GroundWork
COUNSELING
400 South Orlando Avenue, Suite 206
Maitland, Florida 32751
407.378.3000

Client Informed Consent

Welcome to Groundwork Counseling Services LLC. Prior to your first appointment, we invite you to review the following important information regarding our services and practices. Please note any questions that you have in reading through the following information so that we may discuss them further. Signing this form will represent an agreement between us and acknowledge that you feel adequately informed regarding the services and support you receive during your time in counseling.

Therapy, Counseling & Coaching Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Therapy, counseling, and coaching can have benefits and risks. Since therapy often involves discussing difficult or challenging aspects of your life or past, you may find yourself (or your child) experiencing intense emotions while in therapy. On the other hand, therapy, counseling and coaching has shown to be significantly beneficial to those who participate in it. Therapy can often assist individuals to find solutions to problems, improve self-image, reduce negative feelings, and improve relationship quality. There are no guarantees of what you will experience.

If at any time during our counseling relationship you would like more information regarding therapeutic interventions, education, or general information please do not hesitate to ask.

Assessment & Sessions

Our first few sessions will include an evaluation and assessment of your needs (or your child's needs). After several sessions, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. Each session is scheduled for 60 minutes in length, unless the client (or parent) has requested a 90-minute session (additional fee). Frequency of visitation will be mutually agreed upon as part of your plan of care.

Cancelation Policy

Once an appointment is scheduled any client will be required to pay for that appointment at the fee set for the length or purpose of the appointment unless 1 full business day notice is provided (a Monday morning appointment must be cancelled by Friday morning). Cancellations with less than 24 hours notice will be charged the full session fee. I do understand that circumstances beyond an individual's control can arise - in specific cases the fee may be waived at the counselor's discretion. Excessive missing of appointments, whether paid or unpaid, will result in a reevaluation of our contract and your continuation in therapy. I reserve the right to terminate the counseling relationship in the event that 2 consecutive appointments are missed without notification of cancelation. Please note that consistency in counseling, and attending each session will provide you with the optimum potential to benefit from your therapeutic experience.

Service Fees (For All Counseling Appointments)

60 Minute Individual Session: $125
90 Individual Session: $175

In addition to weekly appointments, I charge this amount for other professional services you may request. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized and requested, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I are called to testify by another party. Because of the difficulty of legal involvement, I charge $350 per hour for preparation and attendance at any legal proceeding.
If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment, pro-bono services, or a payment installment plan.

Payment
Cash, checks, and all credit cards are accepted. A credit card must be on-file with release to auto-bill for your appointment if an appointment is missed without 24 hours notice. Also, auto-billing can be utilized for each appointment if it is more convenient for you.

Insurance
At this time I do not reimburse through insurance. You may attempt third part reimbursement; I am happy to supply a bill for you to submit to your insurance provider, however, I do not guarantee reimbursement. Please be aware that if you request a summary or bill to submit to your insurance provider, it is likely that your insurance company will require you to authorize your therapist to provide them with a clinical diagnosis. In other cases, they may request additional clinical information such as treatment plans or summaries.

Contacting Your Therapist & Office Hours
I am not often immediately available by telephone. While I maintain office hours (by appointment only), I am often with clients and unable to answer the phone. When I am unavailable, your call will be answered by my voicemail, which I monitor frequently. I will make every effort to return your call within one business day, with the exception of weekends and holidays. If you do not hear back from me in that time frame please call back as it may mean that your message was not retained by my voicemail. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Qualifications
At Groundwork Counseling, we offer counseling services from licensed mental heath counselors, (LMHC) licensed marriage and family therapists (LMFT), and registered mental health counseling interns (RMHCI). Licensed Mental Health Counselors (LMHC) and Licensed Marriage and Family Therapists (LMFT) hold a master's degree in marriage and family counseling, or clinical mental heath counseling, and are fully licensed with the state of Florida and hold and active license with the state of Florida, Registered Mental Health Counseling Interns (RMHCI / IMH) hold a master's degree in marriage and family counseling, or clinical mental heath counseling and are registered in the state of Florida as a counseling intern seeking state licensure – these individuals have completed over 1000 hours of clinical counseling practicum and internship experience, and practice under the supervision of a licensed counselor. All license and registration numbers as well as supervisor contact information are available by request; please ask your counselor if you have any questions regarding their credentials, education, or Florida state registration or license numbers, we'd be happy to supply them to you.

