Changing Tree
Wellness Center LLC

drscott@ctcentercares.com
(407) 242-3843

Client Information Sheet

Date: _____ MR#_____

Referral By: _____ Telephone _____

Client Name: _____ Race:_____ Marital Status:_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell: _____

D.O.B: _____ Age: _____

SS#_____

Client Occupation: _____

Employer: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip: _____

Health Problems: _____

Medications: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell: _____

1. Drug of Choice _____ Last Use _____ Amt._____
2. Drug of Choice _____ Last Use _____ Amt._____

Admitting Staff Signature: _____ Date: _____

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Client Name: **Client ID:** **Date:**

SYMPTOM CHECKLIST	A	B	C	D	E
PROBLEMS	Never	Occasionally	Frequently	COMMENTS	IF Box 'B' or 'C' is checked list Weekly Frequency here.
Change in appetite					
Binging/Purging Food					
Pica					
Weight loss/gain					
Insomnia/hypersomnia					
Isolative/Withdrawn					
Depression					
Mood Swings					
Anxiety					
Obsessive/Compulsive behavior					
Excessive anger					
Cruelty to animals					
Poor memory					
Processing difficulty					
Fire-setting					
Enuresis					
Encopresis					
Aggression or temper tantrums					
Lying					
Stealing					
Sexual acting out/Sexual dysfunctions					
Dreams/nightmares or night terrors					
Flashbacks					
Fears					
Hallucinations or delusions					
Somatic complaints					
Impulsivity					
Hyperactivity/Lethargy					
Poor concentration					
Short attention span					
Defiant or negative attitude					
Poor relations with family					
Poor relations with peers/co-workers					
Poor relations in the workplace/school					
Truancy					
Difficulty with authority (police)					
Other:					

Therapist Name: _____ Degree/Credentials: _____

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Confidential & Privileged Information for Professional Use Only

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PERSONAL INFORMATION AND INSURANCE FORM

Client's Name (include middle initial): _____ DOB: _____ Sex: _____

Home #: _____ Cell #: _____ Work #: _____ (Accept calls at work? Yes /No)

Email Address: _____ Best way to contact you: _____

Home Address: _____

Occupation: _____ Employer: _____ How long: _____

Your reason for seeking counseling: _____

In Case of emergency contact: _____Phone_____

Would you like to receive periodic informational mailings? Yes/No

Insurance Information

Insured's Name: _____ Insured's DOB: _____
Insured's Employer: _____
Name of Mental Health Benefits Insurance Carrier: _____
Policy number: _____ Insured's ID Number: _____
Group ID Number: _____ Insurance Company phone number: _____
Insurance company's address: _____
Is there another mental health benefits plan? _____

Mental Health Benefit (questions to ask your insurance company)

1. Is Licensed Mental Health Counselor (LPC) in Florida on the approved list of providers? _____
2. Out patient counseling coverage: _____
3. Percent coverage: _____ Deductible: _____ How much has been met? _____
4. Is precertification required? _____
5. Maximum payable per year: _____ Max visits/year? _____ Max visits/week? _____
6. Person Contacted: _____
7. Address for filing claims: _____
8. In network coverage_____ Out of network coverage _____
9. Special instructions for filing claims: _____

Assignment of Insurance benefits

By signing this form I am voluntarily authorizing the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes _____ to submit claims for benefits for services rendered without having to obtain my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed each particular claim.

I, _____, hereby authorize _____
(Name of insured) (Name of Insurance Company)
to pay and hereby assign directly to _____, all benefits, if any, otherwise payable to me for her services as described on this form. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____, will be credited to my account in accordance with the above said assignment.

Insured's Signature: _____ Date _____

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RELEASE OF INFORMATION

Client Name: _____ DOB: _____ SSN: _____

I _____, authorize _____

to **RELEASE/RECEIVE** information **TO/FROM:**

Name/Agency: _____
Address: _____
_____
Telephone: _____ Fax: _____

The specific information to be released **in VERBAL/WRITTEN** format is:

☐ Progress Notes ☐ Test Results ☐ Psychosocial History

☐ Treatment Plan ☐ Diagnosis ☐ Other: _____

For the specific purpose of:

☐ Facilitating Treatment ☐ Continuation of Care ☐ Evaluation

☐ Other_____

I understand that I have the right to refuse its authorization. I also agree to release _____, from any liability arising from the release of this information to the designated persons or agencies. I understand that my counselor may be compelled to release information without my permission under certain legally required circumstances.

