Cindy Wall, LMHC

109 W 4th Avenue Tallahassee, Florida 32303 (850) 445-5689

Client Name _____

Street Address _____ Home Telephone _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Employer _____

Occupation _____ Work Phone _____

Medical Insurance Co. Name _____ Phone _____

Insurance Co. Address _____

Policy Number _____ Group Number _____

Referred by _____

Please be advised that it is necessary to charge the full fee for missed appointments or cancellations without 24-hour notice.
This practice is not an emergency facility. If you require twenty-four hour emergency coverage, please allow us to refer you to an appropriate practice.

Please assign directly to Cindy Wall, LMHC all medical benefits for services rendered. I understand that I am financially responsible for all charges. I authorize the therapist to release all information necessary to secure the payment for benefits. I also authorize a release of information between my therapist and my primary care physician/pediatrician/psychiatrist regarding treatment for me/my child.

My signature below indicates that I understand the previous statements and give consent to be treated.

_____ _____

Signature Date

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CLIENT INFORMATION

Client Name_____

Address_____

City, State, Zip _____Email:_____

Home Phone _____ Cell Phone _____ Marital Status _____

DOB _____ Age _____ Sex _____

Employer_____Email:_____

Occupation _____ Work Phone _____

Education (check if completed. Enter "X" if currently involved but not completed.)

( ) High School ( ) GED ( ) College ( ) Graduate School ( ) Other _____

Family/Personal Physician: _____ Date of last physical_____

Major illnesses/operations _____

Prescribed Medication (currently taking)_____

Over-the-counter Medication (currently taking)_____

Previous Psychotherapy (if yes, list therapists and dates) Yes _____ No _____

Therapist's Name _____ City_____Dates Seen _____

Spouse's Name_____

Children's Name/Age_____

Parent's Name/Age _____

Parent's Name/Age _____

Status of Parent's Marriage: ( ) Married: # of years ____
( ) Separated: your age at the time ___
( ) Divorced: your age at the time___

Ages of Brothers: _____ Ages of Sisters: _____

What brings you to therapy at this time:

Approximately how long have these problems existed:

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NOTICE OF PRIVACY PRACTICES

Following is a statement about how your protected health information may be used and disclosed during your care. These practices are effective April 14, 2003.

IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

I am a mental health provider. More specifically, I am a Licensed Mental Health Counselor (LMHC), I create and maintain treatment records that contain identifiable health information about you (or your child). These records are generally referred to as medical or mental health records and contain your Protected Health Information (PHI).

By law I am required to insure that your PHI is kept private and to provide you with this Notice about my privacy procedures. This Notice explains when, why, and how I would use and/or disclose your PHI.

Your PHI record is kept in a folder with your name on it in a locked file. I am the only person authorized to add, modify, or review your record. I may contact you by phone or mail, but you may request in writing that you not be contacted this way. Your medical record must truthfully and accurately reflect your medical history and current health. I promise to value your confidentiality. Periodically, I will check the laws and may update this notice.

Exceptions to the privacy safeguards include the following.

1. If disclosure is compelled by a court order
2. In the course of legal proceedings brought by you against me
3. If I have a suspicion of child abuse or neglect
4. If I have a suspicion of elder or dependent adult abuse or neglect
5. If I believe that you are dangerous to yourself or to someone else
6. To contact you to provide information about alternatives or other health-related benefits and services that may be of interest to you (Be sure to let me know how you may be contacted.)
7. If disclosure is required by the U.S. Secretary of Health and Human Services to investigate or determine my compliance with privacy requirement under the federal regulations
8. If disclosure is otherwise specifically required by law.

Other Uses and Disclosures Without Your Authorization

Federal privacy rules allow me to use or disclose your PHI without written authorization in order to carry out treatment (example, consultation and referral) to obtain payment, or for health care operations (example, if your health plan decides to audit my office).

Please NOTE:

The above list may not give you all circumstances when disclosures may be made without your written authorization. Even though federal privacy rules or state law may allow more uses or disclosure of your PHI without your written authorization, other uses and disclosures will generally (but not always) be made only with your written authorization. **If Florida law protects your confidentiality or privacy more than the federal "Privacy Rule" does or if Florida law gives you greater rights than the federal rule does, I will abide by Florida law.** In general, uses or disclosures by me of your PHI without your authorization will be limited to the minimum necessary as noted above.