Professional Records
The laws and standards of my profession require that counselors keep treatment records of each session. This information can be requested in writing and will be provided to clients either in full or in summary. This information is maintained in clinical language and is subject to misinterpretation and as a result could be upsetting. If I believe this information is

subject to high levels of misinterpretation I may offer to review the records with you during a scheduled session. Because these records contain sensitive information I strongly suggest patients reviewing them with a mental health provider.
I utilize a "paperless" approach to record keeping. Your files will be stored on a HIPPA approved, secured and password protected cloud-based software. Any hardcopy files will either be filed in accordance with HIPPA / ACA guidelines or scanned into the database and shredded.

Information contained in email and text messages may be privileged and confidential. However, there is some risk that any information that may be contained in such email or text message may be disclosed to, or intercepted by, unauthorized third parties. Please be aware that email and text communication can be intercepted in transmission or misdirected. Your use of email or text to communicate information indicates that you acknowledge and accept the possible risks associated with such communication.

Minors
If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. I request for parents to not examine child or adolescent records, or request a summary without the minor's consent. Before giving parents any information, I will discuss the matter with the client, if possible, and do my best to handle any objections the client may have.

Confidentiality
In general, the privacy of all communications between a patient and counselor is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.
In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.
There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly person, or disabled person] is being abused, I am required to file a report with the appropriate state agency.
If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.
I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.
While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our initial meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signatures below indicates that you have read the information in this document and agree to abide by its terms.

_____ _____
Client (Partner 1) Date

_____ _____
Client (Partner 2) Date

_____ _____
Counselor Date

Revised 12/13

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Notice of Privacy Practices

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU IS PROTECTED AND MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

I. Confidentiality

As a rule, I will not disclose information about you, or the fact that you are my client, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, a diagnosis if applicable, functional status, symptoms, prognosis and progress, and any assessment tools administered or obtained. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing a general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, I require that you sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together. I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· **Emergency:** If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Florida law to report the matter immediately to the Abuse Hotline at 1-800-96-ABUSE.

· **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Florida law to immediately make a report and provide relevant information to the Abuse Hotline at 1-800-96-ABUSE.

· **Court Proceedings:** If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you. If there is a criminal or civil case being pursued or considered I ask that you advise me as this makes records more subject to being requested and may have an effect on your response to therapeutic services provided.

· **Serious Risk to Health or Safety to Self:** Under Florida law, if I am engaged in my professional duties and you indicate an intent and verbalize means to bring harm to yourself I am required to take steps to ensure your safety. If you indicate an intent and verbalize means to complete or attempt a suicidal gesture I am required to take steps to ensure your safety. For both of these instances voluntary or involuntary hospitalization will be utilized and Baker Act procedures initiated to minimize the likelihood that you will be able to bring harm or fatal injury upon yourself.

· **Serious Risk to Heath or Safety to Others:** Under Florida law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to inform the third, or threatened party. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

·**Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your

relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
· **Records of Minors:** Florida law limits the confidentiality of the records of minors. For example, parents may not be denied access to their child's records. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors. Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

II. Patient's Rights and Providers Duties:
· **Right to request restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request but will do my best to disclose the minimum necessary information. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
·**Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
· **Right to an Accounting of Disclosures:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice).
· **Right to Inspect and Copy:** In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
· **Right to Amend:** If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
· **Right to a Copy of This Notice:** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the change notice effective for medical information I already have about you as well as any information I receive in the future. If there are changes a new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.
·**Complaints:** If you believe your privacy rights have been violated, you may file a complaint. To do this, you may submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services or visit their website at www.hhs.gov.

