phone consultations longer than 10 minutes will be charged in 15-minute increments, at one- quarter of your agreed-upon rate for a 50-minute therapy session. **If I will be unavailable for an extended time, I will provide you with the name of a colleague for you to contact if necessary.** This colleague is bound by the same legal, ethical, and privacy guidelines as I am.

EMERGENCY PROCEDURES – **I Do Not** provide emergency medical and/or mental health care. **Therefore, in the event of a life-threatening emergency, or immediate physical or medical crisis, you agree to contact 911 or go to the nearest emergency room or hospital.**

CONFIDENTIALITY - Your privacy is extremely important to me. Information disclosed to me is generally protected by laws and ethics. I need your permission before I may release any information concerning your treatment, except under the following circumstances: 1) if there is a reasonable suspicion of abuse/neglect of a child, elderly, dependent, or disabled person; 2) if you may be in danger of harming yourself or another person; 3) as required by a third-party to obtain reimbursement; and 4) as otherwise ordered or required by law (for example as a result of a court order). This form does not cover every possible exception. **Please refer to the HIPAA Notice of Privacy Practices, which I supplied you.**

PROFESSIONAL DEVELOPMENT – There are two situations where I may share some information about our work together. I may discuss your treatment in consultation with other therapists. I may also share aspects of my work in teaching, presentations, or publications. In each case I will make sure to disguise personal identities and I will not use identifying information, reveal your name or things about you that could lead someone to know whom I am discussing.

RECORDS – I keep confidential records and personal information of our sessions. However, if you are using insurance or the employee assistance program for payment, they have a legal right to your information, including records.

ADDITIONAL CHARGES – Additional charges may be assessed for services other than therapy in session. Additional charges may be discussed with **Steve Davis, LMHC,** in advance for such things as: request for specific letters, copies of records, disability paperwork, litigation or others not listed here. You may request a letter, or you may become involved in litigation, which may require my participation.

CONCLUSION OF THERAPY – Termination is an important aspect of the therapeutic process and should be based on a careful discussion. Sometimes, people feel that they want to end therapy when they are about to face something that is uncomfortable, yet potentially very helpful. I support your decision to end therapy at any time, and find it best to plan the end of therapy at least one session in advance. If you are thinking of ending therapy, please let me know so we can end in a planned way and I can help you find any other needed services.

(The blank space below indicating the fee for the first and additional sessions will be determined in our telephone call scheduling your appointment. Fees are determined by the services to be provided. The amount indicated in the space will be initialed by both client and therapist at our first session).

The fee for my first session will be $ ___________. Additional sessions will be at a rate of $ ___________.

Additional fees may be assessed for services provided other than scheduled therapy sessions, including, but not limited to: missed visits, phone consultations over 10 minutes, reports or letters composed at the client's request or authorization, copies of records, or involvement in litigation. Examples of some additional fees are listed below. Please understand that advanced notice may be required to fulfill some requests, and is greatly appreciated.

- ☐ Missed visits, or those canceled with less than 24-hours notice, will be billed at the full hourly session rate.
- ☐ Phone consultations over 10 minutes in length will be billed in 15-minute increments, with each 15 minutes being billed at one-quarter of your agreed-upon hourly session rate.
- ☐ Letters or reports written at your request will be billed at your agreed-upon hourly session rate x the length of time required to complete this documentation.
- ☐ Court Appearances will be billed at your agreed-upon hourly session rate x the number of hours required, plus travel expenses.

☐ Copies of records will be billed at $1.00 per page, plus any postage costs if mailed by Steve Davis, LMHC/Emerge Therapy Services, Inc.

I give my consent to receive therapeutic services provided by Steve Davis, LMHC/Emerge Therapy Services, Inc. The undersigned understands that Steve Davis, LMHC, is a Licensed Mental Health Counselor in the State of Florida. The undersigned has asked Steve Davis, LMHC, any pertinent questions prior to initiating treatment and is voluntarily seeking his services. I understand that therapy with Steve Davis, LMHC/Emerge Therapy Services, Inc., can be terminated at any time. I understand that, should I cease attending sessions with Steve Davis, LMHC/Emerge Therapy Services, Inc., for thirty (30) days without prior notification, my case will be considered closed. I am aware that I may resume therapy with Steve Davis, LMHC/Emerge Therapy Services, Inc., at a later date by contacting him at 954-647-2111.

I also understand that Steve Davis, LMHC, is not a medical physician, psychiatrist, attorney, or psychologist. Thus, he will not provide advice on medical, psychiatric, or legal matters, other than by means of referral. I understand that Steve Davis, LMHC, is not responsible in any way for the actions of any professionals to whom referrals might be made.

_______________________________________ _______________________
Signature of Legal Guardian Date

____
Print Name of Legal Guardian (Relationship/authority to client)

_______________________________________ _______________________
Signature of Client Date

____
Print Name of Client

_______________________________________ _______________________
Signature of Therapist (Steve Davis, LMHC) Date