Baldwin Park (Main Office)- 1543 Lake Baldwin Ln, Suite B
Orlando, FL 32814
Southwest Orlando - 7345 W. Sand Lake Road Suite 303
Orlando, FL 32819
Titusville - 2323 Washington Ave, Suite 213
Titusville, FL 32780
Phone: 407.894.5202
www.chariscounselingcenter.com

Statement of Counseling Policies and Procedures

COUNSELING SESSIONS:
Counseling sessions last fifty (50) minutes, a clinical hour, unless previously arranged with your therapist. Sessions typically begin on the hour and end at fifty minutes after the hour; therefore it will be to your advantage to arrive on time so that you can benefit from a full length. Please remember the importance of keeping your appointment.

CANCELLATIONS AND RESCHEDULING:

- If for some reason you must cancel your appointment, notify our office at (407) 894-5202 as soon as you know you cannot keep the appointment. You may leave a voicemail if it is after hours. Please do not email your counselor or the receptionist with your cancellation.
- **24-hour <u>business day notice</u> is required in order to avoid payment for the scheduled session. Business days constitute Monday-Friday. Therefore, if an appointment is scheduled for Monday at 9A then notice in regard to cancellation MUST be received by 9A on the Friday prior to Monday appointment.**
- Repeated cancellations or frequent "no-shows" will mean that further appointments may not be scheduled.

FEES FOR COUNSELING:
The fee for your counseling sessions is $_____ per clinical hour. Counseling fees are due at the end of each session. You may pay by MasterCard, American Express, Visa, Discover, cash or check (please make checks payable to Charis Counseling Center) either before or immediately following your session.
*Please be aware that phone communications are considered appointments and will be charged per quarter hour. Further, email correspondence may be charged at the discretion of your counselor.

INSURANCE AND RECEIPTS:
We do not accept third-party payments for service and the counseling fees are due immediately following your session. We will be happy to provide you with a receipt for your services along with the proper coding information for you to submit to your insurance provider. If we can offer any advice on submittals, please don't hesitate to ask.

EMERGENCY SITUATIONS:
If at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance. We do not provide on-call or emergency services at this time.

CONTACTING US:
You may email your counselor at: _____@chariscounselingcenter.com. You may also contact our office using the contact information provided at the top of this form.

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Notice of Privacy Practices

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 DOCUMENT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically , on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how our health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

-*Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

-*Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

-Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the publix. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:
-The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

-The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

-The right to request an amendment to your PROTECTED HEALTH INFORMATION.

-The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

-The right to obtain a paper copy of this notice for us upon request.
We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

The Privacy Officer
Charis Counseling Center, LLC.
1543 Lake Baldwin Lane
Orlando, FL 32814
(407) 894-5202

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
877.696.6775 (toll-free)

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Acknowledgment of Receipt: Privacy Practice Notice

I, _____ have received a copy of Charis Counseling Center, LLC.
(Full Name) Notice of Privacy Practices.

Street Address:_____

City:_____ State:_____ Zip:_____

Client
Signed: _____ Date:_____

Witness
Signed: _____ Date:_____

For Office Staff Only:

Signature:_____ Date Received:_____

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Informed Consent and Release of Liability

Client Name (please print):_____

Our goal is to minister to you with counseling from a Christian perspective. We desire to work with clients who have the capacity to resolve their own problems with our assistance. Some clients need only a few sessions to achieve these goals while others may require many more. As a client, you have the right to end our counseling relationship at any point.

1. I understand that my counselor is working under Florida laws, rules and statutes as a Licensed Mental Health Counselor or as a Registered Intern under the supervision of a licensed counselor.

2. I understand that my counseling records are kept confidential, except where disclosure is required by law or the ethics of the counseling profession (i.e. abuse of a child, elderly or disabled person; potential harm or threat to self or others; child custody cases that go before a court of law; and specific information subpoenaed by a court of law).

3. In consideration of the benefits to be derived from the counseling, the receipt wherof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Charis Counseling Center, LLC., its employees or officers from any and all claims, demands, actions, or causes of action of whatsoever kind and nature related to the counseling process.