Patient's Acknowledgment of
Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgment form. You have been provided a copy of the Notice of Privacy Practices of GroundWork Counseling LLC. We have discussed these policies, and I understand that I may ask questions about them at any time in the future.
I consent to accept these policies as a condition of receiving mental health services.

(Partner 1)
Signature: _____
Printed Name: _____
Date: _____

(Partner 2)
Signature: _____
Printed Name: _____
Date: _____

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Credit Card Authorization Form

PLEASE PRINT OUT AND COMPLETE THE AUTHORIZATION AND BRING IT WITH YOU TO YOUR APPOINTMENT. WE REQUIRE ALL ACTIVE CLIENTS TO HAVE A CREDIT CARD ON FILE.
All information will remain confidential.

Cardholder Name: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

Charge this card automatically for appointments? (Please circle one of the following)

YES (Always, for all appointments)

SOMETIMES (If I do not have a check or cash)

NO (I will be paying with cash or check – only use this card for missed appointments without 24hr notice)

I authorize GroundWork Counseling LLC to charge the agreed service charge to my credit card provided herein. I understand my card will be charged the full service fee for missed appointments if 24 hours notice is not given. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Name: _____

Signed: _____

Dated: _____

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(This form is optional - please only fill out this form if you would like to give us permission to communicate with your doctor, psychiatrist, school, other mental health care practitioner, or a family member that is not a parent or legal guardian.)

CONFIDENTIAL RELEASE OF INFORMATION

I _____ hereby authorize GroundWork Counseling LLC to release to:

_____
Name and title

_____
Address City State Zip Code

_____
Phone number and/or Fax number, including area code

Information regarding services received for the purpose of:

_____

_____

_____

Name:_____ (please print)

Signature: _____ Date: _____

Current Address: _____

Phone Number: _____

Email Address: _____

This consent is valid until _____ (six months maximum before a new release form is signed) (please specify date)

I understand that I may only revoke this form by notifying, in writing, the person, department or office authorized by this form to release information. I further understand that, after this date, I will need to sign a new release form should I wish to continue to authorize the release of information.

For more information, or if you have questions or need clarification, please contact your GroundWork Counseling provider.

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Couples Intake Form

INSTRUCTIONS: To assist your therapist in helping you please fill out this form individually, as fully and openly as possible. We encourage both individuals to fill out separate intake forms. You may choose to not disclose your answers with your partner at this time - your answers can be shared later with your partner during your time in couple's counseling.

Name: _____ D.O.B: _____ Age:_____
Today's Date: _____

How did you hear about us / referred by: (please select one)
Pediatrician __ Google Search __ Theravive__ Psychology Today __ Word of Mouth/Friend __
Other __ Please indicate_____

Address:_____

Home Phone:_____	May I contact you at your home?	YES	NO
Cell Phone: _____	May I contact your cell phone?	YES	NO
	May I text your above cell phone?	YES	NO
E-mail Address:_____	May I contact you via email?	YES	NO

Preferred Method of Contact:_____
*Please note: Email correspondence and texting is not considered to be a confidential medium of communication.

Marital Status & Children

□ Married □ Divorced □ Separated □ Living Together □ Engaged □ Dating

Number of Marriages_____

How long have you and your partner been together? _____

Please list any/all children and their age:

Please complete the following information for each of your and/or your partner's children:

Name of Child	Age	Sex	Whose Child	Lives with Whom
1.		M F		
2.		M F		
3.		M F		
4.		M F		
5.		M F		

Relationship Information

List five qualities that initially attracted you to your partner.

Does your partner still posses this trait?

1. Yes No
2. Yes No
3. Yes No
4. Yes No
5. Yes No

List five negative concerns that you had at the beginning of the relationship.