Your Rights Regarding Protected Health Information

1. You have the right to request restrictions on certain uses and disclosures of your PHI, such as those necessary to carry out treatment, payment or health care operations. I am not required to agree to your requested restriction. If I do agree, I will keep a written record of the restriction.
2. You have the right to receive confidential communications of PHI from me by alternative means or at alternative locations.
3. You have the right to inspect and copy your PHI by making a specific request in writing. You do not have the right to inspect or copy my "psychotherapy notes." The term "psychotherapy notes" means notes which I record in any way to document the contents of a therapy session. These notes are kept separate from the rest of your PHI record. (If you ask for copies of your PHI, I will charge you not more than $1.00 per page.)
4. You have the right to amend PHI in my records by making a request to do so in writing. The request must give a reason. I may agree to the change or give specific reasons and deny it. **You also have the right, subject to limitations, to give me a written statement about any item in your record that you believe to be incorrect or incomplete, and that statement will become a part of the record.**
5. You have the right to know all of the disclosures of your PHI made by me. You must make this request in writing. I may deny the request for specified reasons.
6. You have the right to obtain a paper copy of this notice from me upon request.
7. You may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue SW, Washington, D.C. 20201.

Signature Patient, Parent or Guardian_____Date:_____

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MY OFFICE PRIVACY POLICIES AND PROCEDURES

Confidentiality and privacy are the cornerstones of the mental health professions. Patients have an expectation that their communications with therapists and their treatment records will generally be kept confidential and will not be released to others without the written authorization of the patient. One of the purposes of the Notice of Privacy Practices is to inform and educate patients about the fact that there are exceptions to the general rule of confidentiality. Many of these exceptions have existed for years, and many of them are the result of laws and regulations being passed by state legislatures and by the federal government. These laws and regulations are essentially statements of public policy. My office policies and procedures, as well as the ethical standards of my profession, are intended to shape my practice so that privacy and confidentiality are maintained, consistent with Florida law and the federal Privacy Rule.

1. **Privacy Officer**: I, Cindy Wall, LMHC, am the privacy officer for this practice. I am the one responsible for developing and implementing these policies and procedures.
2. **Contact Person**: I, Cindy Wall, LMHC, am the contact person for this practice. If a patient needs or desires further information related to the Notice of Privacy Practices, or if the patient has a complaint regarding these policies and procedures or our compliance with them, I am the person who should be contacted.
3. The effective date of these policies and procedures is July 2, 2012.
4. I will maintain documentation of all consents, authorizations, Notices of Privacy Practices, Office Policies and Procedures, trainings, and patient requests for records or for amendments to records. I will also document complaints received and their disposition.
5. I will not maintain or use patient sign-in sheets.
6. Conversations regarding confidential material or information will take place in an area and in a manner where they will not be easily overheard.
7. Patient records will be kept in locked file cabinets in my individual office. My individual office is locked when I am not there. Patient records will not be left in places in my office where others are able to see its contents. I will take steps to assure that patient records are accessed only by me.
8. Computers and fax machines will be placed appropriately so that access is limited to authorized personnel and so that confidential information transmitted or received is not seen by others.
9. Information and records concerning a patient may be disclosed as described in the Notice of Privacy Practices and in accordance with applicable law or regulation. Generally, I will obtain a written authorization from the patient before releasing information to third parties for purposes other than treatment payment, and health care operations, unless disclosure is required by law or permitted by law.
10. If mental health records are subpoenaed by an adverse party I will assert the psychotherapist-patient privilege on behalf of the patient and will thereafter act

according to the wishes of the patient and the patient's attorney, unless I am ordered by a Court or other lawful authority to release records or portions thereof.

11. To the extent that I keep patient records electronically (e.g. on my computer), I will backup the computer files on a daily basis and will store the backup offsite. By doing so, I will be prepared in the case of an incident of some kind that causes destruction, deletion, or damage to electronically stored patient records.
12. I keep patient records for at least seven years from the date of last treatment. With respect to the records of a minor, I keep those records for at least seven years or until the patient is twenty-one years old, whichever is longer. Thereafter, I may destroy patient records. When records are destroyed, they will be destroyed in a manner that protects patient privacy and confidentiality.
13. I will attempt to find out from patients, as early as possible, whether they have any objection to my sending correspondence to their residence (e.g., claim forms, bills) and whether I am permitted to call them at their residence or elsewhere to change appointment times or dates, or to discuss matters related to their treatment.
14. If I share protected health information about a patient with third party business associates as part of my health care operations (e.g., a billing or transcription service), I will have a written contract with that business associate that contains terms that will protect the privacy of the patient's protected health information.
15. My duty of confidentiality and the psychotherapist-patient privilege survive the death of a patient.
16. With respect to email communications, I will do my best to ensure that communications are encrypted and can only be opened by the person to whom they are being sent.
17. I will do my best to ensure that electronic information, such as billing records and correspondence, is protected from computer viruses and unauthorized intruders.

Signature of Patient, Parent or Guardian: _____

Informed Consent for Treatment:

1. By signing this form, you provide me with permission to bill you or your insurance company (as applicable) for services rendered. If 24-hour notice is not provided before canceling, you may be charged for the session.
2. I have read and understand this explanation. My signature indicates that I give permission to receive services for my minor child or me.

Name of Patient: _____
Signature of Patient, Parent or Guardian_____
Date: _____