4. The clinical records are the property of Charis Counseling Center, LLC and are deemed records of confidential sessions between therapists and clients. I waive any right I may otherwise have to seek to use the clinical records of the counseling center as evidence in any judicial proceedings. I understand that if anyone from this office is subpoenaed or court ordered to testify in court as an expert witness, court fees are separate from the counselor's regular counseling rates and I will need to contract the Charis Office for the court fees.

5. Counseling sessions last approximately fifty (50) minutes. Please remember the importance of keeping your appointment. If for some reason you must cancel your appointment, notify our office as soon as you know you cannot keep the appointment. **24-hour business day notice is required in order to avoid payment for the scheduled session. Business days constitute Monday-Friday. Therefore, if an appointment is scheduled for Monday at 9A then notice in regard to cancellation MUST be received by 9A on the Friday prior to Monday appointment.** Repeated cancellations or frequent "no-shows" will mean that further appointments may not be scheduled. Counseling fees are due at the end of each session by cash, check made payable to *Charis Counseling Center,* or credit card (American Express, MasterCard, Discover or VISA).

6. If at any time you become emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance. We do not provide an on-call service at this time.

My signature below indicates that I grant informed consent for Charis Counseling Center to provide psychological services and counseling to myself and/or minor members of my family.

_____ /_____ _____ /_____
Client/Guardian Signature Date Client/Guardian Signature Date

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Credit Card Authorization Form

Client Name:_____

Client Address:_____

Our credit card processing is completed through Square. Your credit card will be stored securely through their software. You will receive an email from Square once your credit card has been linked to your profile. You may opt to receive receipts via email if you so wish.

Email:_____

I have read and acknowledge that I will receive emails from square. _____**Initial**
I wish to receive electronic email receipts. _____**Initial**

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
Cardholder Name (As shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CCV: _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Charis Counseling Center to charge my credit
(Cardholder)
card above for services provided to _____. I understand that my information will be
(Client Name)
saved for future transactions on this account.

_____ _____
Cardholder Signature Date

_____ _____
Client Signature (If different) Date

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Confidential Client Information Form

GENERAL INFORMATION

Therapist: _____

Date:_____ Referred by:_____

Full Name:_____ Sex: ▫ Male ▫ Female

Name you Prefer: _____ Age: _____ Date of Birth: _____

Employer: _____ Length of Employment: _____

Occupation: _____ Average hours worked per week: _____

Last year of School Completed: ▫9 ▫ 10 ▫ 11 ▫ 12 ▫ GED ▫ College: ▫ 1 ▫ 2 ▫ 3 ▫ 4 ☐ Other:_____

CONTACT INFORMATION

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ May we send mail here: ▫ Yes ▫ No

Home Address (if different): _____

City: _____ State: _____ Zip Code: _____ May we send mail here: ▫ Yes ▫ No

Home Phone: (_____)_____ May we leave a message here: ▫ Yes ▫ No

Cell Phone: (_____)_____ May we leave a message here: ▫ Yes ▫ No

Work Phone: (_____)_____ May we leave a message here: ▫ Yes ▫ No

Email Address: _____ May we send a message here: ▫ Yes ▫ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

TERMS OF SERVICE

I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.

Signed: _____ Date: _____

All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.

RELATIONAL INFORMATION

Current Marital Status: ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed

Are you content with your current status? ☐Yes ☐No. If no, briefly explain:_____

_____

If married, how long?_____ Number of previous marriages for you:_____ For spouse:_____

If separated or divorced, how long?_____ If widowed, how long?_____

With whom do you currently live? *(Check all that apply)*:

☐Alone ☐Parent ☐Sibling(s) ☐Spouse ☐Boyfriend ☐Girlfriend ☐Children ☐Other:_____

Do you have a personal support system? ☐Yes ☐No. If yes, who?_____

If you live with a partner, please provide the following information.

Partners Name: _____ Sex: ☐Male ☐Female

How long have you known your partner? _____ Age: _____ Preferred Name: _____

What words would you use to describe this person: _____

Children: List your Children (Living or Deceased) as well as children you have placed for adoption. (Use back if necessary.)

