



CLIENT INFORMATION

First name

Last name

Middle name

Preferred Name

EMAIL

Email address

PHONE

Phone number

Phone type

- Mobile
- Home
- Work

- OK to leave a voice message
- OK to send text message
- Send me text message reminders for appointment

ADDRESS

Address

City, State, Zip

DEMOGRAPHICS

Birth date (MM/DD/YYYY)

Gender

Client is a minor

EMERGENCY CONTACT

First Name

Last Name

Relationship

Phone Number

INSURANCE VERIFICATION FORM

All clients must present a legible copy of their insurance card (front and back) before they are seen. Please complete all fields below to aid us in obtaining verification of your benefits and eligibility. Authorizations for treatment may be required by your insurance company.

Insurance Information (as shown on card)	
Coverage:	<input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> VA TriWest <input type="checkbox"/> Other
Plan Type:	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> EPO <input type="checkbox"/> POS <input type="checkbox"/> Private-Pay
Insured's Name and DOB:	
Insured's Medicare or Medicaid Number:	
Insured's Member Number:	
Insured's Group Number:	
Insurance Company Name:	
Insurance Company Phone:	
Insurance Company Address:	
Insurance Company City, State and ZIP:	
Primary Care Physician Name:	
Primary Care Physician Address:	
Primary Care Physician City, State and ZIP:	
Primary Care Physician Phone:	

I, _____, authorize authorize Only Live, LLC DBA Sage Counseling and or Sage Senior Counseling to verify my benefits eligibility for treatment. I understand that my information will be saved to file for future insurance claims on my account.

Client Signature

Date

CLIENT COPY : RATES, FEES & SCHEDULING

RATES AND FEES

Rates vary and depend on the client's insurance benefits and or their election to private pay where applicable. Once eligibility, deductible, co-pay and co-insurance have all been verified, we will inform you of your rate and client responsibility. An \$18.00 fee will be charged for any checks returned for any reason for special handling.

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule at least 24 hours in advance. If an appointment is cancelled and rescheduled with less than 24 hours notice, a cancellation and re-scheduling fee of **\$54.00** will be charged. No-shows and cancellations (without rescheduling) with less than 24 hours notice may be subject to the full fee at the practice rate for the scheduled service. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time in order to maintain schedule integrity for all our scheduled clients and clinicians.

Your Per Session Rate	
Rate:	
Co-Pay:	Co-Insurance:
Recommended Appointment Frequency:	
Limits and Related Dates:	
Notes:	

INTAKE QUESTIONNAIRE

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

What are your goals for counseling?

Have you seen a mental health professional before?

- Yes
- No

Specify all medications and supplements you are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Who is your primary care physician? Please include type of MD, name and phone number.

Do you drink alcohol?

- Yes
- No

Do you use recreational drugs?

- Yes
- No

Do you have suicidal thoughts?

- Yes
- No

Have you ever attempted suicide?

- Yes
- No

Do you have thoughts or urges to harm others?

- Yes
- No

Have you ever been hospitalized for a psychiatric issue?

- Yes
- No

Is there a history of mental illness in your family?

- Yes
- No

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others, with family, etc...

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months

- Increased appetite
- Decreased appetite
- Trouble concentrating
- Difficulty sleeping
- Excessive sleep
- Low motivation
- Isolation from others
- Fatigue/low energy
- Low self-esteem
- Depressed mood
- Tearful or crying spells
- Anxiety
- Fear
- Hopelessness
- Panic
- Other

Please check any of the following that apply

- Headache
- High blood pressure
- Gastritis or esophagitis
- Hormone-related problems
- Head injury
- Angina or chest pain
- Irritable bowel
- Chronic pain
- Loss of consciousness
- Heart attack
- Bone or joint problems
- Seizures
- Kidney-related issues
- Chronic fatigue
- Dizziness
- Faintness
- Heart valve problems
- Urinary tract problems
- Fibromyalgia
- Numbness & tingling
- Shortness of breath
- Diabetes
- Hepatitis
- Asthma
- Arthritis
- Thyroid issues
- HIV/AIDS
- Cancer
- Other _____

What else would you like me to know?

PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule at least 24 hours in advance. If an appointment is cancelled and rescheduled with less than 24 hours notice, a cancellation and re-scheduling fee of **\$54.00** will be charged. No-shows and cancellations (without rescheduling) with less than 24 hours notice may be subject to the full fee at the practice rate for the scheduled service. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time in order to maintain schedule integrity for all our scheduled clients and clinicians.

SESSION DURATION

The standard meeting time for an initial intake is 60 - 75 minutes. Additional psychotherapy sessions are 50 - 60 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50 - 60 minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

On July 1, 2019. The State of Florida began recognizing telehealth with the passage of HB 23. Telehealth is defined as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. Telehealth does not include audio-only telephone calls, e-mail messages, or fax transmissions. Telehealth is broadly defined as the use of information technology to deliver medical services and information from one location to another.

