Charisse Diaz LMHC
2708 Alternate 19 North, Suite 507-13
Palm Harbor, Florida 34683
(813) 601-0595 Phone (727) 499-7888 Fax
www.counselingservicesofparlmharbor.com

Date: _____ Home Phone_____May we use this as a contact number?____
Cell Phone_____May we use this as a contact number?____
Business Phone_____May we use this as a contact number?____
Email_____May we use this to contact you?____

Client Information (If minor use minor's information)
Name_____ Soc. Sec #_____
Last Name First Name Initial
Address_____
City_____State_____ZIP_____ May we contact you at this address?___
Sex: ( )F ( )M AGE____ Date of Birth_____ ( )Single ( )Married ( )Divorced ( )Widowed
Client Employed By_____ Occupation_____
Business Address_____
Street Address City State Zip
Whom may we thank for referring you?_____
In case of emergency who should be notified?_____Phone:_____

Responsible Parties Information
Person Responsible For Account_____
Last Name First Name Initial
Relationship to Client_____ Birthdate_____ Soc. Sec #_____
Address if different from patient_____
Street Address City State Zip

Insurance Information
Policy Holder's name_____ Relationship to client_____
Birthdate of Policy Holder_____ Policy Holder's Employer_____
Insurance Company_____Policy Hholder's Soc. Sec #_____
Policy Number_____Group Number_____ Is there a secondary insurance ( )Y ( )N

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAS THE ABOVE MENTIONED INSURANCE COVERAGE.
I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE WHENEVER ANY INFORMATION ON THIS FORM CHANGES.
I AGREE TO PRESENT THIS OFFICE WITH A PICTURE ID CARE (DRIVER'S LICENSE, MILITARY ID, STATE ID) AND IF APPLICABLE MY INSURANCE CARD. I UNDERSTAND THAT THIS OFFICE WILL MAKE A COPY OF MY ID AND INSURANCE CARD TO KEEP ON FILE.

_____ _____ _____
SIGNATURE OF RESPONSIBLE PARTY **RELATIONSHIP** **DATE**

_____ _____
PRINT RESPONSIBLE PARTIES NAME **SIGNATURE OF CLIENT IF DIFFERENT**

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CLIENT RIGHTS

All individuals who apply for services, regardless of sex, race, age, color, creed, financial status or national origin are assured that their lawful rights as client hall be guaranteed and protected.

1. To be provided a copy of our office's Privacy Notice.
2. To be treated with respect and dignity
3. To privacy for interview/counseling sessions.
4. To confidentiality
   Exceptions:
   (a) The court may request information about clients and/or treatment without client consent
   (b) By law, all suspect cases of child abuse/neglect must be reported
   (c) By law, all suspected cases of elderly abuse/neglect must be reported
   (d) By law, "Whenever a patient has declared an intention to harm other persons, such declaration may be disclosed".
   (e) If client fails to make good on a bounced check within a reasonable amount of time, some confidentiality information may be released so that the State Attorney's office can collect on the outstanding debt.
   (f) If client fails to pay the balance of his or her account in full within a reasonable amount of time, some confidential information may be released so that the collections of the fees may be pursued.
5. To refuse treatment
6. To be informed of the client grievance procedure upon request
7. To receive full information regarding treatment process

Please initial in the ( ) parenthesis that are applicable

( ) I agree ( ) I refuse

To have family/significant others participate in the treatment process including the provision of information about the effects of medication

Family/Significant other who is participating please initial in parenthesis below

( ) I agree ( ) I refuse to participate in_____treatment process

Additional information and explanation of the above right has been given in the Notice of Privacy and is available upon request. Our office welcomes any questions or concerns.

I hereby acknowledge the receipt of this Client Rights Statement.

_____ _____ _____
Signature of Client Social Security Number Date of Birth

_____ _____
Print Client's Name Date

_____ _____ _____
Signature of Family/Significant Other Print Family/Significant Other's Name Date

_____ _____ _____
Witnessed By Position Date

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CONSENT FOR SERVICES/TREATMENT

Client's Name_____ Date of Birth_____ Social Security #_____

I, the undersigned a client of Charisse Diaz, LMHC
I, the undersigned, a (Parent of minor, Guardian, Guardian advocate) of the above named client

Who is a client of this office and the subject of this authorization, hereby authorize Charisse Diaz LMHC to administer mental health and/or substance abuse services/treatment, which may include psychotherapy, psychoeducational services and/or emergency evaluations.

I have been information that this consent can be revoked orally or in writing prior to our during the treatment period. I acknowledge that there have been no guarantees or assurances made to me as to the results of services/treatments rendered by Charisse Diaz LMHC.

I am aware that I am financially responsible for any costs incurred as the result of services/treatment rendered by this office.

I have read and fully understand the above Consent for Services/Treatment.