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Natural, Step, Adopted)	Living with You?	Describe Him/Her

Have you ever had a miscarriage or medical abortion? ☐Yes ☐No. If yes, when? _____

RELIGIOUS BACKGROUND

Briefly describe the religious environment of your home as you were growing up:_____

_____

Do you regularly attend a place of worship? ☐Yes ☐No. If yes, Where? _____

PRESENTING ISSUES AND GOALS

Please describe why you are coming to counseling *(What are your issues, problems?)* _____

_____

What do you hope to gain or change by coming for counseling? _____

_____

LEVEL OF DISTRESS

Indicate how distressed you are by placing an"X" on the scale below (1= Very Little Distress; 10= Extreme Distress):

_____

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts? ☐Yes☐No. Have you experienced them in the past? ☐Yes ☐No

Have you ever attempted suicide? ☐Yes ☐No. If yes, when & how? _____

Have any of your friends or family ever committed or attempted suicide? ☐Yes ☐No. If yes, explain on back:

PREVIOUS COUNSELING

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received. (Use back if necessary)

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

CURRENT STATUS

Please check any of the following physiological symptoms that apply to you presently or in the recent past:

Headaches	☐Past ☐Present	Dizziness	☐Past ☐Present	Stomach Trouble	☐Past ☐Present
Visual Trouble	☐Past ☐Present	Sleep Trouble	☐Past ☐Present	Trouble Relaxing	☐Past ☐Present
Weakness	☐Past ☐Present	Tension	☐Past ☐Present	Rapid Heart Rate	☐Past ☐Present
Difficulty Breathing.	☐Past ☐Present	Intestinal Trouble	☐Past ☐Present	Hearing Noises	☐Past ☐Present
Change in Appetite.	☐Past ☐Present	Tiredness	☐Past ☐Present	Pain	☐Past ☐Present
Hearing Voices	☐Past ☐Present	Seeing Things	☐Past ☐Present	Other	☐Past ☐Present

How has your weight changed in the last 2-3 months? (If so, how?) _____

Please check any of the following problems that apply to you and/or your family.

Stress	☐You ☐Family	Nervousness	☐You ☐Family	Anxiety	☐You ☐Family
Panic	☐You ☐Family	Unhappiness	☐You ☐Family	Depression	☐You ☐Family
Guilt	☐You ☐Family	Apathy	☐You ☐Family	Terminal Illness	☐You ☐Family
Recent Death	☐You ☐Family	Grief	☐You ☐Family	Hopelessness	☐You ☐Family
Inferiority Feelings	☐You ☐Family	Defective Feelings.	☐You ☐Family	Loneliness	☐You ☐Family
Shyness	☐You ☐Family	Fears	☐You ☐Family	Friends	☐You ☐Family
Marriage	☐You ☐Family	Communication	☐You ☐Family	Physical Abuse	☐You ☐Family
Emotional Abuse	☐You ☐Family	Verbal Abuse	☐You ☐Family	Sexual Abuse	☐You ☐Family
Temper	☐You ☐Family	Anger	☐You ☐Family	Aggressiveness	☐You ☐Family
Bad Dreams	☐You ☐Family	Concentration	☐You ☐Family	Racing Thoughts	☐You ☐Family
Unwanted Thoughts	☐You ☐Family	Memory	☐You ☐Family	Loss of Control	☐You ☐Family
Impulsive Behavior	☐You ☐Family	Self-Control	☐You ☐Family	Compulsivity	☐You ☐Family
Sexual Problems	☐You ☐Family	Pregnancy	☐You ☐Family	Abortion	☐You ☐Family
Legal Matters	☐You ☐Family	Trauma	☐You ☐Family	Eating Problems	☐You ☐Family
Drug Use	☐You ☐Family	Alcohol Use	☐You ☐Family	Trouble with Job	☐You ☐Family
Career Choices	☐You ☐Family	Ambition	☐You ☐Family	Making Decisions	☐You ☐Family
Children	☐You ☐Family	Being a Parent	☐You ☐Family	Finances	☐You ☐Family
Recent Loss	☐You ☐Family	Disaster	☐You ☐Family	Other	☐You ☐Family

MEDICAL INFORMATION

Primary Physician: _____ City: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are you currently receiving medical treatment? ☐Yes ☐No. If yes, please specify: _____

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you've had. (Use back if necessary.)

_____

_____

List all current medications you are taking, including those you seldom use or take only as needed. (use back if necessary.)

Medication	Dosage	Purpose for Medication

Are you taking these medication(s) according to your doctor's recommendations. ☐Yes ☐No.

If no, briefly explain: _____