This release is limited to information which is necessary for effective case management and treatment. I understand the material released may include information about drug and alcohol use.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

This consent may be revoked at any time except to the extent that the persons/agency, which is to make disclosure, has already taken action in reliance upon it. This authorization will expire one (1) year from the date signed. Also I understand that a photocopy of this authorization is valid for release of the above information.

Signature of Client: _____ Date: _____

Signature of legal Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

REDISCLOSURE PROHIBITED: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation prohibits you from making further disclosure. A general authorization for the release of medical or other information is NOT SUFFICIENT for this purpose.

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INFORMATION AND CONSENT FORM

WHAT IS COUNSELING?

The process of counseling may include, but is not limited to:

- Helping you to resolve personal issues
- Education concerning the root of personal difficulties
- Learning and applying new skills
- Rejecting destructive ways of thinking and behaving
- Gaining knowledge and insight concerning personal motivations
- Working through issues of woundedness and unforgiveness
- Learning to develop healthy relationships with yourself or others

Counseling may also incorporate the use of techniques from a variety of therapeutic approaches such as Insight Oriented, Object Relations, Cognitive Behavioral, Psycho-educational, as well as the application of your personal faith principles.

No guarantee is made that the counseling you receive will effect the desired results. Individual success largely depends on the intentional application of the insights, skill and knowledge the client gains through the counseling process and their willingness to be active, open, honest and as consistent as possible with their therapist.

No one else can solve your problems for you, but through gaining knowledge, insight, understanding and wisdom you can experience increased success in your life and relationships.

What your therapist expects from you: _____ (initial)

- Express concerns, ask questions
- Complete assignments
- Come to counseling free from the influence of any substances
- Pay your fees upon arriving to your session (have checks made out in advance)
- Be on time for your appointments
- Cancel 24 hours in advance (by phone or email) unless you have a serious illness or emergency
- (No shows and cancellations made less than 24 hours in advance are billed at the per session rate)

What is counseling like?

- A safe place where you will be accepted no matter what your struggle or difficulty
- An opportunity to grow personally and spiritually
- Personally challenging
- Teaches responsibility for the things you have control over
- Most sessions are 55 to 60 minutes in length

What to expect from your therapist:

- Return your calls within 24 hours in most cases
- Continue to update her skills and obtain ongoing training for him/herself
- Treat you with kindness and respect
- Develop a plan with you to help you achieve your goals and objectives
- Discuss discharge planning with you as soon as clinically appropriate
- Seek confidential consultation with other professionals when appropriate
- Help you to find an appropriate referral if necessary

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INFORMATION AND CONSENT FORM

Discharge and Termination _____ (initial)
The client has the right to terminate the counseling relationship at any time. However, it is in the client's best interest to discuss and plan for discharge with your counselor.

Counseling may be terminated for consistent failure to complete assignments, failure to pay fees, and failure to consistently show for scheduled appointments.

If there is a lapse in treatment for 1 month, unless arrangements have been made with your counselor, you will automatically be discharged from treatment.

Couples Therapy _____ (initial if applicable)
Successful marriages are based on trust. Therefore openness and honesty is the best policy. For successful therapy there can be no secrets within couples counseling. However, sometimes there are issues that are disclosed during individual sessions that may be difficult for one spouse to disclose to the other. When that is the situation, you and your counselor will work together on the best way to share that information with your spouse.

Records and Confidentiality_____ (initial)
The code of ethics for counselors and the state laws regulating most kinds of counseling consider personal information you discuss to be confidential. Except in a small number of situations, the helping professional may not reveal any information about you to another person without your explicit permission. Records of your treatment will be kept for seven years after your final session.

One exceptions to this rule includes if your fees are paid by a third party such as an insurance company, certain details of your treatment (e.g. dates of treatment, diagnosis, symptoms, progress) may be required to be revealed in order to obtain reimbursement. Most insurance companies allow you to file claims directly with them so that your employer will not see the information.

In cases where a court order has been issued and records have been subpoenaed the counselor has a legal responsibility to comply.

Suicidality and Abuse _____ (initial)
Another exception where counselors are legally required to disregard confidentiality involves situations where there is a potential for suicide or homicide. For example, if you reveal information that indicates a clear danger of injury to yourself or others the counselor will need to contact the appropriate authorities or family members.

