



Total Health Guidance Counseling

Welcome!

We are honored to have the opportunity to work with you. This packet contains information and forms that we will need to have on file for the first meeting.

Please review and complete the following documents:

1. Disclosure Statements — to be reviewed, *signed*, and returned to counselor.
2. Client Information Form — to be completed and returned to counselor.
3. HIPAA Notice of Privacy Rights - keep for your records.
4. Referral Sources – for you to review.

TOTAL HEALTH GUIDANCE
www.TotalHealthGuidance.com

REGIONS BANK BUILDING
5401 S. KIRKMAN RD. #760
ORLANDO, FL 32819

(321)-332-6984

Total Health Guidance, LLC. – Disclosure Statement

Thank you for deciding to seek out treatment at Total Health Guidance. We have listed below our various policies for your information. Please read through these, ask any questions, and sign at the bottom. You may call (321) 332-6984 regarding any questions you may have. All of the therapists at THG are licensed through the State of Florida and/or the Florida Association of Christian Counselors & Therapists. Total Health Guidance is not a 24 hour treatment center. In an emergency, please call 911.

We have been trained in a variety of counseling techniques. We will work with you to verify which techniques might be most effective for your particular needs. You may, at any time, seek a second opinion from another therapist and/or you may terminate our services at any time without penalty.

SESSIONS

Sessions are typically scheduled for **50 minutes** at a frequency to be determined by the counselor and client.

PAYMENT POLICY

We see clients on a fee-for-service basis only. The client/parent is responsible for payment in full at the time of each session. Our policy is for each person to pay for services at the time they are rendered. Any other arrangements must be made in advance. A \$25 administrative fee will be charged on all checks that are returned for non-sufficient funds. Payments can be made by cash, check or credit card. Charges for testing services are an additional fee.

INSURANCE

If you desire to use in-network benefits, confirmation of coverage must be completed prior to your appointment. We are not in-network with many insurance carriers. Until coverage is confirmed, you will be required to pay in-full for all appointments. If you desire to use out-of-network benefits, please direct questions about reimbursement amounts and timeliness to your insurance company. We can provide you with a receipt for the counseling service that may be used to submit for reimbursements if you choose. We do not complete any insurance paperwork for out-of-network benefits. If you elect to use your health insurance plan to assist in the payment of treatment then you understand that your insurance carrier and the National Information Center will have access to your diagnosis code and other pertinent data needed for processing.

CANCELLATIONS

We understand that it may, at times, be necessary to cancel an appointment. **We require that changes / cancellations be made 24 hours in advance. Any changes, cancellations, or missed appointments within the 24 hour period will result in a \$40 cancellation charge.**

CONFIDENTIALITY

The confidentiality of the services provided by us is protected by law. Unless you grant us permission to do so in writing, we will neither inform anyone that you are a client, nor will we disclose the content of any session. The only circumstances under such professional confidentiality may be broken is if one or more of the following conditions apply:

- If you pose a serious physical danger to yourself or to another person,
- If you disclose that you or another person has physically or sexually abused or molested a child, an incompetent or disabled person, or
- If you disclose that a child, an incompetent or a disabled person is suffering because of neglect.

If such abuse or neglect is disclosed, we are mandated by Florida law to report such information to an appropriate state agency.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I have read the preceding information and agree to it. I authorize treatment of the person named below and agree to pay all fees. I have received a copy of our HIPAA Notice of Privacy Rights.

Signature of Client or Legal Guardian

Signature of Spouse (when in joint therapy)

Date

Date

Signature of Counselor

Date

\$ _____
Agreed Upon Rate per Session



Confidential Client Information

**Total Health
Guidance**

Personal Information:

Today's Date: _____

Last Name: _____ First _____ Middle Initial _____

Address: _____

City: _____ State _____ Zip _____

E-Mail Address: _____

Occupation _____ Highest Level of Education _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Is it okay to leave a message? Cell: Y / N Work: Y/N Home: Y/N

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

Referred by: _____

Marital Status:

Single _____ Married _____ Partnered _____ Divorced _____ Separated _____ Engaged _____

How long? _____

If married/partnered, spouse/partner's name: _____

Is your spouse/partner supportive of you seeking counseling? Y / N

If no please explain: _____

Children:

Number of Children: _____ Ages of children: _____ / _____ / _____ / _____ / _____ / _____

If counseling is for a minor:

Name of child(s) legal guardian(s) if other than your spouse/ partner or yourself:

Name: _____ Phone#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

In case of emergency please notify:

Name: _____ Phone#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

Medical History:

Are you currently under medical care? ____ If yes, please indicate reason _____

Physician's Name: _____ Phone: _____

Do you (or spouse if marriage counseling) take any prescription medications? ____ If yes, what are they?

Other significant medical history _____

Counseling History:

Have you previously seen a counselor/therapist/psychologist/psychiatrist? Y /N

Name: _____ Location: _____ Date Last seen: ____ / ____ / ____

Name: _____ Location: _____ Date Last seen: ____ / ____ / ____

Name: _____ Location: _____ Date Last seen: ____ / ____ / ____

Name: _____ Location: _____ Date Last seen: ____ / ____ / ____

Have you ever attempted suicide? ____ Have any family members attempted suicide? _____

In your own words, write why you are seeking counseling: _____

How long have these concerns been causing you distress? _____

By whom were you referred to our counseling center? _____

How do you hope counseling will help? _____

Is there anything else you feel that is important for the counselor to know? _____

On a scale of 1 – 10 with 10 being great, how would you rate your current health in each of these areas?

Financially ____ **Spiritually** ____ **Nutritionally** ____ **Emotionally** ____ **Relationally** ____ **Physically** ____

Notice of Privacy Practices

Please keep for your records

This Notice describes the confidentiality of your medical information, and the limited ways that medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to confidentiality of your medical information, and we are required by law to maintain the privacy of that protected information. We are required to abide by the terms of this Notice of Privacy Practices, and to provide you with notice of our legal duties and privacy practices with respect to protected health information you provide to us. If you have any questions about this Notice, please contact the privacy officer, John Stiteler, at this office.

Who Will Follow This Notice

Your counselor and all business associates working with Total Health Guidance (THG), who share your personal health information, such as insurance or managed care companies, must follow these same privacy practices. When personal health information is shared, only the minimum necessary information needed to accomplish this task will be disclosed.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

In most cases, THG may not use or disclose information in your health records that could identify you (Protected Health Information) without your written authorization except for the reasons described below. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

How We May Use and Disclose Medical Information Without Your Authorization

There are limited circumstances where an authorization is not needed for disclosure of personal information. Most, but not every possible use or disclosure category are listed below. This Notice applies primarily to information contained in your medical and billing records. More detailed and personal information contained in provider's "psychotherapy notes" are kept separately, and are given an even greater degree of privacy and protection than the personal health information contained in your medical and billing records. As such, these would require written authorization even for the standard disclosure exceptions listed below.

For Payment. We may use and disclose medical information about you without specific authorization so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may release your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment. In most cases, insurance companies may review your medical record to verify services were rendered and were medically necessary in accordance with your contract.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization. We may, at our discretion, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you without your specific release.

- To avert a serious threat to health or safety
- Child abuse or neglect
- Abuse of elderly or incapacitated adults
- Court ordered evaluations or information
- Health oversight activities, such as for federal enforcement of these privacy practices

Your Rights Regarding Complaints Concerning Use or Disclosure of Your Health Information. If you believe your privacy rights have been violated, you may file a complaint with THG's Privacy Officer or with the Secretary of the Department of Health and Human Services, whose address will be provided to you by the Privacy Officer, at your request. All complaints must be submitted in writing.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, THG is not required to automatically agree to a restriction you request if the provider is otherwise obligated to release that information. Your request must be in writing and specifically state what information you wish to limit.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of private health information by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a provider at this practice. Upon your request, this practice will send your bills to another address, or arrange to call you only at work instead of home.)

Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of private health information in this practice's mental health and billing records used to make decisions about you for as long as the information is maintained in the records. On your request, your provider or the privacy officer will discuss with you the details of the request process.

Right to Amend. You have the right to request an amendment of private health information as it is maintained in the record. Your provider may deny your request if, in his or her opinion, it would compromise the accuracy of your medical information.

Right to an Accounting. You generally have the right to receive an accounting of any disclosures of medical information. On your request, your provider or the privacy officer will discuss with you the details of the accounting process.

Right to a Paper Copy. You have the right to obtain a paper copy of this notice from your provider or the practice upon request, even if you have agreed to receive the notice electronically.

Changes To This Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

REFERRAL SOURCES

Our counselor will review this page with you and answer any questions you may have.

We network with a group of trusted professionals on a weekly basis. If you are looking for someone to help you with any of the following services, please place an X next to that category and we will provide you with their business card or contact information.

Your Name: _____ **Date:** _____ **Okay to share:** E-mail: Y / N - Phone: Y / N

- _____ A/C & Heating (sales & service)
- _____ Acupuncture (*Offered here at Total Health Guidance*)
- _____ Attorney - Business Law
- _____ Attorney - Criminal Defense Traffic Tickets
- _____ Attorney - Family (Divorce, Custody, Child-support, etc.)
- _____ Attorney - Personal Injury
- _____ Banker (personal or business)
- _____ Business Consulting
- _____ Business Marketing
- _____ Caterer
- _____ Chiropractor
- _____ Counselor/Life Coach (Individual, Marriage & Family, Career) (*Offered here at Total Health Guidance*)
- _____ CPA (Audit representation, Tax returns, Business Start-ups)
- _____ Digital Marketing (SEO, Website Design, Video, Social Media)
- _____ Financial Planner (Investments, IRA, 401k, etc.)
- _____ Handyman/ Lawn Maintenance
- _____ Health Insurance (Individual & Group benefits)
- _____ Home Care Assistance
- _____ Home Organizing
- _____ Insurance (Auto, Home, Business)
- _____ Interior Design
- _____ Legal Shield/ Identity Theft
- _____ Life Insurance
- _____ Massage Therapy (*Offered here at Total Health Guidance*)
- _____ Merchant Services
- _____ Mover – Residential or Commercial
- _____ Nutritional Counselor (*Offered here at Total Health Guidance*)
- _____ Office Supplies
- _____ Payroll Services
- _____ Printing/ Promotional Products
- _____ Private Investigator
- _____ Residential Cleaning Service
- _____ Residential Mortgage (purchase, re-fi, construction, reverse)
- _____ Residential or Commercial Real Estate (Buying or selling)
- _____ Travel Agent
- _____ Wedding Minister