Does your partner still posses this trait?

1. Yes No
2. Yes No
3. Yes No
4. Yes No
5. Yes No

List five current positive attributes of your partner.

Do you praise your partner for this attribute/trait?

1. Yes No
2. Yes No
3. Yes No
4. Yes No
5. Yes No

List five current negative attributes of your partner.

Do you complain to your about this trait?

1. Yes No
2. Yes No
3. Yes No
4. Yes No
5. Yes No

List five things you do (or could do) to make your relationship more fulfilling for your partner.

Do you often implement this behavior?

1. Yes No
2. Yes No
3. Yes No
4. Yes No
5. Yes No

List five things your partner does (or could do) to make your relationship more fulfilling for you.

Does he/she often implement this behavior?

1. Yes No
2. Yes No
3. Yes No
4. Yes No
5. Yes No

What is the issue that led you to decide to come to therapy?

_____

_____

_____

What have you already done to deal with the difficulties?

_____

_____

_____

What are your biggest strengths as a couple?

_____

_____

_____

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does (something you would like to work on)

_____

_____

Do you ever wish your partner would cut back on his/her drinking and/or drug use? YES NO NONE ISSUE

Describe_____

_____

Do you perceive that either you or your partner has withdrawn from the relationship? YES NO

Describe_____

_____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship. (Circle One)

1 2 3 4 5 6 7 8 9 10

(extremely unhappy) (extremely happy)

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10

(extremely unpleasant) (extremely enjoyable)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

Relationship History

Have you received prior couples counseling related to any of the above problems?

_____

_____

Have either you been in individual counseling before? If so, give a brief summary of concerns you addressed.

_____

_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

_____

_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

_____

_____

Individual Information

Are you currently taking any prescription medication? □ Yes □ No

Please list: _____

Have you ever been prescribed psychiatric medication? □ Yes□ No

Please list and provide dates and medications previously prescribed:_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

Do you have thoughts of suicide or self-harm □ Yes □ No

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Do you drink alcohol? □ No □ Yes □ Occasionally Frequency:_____

Do you engage recreational drug use? □ No □ Yes □ Occasionally Frequency:_____

Have any aspects of your sexuality ever been a cause of concern for you? □ No □ Yes

If so, please describe:

_____

_____

Any significant life changes or stressful events have you experienced recently:

_____

_____

Are you currently employed □ Yes □ No Place of employment _____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:

_____

_____

Please list any information you deem to be important for the therapist to know:

_____

_____

_____

Thank you for taking the time to fill out the client intake documents. Please sign and date below.

_____ _____

Client Name Date

_____

Client Signature

_____ _____

Counselor Signature Date

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Name: _____ D.O.B: _____ Age:_____
Today's Date: _____

How did you hear about us / referred by: (please select one)
Pediatrician __ Google Search __ Theravive__ Psychology Today __ Word of Mouth/Friend __
Other __ Please indicate_____

Address:_____

Home Phone:_____	May I contact you at your home?	YES	NO
Cell Phone: _____	May I contact your cell phone?	YES	NO
	May I text your above cell phone?	YES	NO
E-mail Address:_____	May I contact you via email?	YES	NO

Preferred Method of Contact:_____
*Please note: Email correspondence and texting is not considered to be a confidential medium of communication.

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_____

_____

What have you already done to deal with the difficulties?

_____

_____

_____

What are your biggest strengths as a couple?

_____

_____

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Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does (something you would like to work on)

_____

_____

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Describe_____

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Describe_____

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If so, please describe:

_____

_____

Any significant life changes or stressful events have you experienced recently:

_____

_____

Are you currently employed □ Yes □ No Place of employment _____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:

_____

_____

Please list any information you deem to be important for the therapist to know:

_____

_____

_____

Thank you for taking the time to fill out the client intake documents. Please sign and date below.

_____ _____

Client Name Date

_____

Client Signature

_____ _____

Counselor Signature Date