_____
Date of Consent

_____ _____
Client Signature Print Client's Name

_____ _____
Parent of Minor/Guardian/Guardian Advocate Signature Print Name

_____ _____ _____
Witness Signature Print Witness Name Position

***The client shall always be asked to sign this authorization form. In addition, a parent of a minor, guardian or guardian advocate may be asked to give consent.**

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APPOINTMENT POLICIES, FEES AND AGREEMENTS

1. Should you need to cancel or reschedule an appointment, we require at least 24 hour's notice. Should you not provide this notice, or not show for an appointment, you will be charged the full session fee.
2. Our office does not have an answering service. We apologize for any inconvenience that this may cause you. We will do our best to respond within 24 business hours, however we are unable to guarantee immediate returns of emergency telephone calls. There, **in the case of an emergency, please go to the nearest hospital or call 911.**
3. The fees for services are $125.00 per 45 minute sessions. Reports, letters, court reports, court appearances, and additional services have different fees and those will be discussed and agreed upon prior to the service.
4. **My insurance company is entitled to any medical or other information necessary to process my claims. Signature of File is to be used on all my insurance submissions. My counselor may act as my agent in helping me obtain payment from my insurance company. The insurance payment is to go directly to my counselor. The insurance co-payment is due at the time of service. I authorize use of this form on all my insurance submissions. I permit a copy of this authorization to be used in place of the original.**
5. Clients without insurance are expected to pay in full at the time of the service. Therefore it is agreed that I will pay $125.00 for each 45 minute session.

Client Signature_____ Date_____

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APPOINTMENT POLICIES, FEES AND AGREEMENTS

6. If your insurance payment is not received within 60 days, or if the amount paid by your insurance is less than expected, you will be responsible for the total amount remaining.
7. For services rendered to a minor dependent, the **Parent who signs this form** is the one responsible for the balance.
8. There is a $30.00 **fee for any returned checks.** If failure for paying on a bad check in a timely manner, I give my consent for this office to employ the State Attorney's Office to collect on the outstanding debt. I understand to bounce a check and not make the outstanding check good in a timely manner is crime, and this office does prosecute to the fullest extent by law.
9. **In failure of paying my account in a timely manner, I give my consent for this office to employ another agency** (i.e., attorney, or collection agency) to collect any outstanding debt. I understand that I will be responsible for any additional costs. I understand that all necessary records will be released to the retained agency.

If you have any questions regarding the above agreement, please feel free to speak with your therapist.

I have read, understood and agreed to the following terms for services:

_____ _____
Print Name Social Security Number

Date of Birth_____

_____ _____
Signature Date

_____ _____
Minor's Date of Birth Minor's Name

_____ _____
Minor's Signature Date

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CREDIT CARD INFORMATION ON FILE

In the event that you do not show up for a scheduled appointment, or if you give less than **24 hours' notice** for a cancellation (without a **mutually agreed** upon emergency), your credit card on file will be charged the full fee for your missed session. By signing this form, you authorize Charisse Diaz LMHC to charge your credit card on file in these circumstances.

*Please note that your credit card information will be uploaded into a secure and encrypted online system and this original form will be destroyed. Under **NO** circumstances will your credit card information ever be shared.

Please provide your credit card information below

_____ _____
Credit Card Number Expiration Date

_____ _____
Name of the person listed on the credit card Zip code

_____
CVV Code

_____ _____
Signature of Cardholder Date

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SIGNATURE ON FILE

Please initial in front of each subject that applies to you and sign at the bottom of the page. Thank you.

_____ I authorize use of this form on all my insurance submissions
_____ I authorize release of information to all my insurance companies
_____ I understand that I am responsible for my bill
_____ I authorize Charisse Diaz LMHC to act as my agent in helping me obtain payment from my insurance companies
_____ I authorize payment direct to Charisse Diaz LMHC
_____ I permit a copy of this authorization to be used in place of the original
_____ I authorize Charisse Diaz LMHC to use the term Signature on File, when submitting my claims

_____ _____
Please print responsible parties name Date of Birth

_____ _____
Signature of responsible party Date

Insurance Company _____ ID#_____

_____ _____
Client signature to include minors Print client name

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUTYOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE OF THIS NOTICE

Our Office is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This Notice describes your legal rights, advises you of our privacy practices, and lets you know how our office is permitted to use and disclose PHI about you.

This Notice is covered under HIPAA (Health Insurance Portability & Accountability Act)Any state law that is more stringent than the HIPAA rules and regulations has priority.

We required to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. If we do so, we will post a new Notice in our waiting area. You may request a copy of the new notice from Charisse Diaz LMHC by calling (813) 601-0595.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED MENTAL HEALTH INFORMATION

We use and disclose PHI for a variety of reasons. For most uses/disclosures, we must obtain your consent. However, the law provides that we are permitted to make some uses/disclosures without your consent. The following offers more description and examples of our potential uses/disclosures of your PHI.

