Statement of Counseling Policies and Procedures

1543 Lake Baldwin Lane (T) 407-894-5202
Suite B (F) 407-894-5620
Orlando, FL 32814

www.chariscounselingcenter.com

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 session. 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 notice is required in order to avoid payment for the scheduled session.**
- 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, 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, e-mail correspondence may be charged at the discretion of your counselor.

INSURANCE AND RECIEPTS:
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.

CHARIS Counseling Center

1543 Lake Baldwin Ln, Suite B • Orlando, FL 32814
Phone (407) 894-5202 • Fax (407) 894-5620
http://www.charisorlando.com

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 your 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 public. 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 or 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 PROTECED 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 Avenue, 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: ____________________

Parent/Guardian
Signed: ____ Date: ____________________

Witnessed
Signed: ____ Date: ____________________

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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 whereof 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 contact 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 notice is required in order to avoid payment for the scheduled session.** 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 or VISA).

6. 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 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

1543 Lake Baldwin Lane, Suite B
Orlando, FL 32814
(P): 407.894.5202

Charis Counseling Staff

- Melissa Hunt, M.A. LMHC, MH 8275
- Julia Jancek, M.S., LMHC, MH 9813
- Jim Keller, M.A., C.A.S., LMHC, MH 8431
- Tim Tedder, M.A., LMHC, NCC, MH 10998
- Laura Demetrician, M.A., LMFT, MT 2582

Confidential Client Information Form

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GENERAL INFORMATION

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.

Credit Card Number: ________________________________ Exp Date: __________

Billing Zip Code: ____________________ Type of Card: □ AMEX □ VISA □ MC

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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(s) □ 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.

Partner's Name: ____ Sex: □ Male □ Female

How long have you known your partner? _____________ Age: ________ Prefered 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

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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
Visual Trouble ☐ Past ☐ Present
Weakness ☐ Past ☐ Present
Difficulty Breathing ☐ Past ☐ Present
Change in Appetite ☐ Past ☐ Present
Hearing Voices ☐ Past ☐ Present
Dizziness ☐ Past ☐ Present
Sleep Trouble ☐ Past ☐ Present
Tension ☐ Past ☐ Present
Intestinal Trouble ☐ Past ☐ Present
Tiredness ☐ Past ☐ Present
Seeing Things ☐ Past ☐ Present
Stomach Trouble ☐ Past ☐ Present
Trouble Relaxing ☐ Past ☐ Present
Rapid Heart Rate ☐ Past ☐ Present
Hearing Noises ☐ Past ☐ Present
Pain ☐ 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
Panic ☐ You ☐ Family
Guilt ☐ You ☐ Family
Recent Death ☐ You ☐ Family
Inferiority Feelings ☐ You ☐ Family
Shyness ☐ You ☐ Family
Marriage ☐ You ☐ Family
Emotional Abuse ☐ You ☐ Family
Temper ☐ You ☐ Family
Bad Dreams ☐ You ☐ Family
Unwanted Thoughts ☐ You ☐ Family
Impulsive Behavior ☐ You ☐ Family
Sexual Problems ☐ You ☐ Family
Legal Matters ☐ You ☐ Family
Drug Use ☐ You ☐ Family
Career Choices ☐ You ☐ Family
Children ☐ You ☐ Family
Recent Loss ☐ You ☐ Family
Nervousness ☐ You ☐ Family
Unhappiness ☐ You ☐ Family
Apathy ☐ You ☐ Family
Grief ☐ You ☐ Family
Defective Feelings ☐ You ☐ Family
Fears ☐ You ☐ Family
Communication ☐ You ☐ Family
Verbal Abuse ☐ You ☐ Family
Anger ☐ You ☐ Family
Concentration ☐ You ☐ Family
Memory ☐ You ☐ Family
Self-Control ☐ You ☐ Family
Pregnancy ☐ You ☐ Family
Trauma ☐ You ☐ Family
Alcohol Use ☐ You ☐ Family
Ambition ☐ You ☐ Family
Being a Parent ☐ You ☐ Family
Disaster ☐ You ☐ Family
Anxiety ☐ You ☐ Family
Depression ☐ You ☐ Family
Terminal Illness ☐ You ☐ Family
Hopelessness ☐ You ☐ Family
Loneliness ☐ You ☐ Family
Friends ☐ You ☐ Family
Physical Abuse ☐ You ☐ Family
Sexual Abuse ☐ You ☐ Family
Aggressiveness ☐ You ☐ Family
Racing Thoughts ☐ You ☐ Family
Loss of Control ☐ You ☐ Family
Compulsivity ☐ You ☐ Family
Abortion ☐ You ☐ Family
Eating Problems ☐ You ☐ Family
Trouble with Job ☐ You ☐ Family
Making Decisions ☐ You ☐ Family
Finances ☐ 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: ____