Counseling Specialists
OF CENTRAL FLORIDA

CONSENT FOR TREATMENT

Welcome to Counseling Specialists of Central Florida (Counseling Specialists Inc., CSI). We are a Christian counseling center providing therapeutic services to individuals; couples; children; and families, regardless of religious persuasion, throughout Central Florida. Providers are licensed through the State of Florida as Mental Health Counselors, Marriage & Family Therapists, Qualified Parent Coordinators, or Psychiatrists. Additional providers may include Certified Life Coaches, Registered Interns, or Student Interns.

All client records are kept confidential, except where disclosure is required or permitted by law or the ethics of the counseling profession (e.g. child, elder, disabled abuse/neglect, threat of harm to self or others, etc.). These records are the property of CSI and are deemed records of confidential sessions between the provider and the client. Other than as required by law/ethics, these records will only be released in the form of a Therapeutic Summary and with the advanced written consent of the client (or parent/legal guardian) and agreement by CSI. Requests for records will be fulfilled by our office as quickly as possible.

Sessions are typically scheduled to start at the beginning of each hour and last approximately 50 minutes unless otherwise scheduled by the client or determined to be necessary by the provider (e.g., intake, crisis). Sessions that exceed the scheduled time will be billed in ten (10) minute increments, rounded to the nearest 10-minute increment. Sessions that occur outside normal business hours, involve more than one counselor, or constitutes a crisis may incur additional charges. Clients are expected to arrive on time; at no time will the cost of a session be prorated due to a client arriving late or leaving early. If circumstances require a client to cancel their scheduled session, **a 24-hour cancellation notice is required**. If a session is not cancelled within this time frame, the client (or parent/legal guardian) will be responsible for the full cost of the session.

For the sake of both our staff and other clients, at no time will a sick client or other individual be allowed in the office. If a client is sick, he/she (or their parent/legal guardian) can either reschedule their appointment or switch to a virtual appointment.

Phone calls with a provider **that exceeds 5 minutes** will be rounded to the next 10th of an hour (6-minute increments) and charged at the provider's non-discounted prevailing hourly rate; this policy also applies to email/text exchanges and any document requests. All time necessary for any legal matter (e.g., preparation, communication, travel, attendance, follow-up, reports, etc.), including court assigned counseling, will be charged at 2x's the provider's non-discounted prevailing hourly rate. Documents printed will be charged at the legally allowed rate. If subpoenaed for court, the client will be charged an up-front retainer to cover all anticipated charges; this retainer, and any outstanding balances, must be paid in full no less than two (2) weeks prior to the scheduled court date.

Clients are required to keep a valid credit card on file at all times. Payment is due at the time the service is rendered; cash, checks, credit/debit cards, and FSA/HSA cards are accepted. Checks can be made payable to Counseling Specialists or CSI. If a client's check fails to clear (i.e. insufficient funds), a $25 NSF fee will be assessed. Clients who fail to keep their accounts current will not be allowed to schedule additional sessions until their balance is paid in full. Additionally, CSI reserves the right to revoke any discount afforded to a client for whatever reason it deems necessary (e.g. failure to provide 24 hours' notice, failure to pay at the time of service); In the case of a failure to pay, the right to revoke discounts may also be extended to any outstanding balances as well.

By signing below, the undersigned acknowledges that he or she has read, understands, and agrees to the terms and conditions contained in this form and that treatment may be stopped at any time. Additionally, the client acknowledges that he or she has received CSI's Notice of Privacy Practices, which details how one's protected health information may be used, stored, or disclosed.

______________________________	____________
Signature of Client, Parent, or Legal Guardian	Date
______________________________	____________
Printed Name of Client, Parent, or Legal Guardian	Relationship to the Client/Minor/Disabled Adult

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CONSENT TO TREAT A MINOR OR DISABLED ADULT

As the parent/legal guardian of ________________________________, my above signature hereby gives consent for him/her to receive therapeutic services. I affirm that I, as the individual's parent/legal guardian, have full legal authority to consent for treatment for the above-named individual and that no additional party, or individual, can legally object to such consent. I accept that it is my responsibility to provide CSI with a copy of any signed legally binding documentation that bears proof of this full legal authority.

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DEMOGRAPHICS FORM

CLIENT INFORMATION – (If the client is a minor, complete from their perspective)

Last Name: _____ First Name: _____ Middle Initial: ____

Marital Status: _____ Nickname: _____ Suffix: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Phone: _____ Email: _____

Street Address: _____ Suite/Apt: _____

City: _____ State: _____ Zip Code: _____

PRIMARY CONTACT INFORMATION – (If the client is a minor, his/her parent or the client's Significant Other/Emergency Contact)

Name: _____ Relationship to the Client: _____

Phone: _____ Email: _____

☐ Same Address as Client ☐ Different Address from Client (Note primary contact address below)

Street Address: _____ Suite/Apt: _____

City: _____ State: _____ Zip Code: _____

SECONDARY CONTACT INFORMATION – (If the client is a minor, his/her other parent)

Name: _____ Relationship to the Client: _____

Phone: _____ Email: _____

☐ Same Address as Client ☐ Different Address from Client (Note primary contact address below)

Street Address: _____ Suite/Apt: _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION – (For completion of claim forms if requested by the client)

Primary Insured (If other than client): _____ Primary's Date of Birth: _____

Relationship to the Client: _____ Name of Primary's Employer: _____

Insurance Company: _____ Type of Insurance: ☐ HMO ☐ PPO ☐ EPO ☐ Other _____

Insurance ID Number: _____ Group #: _____

SIGNATURE

_____ _____
Signature of Client, Parent, or Legal Guardian Date

_____ _____
Printed Name of Client, Parent, or Legal Guardian Relationship to the Client/Minor

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CREDIT CARD AUTHORIZATION FORM

CREDIT CARD INFORMATION

☐ Visa
☐ Master Card
☐ American Express
☐ Discover

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

Billing Street Address: _____

AUTHORIZATION

I, _____ authorize Counseling Specialists to charge my above stated credit card for services rendered to the following individual(s):

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____
5. _____ Relationship: _____

I understand that this credit card information will be placed on file to cover current, future, and any outstanding past transactions for the above stated individual(s). I also acknowledge that future transactions will be billed at the time the services are rendered, unless otherwise agreed upon in writing.

SIGNATURE

_____ _____
Signature of Client, Parent, or Legal Guardian | Date

_____ _____
Printed Name of Client, Parent, or Legal Guardian | Relationship to the Client/Minor

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used/disclosed and how you can get access to this information.

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 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 such things as treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers and/or authorities as required by law or court order.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

- 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.

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. As to disclosures:

- We will 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 disclose your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

- We may 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 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; or required by court order; and/or by law.

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.