<u>Uses and Disclosures Requiring You Consent</u>

- For treatment: We ay disclose your PHI to other mental health care practitioners who are involved in providing your mental health care. For example, a referral to a mental health practitioner for assessment and/or long-term treatment would require a signed consent from you for us to release and/or receive PHI about you to appropriately coordinate your care.
- For mental health care operations: We may use/disclose your PHI in the course of operating our program. For example, we may use your PHI in evaluating the quality of services provided, creating reports that do not individually identify you, or disclose your PHI to our accountant or attorney for auditing purposes.
- For payment: We may use/disclose your PHI in the course of collecting outstanding payment from you. For example, if failure for paying on a bad check in a timely manner, we may employ the State Attorney's office to collect on the outstanding debt. Or if failure to pay on your account in a timely manner, we may employ an attorney or collection agency to collect any outstanding debt.

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Exceptions: Although your consent is usually required for the use/disclosure of your PHI for the activities described above, the law allows us to use/disclosure of your PHI for the activities described above, the law allows us to use/disclose your PHI without your consent in certain situations. For example, we may disclose your PHI if needed for emergency treatment if it is not reasonably possible to obtain your consent prior to the disclosure and we think that you would give consent if able. Also if we are required by law to provide your treatment, we may use/disclosure your PHI for treatment and operations without obtaining your prior consent.

Uses and Disclosures Requiring Authorization

For uses and disclosures beyond treatment and operations purposes we are required to have your written authorization (signed permission), unless the use or disclosure falls within one of the exceptions described below. Like consents, authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

Uses and disclosures requiring authorization by a minor: The law provides that we may not use/disclose a minors PHI to the parent/legal guardian without a consent or authorization in the following circumstances.

- When required by law: We may not disclose a minors PHI to the parent/legal guardian when a law requires that we keep confidentiality about:
- Substance Abuse/Chemical Dependency
- Pregnancy
- Abortion

Uses and Disclosures NOT requiring consent or authorization: The law provides that we may use/disclose your PHI without consent or authorization in the following circumstances:

- When required by law: We may disclose PHI when a law requires that we report information about:
- Suspected abuse
- Neglect or domestic violence
- Suspected criminal activity
- In response to a court order

We must also disclose PHI to authorities who monitor compliance with these privacy requirements.

- For health oversight activities: We may disclose PHI for audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) to oversee the health care system.

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- To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclosure PHI a necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm. For example, a plan to commit suicide or a homicidal act.
- For specific government functions: We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

Uses and Disclosures requiring you to have an opportunity to object: In the following situations, we may disclose your PHI if we inform you about the disclosure in advance and you do not object. However, if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

- To families, friends or other involved in your care: We may share with these people information directly related to your family, friends, or other person's involvement in your care. We may also share PHI with these people to notify them about your location or general condition. For example, parents of a minor have certain right to PHI. Also, we may have to locate family members to inform them of the location of a client who as hospitalized after being diagnosed as severely depressed.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION. You have the following rights relating to your protected mental health information:

- To request restrictions on uses/disclosures. You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.
- To choose how we contact you: You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for use to do so.
- To inspect and copy your PHI. Unless your access is restricted for clear and documented treatment reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within 30 days. If we deny your access, we will you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- To request amendment of you PHI. If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine

that the PHI is (1) amended and complete; (2) not created by us and/or not part of our records; or (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will amend the PHI and so inform you, and tell others that need to know about the amendment in the PHI.

- To find out what disclosures have been made. You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made. If you would like to receive an accounting, you may send us a letter requesting an accounting or contact our Privacy Officer. The accounting will not include several types of disclosures, including disclosures made prior to April 14, 2003. However, from that day forward, disclosures must be documented and retained for a period of 6 years. We will respond to your written request for such a list within 60 days of receiving it. There will be no charge for up to one such list each year/ (12) month period. There may be a charge for more frequent requests.
- To receive this notice. You have a right to receive a paper copy of this Notice and/or electronic copy by email upon request.

How to complain about our privacy practices

If you believe that your privacy rights have been violate or if you are dissatisfied with our privacy policies or procedures, you may file a complaint either with us or with the federal government. We will not take any action against you or change our treatment of you in any way if you file a complaint. You may file a written complaint with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street SW, Atlanta, GA 30303-8909.

Contact person for information or to submit a complaint and questions

If you have any questions about this Notice or any complaints about our privacy practices, please contact:
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ACKNOWLEDGMENT FORM

I have **received the Notice of Privacy Practices** and I have been provided with an opportunity to ask questions.

Today's Date:_____

Name_____

Signature_____

Social Security Number:_____

_____
Street Address

_____
City State Zip

_____
Contact Telephone Number