If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.

3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.

Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the therapist.

MINORS

If you are a minor, your parents are legally entitled to complete information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature

Date

NOTICE OF PRIVACY PRACTICES

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.

I can change the terms of this Notice, and such changes will apply to all the information I have about you. The current notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client’s personal health information without the patient’s written authorization, to carry out the health care provider’s own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. PROGRESS NOTES, OUR POLICY ON MARKETING AND OR SALE OF PHI:

1. **Progress Notes.** The 2019 State of Florida [Chapter 394](#) (Mental Health) statute **394.453** defines your PHI as your "clinical record". "Clinical record" means all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by facility staff which pertains to the patient's hospitalization or treatment. I do keep "progress notes"; the confidentiality of which is covered in Florida Statute **394.415**, which states:

A clinical record is confidential and exempt from the provisions of s. 119.07

(1) Unless waived by express and informed consent, by the patient or the patient's guardian or guardian advocate or, if the patient is deceased, by the patient's personal representative or the family member who stands next in line of intestate succession, the confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency.

(2) The clinical record shall be released when:

(a) The patient or the patient's guardian authorizes the release. The guardian or guardian advocate shall be provided access to the appropriate clinical records of the patient. The patient or the patient's guardian or guardian advocate may authorize the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care.

(b) The patient is represented by counsel and the records are needed by the patient's counsel for adequate representation.

(c) The court orders such release. In determining whether there is good cause for disclosure, the court shall weigh the need for the information to be disclosed against the possible harm of disclosure to the person to whom such information pertains.

(d) The patient is committed to, or is to be returned to, the Department of Corrections from the Department of Children and Families, and the Department of Corrections requests such records. These records shall be furnished without charge to the Department of Corrections.

(3) Information from the clinical record may be released in the following circumstances:

(a) When a patient has communicated to a service provider a specific threat to cause serious bodily injury or death to an identified or a readily available person, if the service provider reasonably believes, or should reasonably believe according to the standards of his or her profession, that the patient has the apparent intent and ability to imminently or immediately carry out such threat. When such communication has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.

(b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.

For the purpose of determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan pursuant to s. 394.4655, the clinical record may be released

to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals, including the service provider identified in s. 394.4655(7)(b)2., in accordance with state and federal law.

(4) Information from the clinical record must be released when a patient has communicated to a service provider a specific threat to cause serious bodily injury or death to an identified or a readily available person, if the service provider reasonably believes, or should reasonably believe according to the standards of his or her profession, that the patient has the apparent intent and ability to imminently or immediately carry out such threat. When such communication has been made, the administrator must authorize the release of sufficient information to communicate the threat to law enforcement. A law enforcement agency that receives notification of a specific threat under this subsection must take appropriate action to prevent the risk of harm, including, but not limited to, notifying the intended victim of such threat or initiating a risk protection order. A service provider's authorization to release information from a clinical record when communicating a threat pursuant to this section may not be the basis of any legal action or criminal or civil liability against the service provider.

(5) Information from clinical records may be used for statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals.

(6) Information from clinical records may be used by the Agency for Health Care Administration, the department, and the Florida advocacy councils for the purpose of monitoring facility activity and complaints concerning facilities.

(7) Clinical records relating to a Medicaid recipient shall be furnished to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request.

(8) Any person, agency, or entity receiving information pursuant to this section shall maintain such information as confidential and exempt from the provisions of s. 119.07(1).

(9) Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to this section is not subject to civil or criminal liability for such release.

(10) Nothing in this section is intended to prohibit the parent or next of kin of a person who is held in or treated under a mental health facility or program from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.

(11) Patients shall have reasonable access to their clinical records, unless such access is determined by the patient's physician to be harmful to the patient. If the patient's right to inspect his or her clinical record is restricted by the facility, written notice of such restriction shall be given to the patient and the patient's guardian, guardian advocate, attorney, and representative. In addition, the restriction shall be recorded in the clinical record, together with the reasons for it. The restriction of a patient's right to inspect his or her clinical record shall expire after 7 days but may be renewed, after review, for subsequent 7-day periods.

(12) Any person who fraudulently alters, defaces, or falsifies the clinical record of any person receiving mental health services in a facility subject to this part, or causes or procures any of these offenses to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

2. **Marketing Purposes.** As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. **Sale of PHI.** As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION:

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and its use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on the disclosure of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on [January 1, 2021]

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature

Date

INFORMED CONSENT FOR PSYCHOTHERAPY

GENERAL INFORMATION

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

THE THERAPEUTIC PROCESS

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you, and repeating patterns, as well as to help you clarify what it is that you want for yourself.

CONFIDENTIALITY

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature

Date