Another exception to confidentiality is that all helping professionals are required by law to report any knowledge of abuse or neglect of a child or an incompetent or disabled person including suspected abuse.

Your counselor will be happy to discuss any concerns you have about the protection of the information you provide.

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INFORMATION AND CONSENT FORM

Fees and insurance reimbursement: _____ (initial)
Your insurance company may reimburse you for part of your fee; however it is your responsibility to pay your fee upfront unless other arrangements are made. If you cannot pay the full fee, please ask for a sliding scale fee evaluation form and submit it to your therapist. Your fee will not be changed until the form is fully filled out and returned to your therapist for evaluation. Your fee reduction is based on the information you have provided. If you are having difficulty keeping up with the charges please notify your counselor, and he/she will be glad to reevaluate at any time.

Fees for court appearances, phone sessions, copies of records etc. will be discussed with you by your therapist as the need arises. Phone consults initiated by the client, that exceed 10 minutes will be billed in quarter hour increments based on the per session fee. _____ **(initial)**

Your fee will be collected at the beginning of each session. Checks and cash are accepted. If you are going to use a check please have it ready when you come in to save time. For a small additional fee you can use your credit or debit card and pay through PayPal.

By your signature below you are indicating that you have read and understood this Information and Consent Form and/or that any questions you have had about this statement have been answered to your satisfaction. Your signature also indicates that you are over 18 years of age and legally competent. If you are under 18 years of age you must have your parent or guardian's signature as well. **Please sign one copy and return to your counselor and keep one copy for yourself.**

_____ _____
(Client's signature/date) (Parent/guardian's signature/date)

_____ _____
(Client's signature/date) (Parent/guardian's signature/date)

_____
(Witness signature/date)

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Client Name: _____ MR#: _____

FINANCIAL AGREEMENT

In compliance with commercial insurance regulations, arrangements for payment of co-payment and deductibles will be made at the time of admission. Please be advised that we bill your insurance company as a courtesy to you. Any remaining balances are your responsibility.

The following constitutes the financial policy of **CHANGING TREE WELLNESS CENTER** hereafter called "facility", with respect to services rendered at this facility.

1. Facility change for Outpatient Individual services is $_____ per hour.
2. Facility charge for Outpatient Group services is $_____ hour groups.
3. Facility will bill insurance carriers on behalf of the client where applicable. This is a service we provide for our Clients. The Client is still responsible for all charges incurred.
4. If insurance carrier fails to remit payment for services within ninety days, the Client will be billed for the balance of the account. All statements are due in full upon receipt.
5. Facility does not provide refunds of any moneys paid by or on the behalf of the Client when the Client leaves the facility against medical advice or for major rule violations.
6. Initial payment for treatment has been agreed as down payment of _____. Due upon admission unless Insurance assignments are accepted. Subsequent payments are due on the first day of each subsequent treatment period. As per payment plan_____.
7. I understand that my records are protected under Federal Confidentiality Regulations (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations) published August 10, 1997, and cannot be disclosed without written consent unless other provided in the regulations. I understand that my medical records may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/AIDS and or related conditions.
8. CHANGING TREE WELLNESS CENTER is not responsible under any conditions for covering co-pays on behalf of clients. A $_____ deposit is required or a credit card must be on file to cover all personal items including, but not limited to co-pays.

*Sliding scales and individualized payment plans may be arranged: _____

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Date

_____ _____
Staff Signature Date

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Service Fees

Regular Clients Fees

Intake/ Assessment session for Insured Clients	$200.00
45 minute individual session for Insured Clients	$125.00
Intake/ Assessment session for Self Paid Clients	$105.00
45 minute individual session for Self Paid Clients	$65.00

Couple/ Family Fees

Couple/ Family Therapy for	$130.00

Anger Management Fees

Anger Management Intake/ Assessment session	$75.00
Anger Management Individual Session	$30.00

Substance Abuse Fees

Substance Abuse Intake/ Assessment session	$75.00
Substance Abuse Group Sessions	$25.00
30 minute Substance Abuse Session	$25.00
45 minute Individual Session	$50.00
Missed Appointments for SA Clients	$25.00

Clients Signature: _____ **Date:** _____.

Admitting Staff/ Witness Signature: _____ **Date:** _____.

For other service fees that are not displayed, please feel free to ask at the front desk.... Thank you!