integrity counseling inc.

CLIENT INFORMATION FORM

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME #: _____ WORK #: _____ CELL #: _____

MAY WE LEAVE DISCREET MESSAGES AS NEEDED AT ABOVE LISTED NUMBERS? YES ☐ NO ☐

EMAIL: _____ MAY WE CONTACT YOU AT THIS EMAIL? YES ☐ NO ☐

SOCIAL SECURITY NUMBER: _____ DOB: _____ AGE: _____

NAME AND NUMBER OF EMERGENCY CONTACT PERSON: _____

HOW DID YOU HEAR ABOUT INTEGRITY COUNSELING? _____

BRIEFLY DESCRIBE THE ISSUES/PROBLEMS THAT LED YOU TO SEEK THERAPY TODAY: _____

_____

WHAT GOALS WOULD YOU LIKE TO ACHIEVE IN THERAPY? _____

DESCRIBE ANY HEALTH PROBLEMS, MEDICAL CONDITIONS, OR RECENT OPERATIONS: _____

_____

ALLERGIES: _____

LIST ALL MEDICATIONS YOU ARE TAKING: _____

_____

LIST YOUR PHYSICIAN(S) NAME(S): _____

LIST ANY PAST PSYCHOLOGICAL/PSYCHIATRIC/COUNSELING/TREATMENT YOU HAVE HAD: _____

_____

HOW OFTEN DO YOU DRINK ALCOHOL? _____ IS THERE ALCOHOLISM IN YOUR FAMILY? _____

WHAT ILLICIT DRUGS HAVE YOU USED? _____

DO YOU BELIEVE YOU HAVE, OR HAD AT ANY TIME IN THE PAST, A PROBLEM WITH ALCOHOL OR DRUGS? _____
EXPLAIN: _____

IS THERE ANYTHING ELSE WE SHOULD KNOW? _____

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM

Integrity Counseling & Coaching

FINANCIAL POLICY

Full payment is due at time of service (unless prior arrangements have been made).
Please feel free to ask if you have any questions about our financial policy. Understanding our financial policy is important to our relationship. Insurance is a contract between you and your insurance company. We will file your claim to your insurance company or provide you with the proper information needed for you to file a claim. You are responsible for the timely payment of your Account. We will send information, including clinical information i.e. diagnosis, to your insurance company unless you specifically instruct us not to do so. We will send information electronically, so please read the HIPPA notice.

Uncollected balances may be turned over for collection or reported to the state's attorney's office.

CANCELLATION POLICY

Please help us to serve you and others better by keeping your scheduled appointments. If you need to cancel or reschedule, please give us as much notice as possible so we can offer that time to someone else.
Unless cancelled **at least 24 hours in advance**, our policy is to charge for missed appointments at the rate of a normal counseling session. This will be billed to you. We may require prepayment in order to schedule a subsequent appointment.

CONFIDENTIALITY

Federal and State laws protect your confidentiality (See 42 U.S.C. 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). Your counselor will not share information with any person outside of Integrity Counseling, Inc. without your written permission, except as required by law or as needed to file your insurance claim. Information obtained from minors is not generally shared with parents without permission.

Exceptions to Confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, or individual with a disability. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Your counselor has the option of breeching confidentiality if you report a specific plan or intent to cause serious bodily harm to an identifiable person.

HIPPA (Health Insurance Portability and Accountability Act) laws allow you access to your file and protect the electronic transfer of information.

CONSENT TO TREATMENT

I am voluntarily seeking outpatient counseling at Integrity Counseling & Coaching. I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy. I am strongly encouraged to discuss my treatment plan and status in treatment with my counselor. Counselors will also discuss alternatives, procedures, qualifications, and drawbacks to therapy. **With my signature below, I acknowledge that I have read, understand, and agree to all of the above. I also acknowledge that I have been given a copy of HIPPA/Privacy Practices implemented here at Integrity.**

Individual counseling sessions are intended to be 45-50 minutes in length.

Please note: We do not provide emergency services. In true crisis call 911.

_____ _____

Signature of Client and/or Legal Guardian Date

1101 S. Belcher Road, Suite J
Largo, FL 33771
Phone (727) 531-7988 // Fax (727) 531-0950

CONSENT TO RELEASE CONFIDENTIAL INFORMATION TO JUVENILE DRUG COURT

I, _____ SS#/DOB: _____

HEREBY AUTHORIZE: Integrity Counseling & Coaching, Inc., its therapists and its representatives.

TO DISCLOSE TO THE FOLLOWING SPECIFIED PERSON OR AGENCY:

JUVENILE DRUG COURT:	14250 49th St. N. 3rd Floor Clearwater, FL 33762
	PHONE: (727) 464-7013 // FAX: (727) 464-7205
JUVENILE ASSESMENT CENTER:	**PHONE: (727) 464-7437 // FAX: (727) 453-7390**

THE FOLLOWING INFORMATION: Results of evaluation including recommendations and urinalysis drug screen (abstinence) results. Records substantiating treatment including compliance with treatment recommendations and abstinence status including subsequent drug tests, discharge information such as discharge summary and after treatment plan.

FOR THE PURPOSE OF: Compliance with Drug Court/ assistance with treatment.

I UNDERSTAND THAT THIS CONSENT TO OBTAIN CONFIDENTIAL INFORMATION IS SUBJECT TO REVOCATION BY ME, EXCEPT TO THAT ACTION WHICH HAS BEEN TAKEN IN RELIANCE THEREON AND UNLESS OTHERWISE STATED, THIS CONSENT SHALL HAVE A DURATION NO LONGER THAN THAT NECESSARY TO EFFECTUATE THE PURPOSE FOR WHICH IT IS GIVEN. **Unless otherwise stated – seven years from the date of signing.**

CLIENT SIGNATURE:_____ DATE:_____

GUARDIAN SIGNATURE:_____ DATE:_____

WITNESSESED BY:_____ DATE:_____

I give permission to send information electronically or by fax (initial). _____

CONFIDENTIALITY NOTICE

"THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL REGULATIONS (42 CFR PART 2) AND PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE."