***CW Holistic Counseling LLC*** Logo, company name

Description automatically generated

*907 Marwalt Dr. Ste 2022*

*Fort Walton Beach, FL 32547*

*Phone (850)243-0095*

*Fax (850)374-3192*

**NEW PATIENT REGISTRATION FORM**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_ Minor Y or N

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**You can choose to disclose or to not disclose these questions inside this box**

Birth Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Identification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Languages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sexual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If patient is a minor who is legal guardian? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-MAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone-Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INSURANCE INFORMATION**

Name of Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID/Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay $:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT SECONDARY INSURANCE INFORMATION**

Name of Secondary Insurance or Supplemental (i.e. ASI):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID/Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay $:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BILLING INFORMATION**

Name of Person responsible for the charges: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am providing an automatic Release of information, for bills to be mailed to party's responsible address or for that party to be contacted.

All payments and co-pays are **due** at the time services are rendered. If Ms. Williams is a network provider with your insurance company, you are responsible for paying your co-pay according to your plan. If you have an out-of-network insurance claim, Ms. William’s office will be happy to assist you in any way and will provide super bills and/or Health Care Financing Forms under these circumstances.

|  |  |
| --- | --- |
| **Medications Log** | |
| **Name:** | **Date of Birth:** |
|  | |
| Medication: | |
| Dose/Directions: | |
| Date Started/ended: | |
| Purpose: | |
| Prescribed By Dr.: | |
| Notes/Comments: | |
|  | |
|  | |
|  | |
| Medication: | |
| Dose/Directions: | |
| Date Started/ended: | |
| Purpose: | |
| Prescribed By Dr.: | |
| Notes/Comments: | |
|  | |
|  | |
|  | |
| Medication: | |
| Dose/Directions: | |
| Date Started/ended: | |
| Purpose: | |
| Prescribed By Dr.: | |
| Notes/Comments: | |
|  | |
|  | |
|  | |
| Medication: | |
| Dose/Directions: | |
| Date Started/ended: | |
| Purpose: | |
| Prescribed By Dr.: | |
| Notes/Comments: | |
|  | |
|  | |
|  | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**ATTENTION:**

Would you like to have E-mail appointment reminders and join our ***Patient Portal***?

**(REMINDERS ARE A COURTESY)** **patients are 100% responsible for their appointments.**

Here is a **sample** of our Email Reminders:

**Appointment Reminder**

Jane Doe,

This is a reminder that you have an appointment with Christina Williams at

**4:00 PM on April 9th**

Christina Williams MS, LMHC,

907 MarWalt Dr.

Suite 2022

Fort Walton Beach, FL, 32547

(850) 243-0095

Directions

**Please contact our office with any questions or changes.**

**Email by** ClientWelcome.com on behalf of Christina Williams, MS, LMHC

Reminder settings or unsubscribe

If so, please provide Hannah, Sonshine Counseling’s Office Mgr., with your email address.

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you choose to opt out of email or Patient Portal later, you can click on “unsubscribe”.

**FINANCIAL RESPONSIBILITY POLICY**

I understand and agree that I will be charged a fee for all direct and indirect professional services rendered on my behalf.

Billable services may include, but are not limited to, any of the following:

1.) Direct (face-to-face) therapeutic services

2.) Clinical interviews

3.) Behavioral observations

4.) Consultation services

5.) Document preparation

6.) Phone calls initiated by or for the patient will be billed at the standard professional fee, per amount

of time: there will be no charge for phone calls less than five (5) minutes in duration.

7.) Court appearances, depositions

8.) Indirect therapeutic services

9.) Monthly Administration Fee

**APPOINTMENT CANCELLATION/NO SHOW POLICY**

• A 24-hour notice is required for cancelled appointments. If you are cancelling without 24-hour notice, you will

be charged the cancellation fee as listed on the fee schedule. Insurance will **NOT** cover cancellation charges.

• Appointment reminders are provided to you as a courtesy. The absence of an appointment reminder does not

waive the requirement for 24-hour notice of cancellation.

• Re-scheduling a cancelled appointment will not waive the cancellation fee described above.

• Failure to re-schedule a cancelled appointment will constitute a No-show appointment.

• Three No-show appointments within a 12-month period may result in termination of services.

**BILLING and COLLECTIONS**

•It is your responsibility to understand the benefits provided by the insurance policy.

• For most patients I will be out-of-network, or non-participating, provider. This means we will be unable to bill your insurance company. Therefore, the full fee payment is due at the time of service. You will receive a receipt or statement of service, including the charge, diagnosis and appropriate CPT code. You may then submit this statement to your insurance company, if you decide to do so, in order to collect the amount that your policy allows under the circumstances.

**Christina Willaims, LMHC**

**Fee Schedule**

|  |  |  |  |
| --- | --- | --- | --- |
| **CPT Code** | **Type** | **Amount** | |
| 90791 | Intake (Bio-Psychosocial Assessment) | $200.00 | |
| **\*\*This will be billed annually in most cases** | | | |
| 90834 | Individual Therapy 45-50minutes | | $140.00 |
| 90837 | Individual Therapy 60 minutes | | $150.00 |
| 90847 | Family Therapy w/ patient present | | $150.00 |
| 90846 | Family Therapy w/o patient present | | $150.00 |
|  | Group Therapy | | $150.00 |
|  | Report Preparation and Administration Fee (per hour- 1 hour minimum) | | $150.00\* \*Subject to change |
|  | Travel (per hour) | | $60.00 |
| 90832 | Therapy Session (20-30min) | | $75.00 |
|  |  | |  |

\*\*Telephone consults as follows: 15 minutes $30, 30 minutes $60.00 and 60 minutes $150.00 any phone conversation over 5 minutes will be charged $25.00

Administration Fee $150.00

\*\*E-mails responses will be $30.00

\*\*Any Court related cases will be charged a designated fee of $250 **Minimum per hour (Including travel hours)**

\*\*No Show/Cancellation Fee without 24-hour notice $150.00

\*\*These items are not billable to insurance and payment is expected at time of service.

**ACKNOWLEDGEMENT AND AGREEMENT TO TERMS OF SERVICES**

I acknowledge that I have reviewed and agree to the information described in this document.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient and Responsible Party(s) Name (please print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WitnessDate

NO SHOW/CANCELLATION POLICY:

TO ALL OF OUR PATIENTS:

Effective March 16, 2021-It is our goal to provide quality care to our patients in a timely manner. In order to effectively accomplish this, we have to adhere to an appointment schedule.

We understand complications may arise preventing you from attending the scheduled appointment, we request that you notify us within ***24 hours*** advance to reschedule or cancel the appointment. *Our office only completes reminder calls as a courtesy. Email reminders are also provided as a courtesy.* You are entirely responsible to remember the appointment time and date you are given.

1 No Show/Cancellation Appointment- $0.00

2 No Show/Cancellation Appointments- $25.00 fee

3 No Show/Cancellation Appointments-$60.00 fee, Dismissed from

our office.

All No Show Appointments **MUST** be paid prior to any other appointment made by our office staff.

**Patient (Guardian/Parent) Signature:**

**OFFICE POLICES & GENERAL INFORMATION**

**AGREEMENT FOR PSYCHOTHERAPY SERVICES**

***CW Holistic Counseling LLC***

***Christina Williams, MS, LMHC (FL MH 22069)***

**This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices.**

**CONFIDENTIALITY:**  All information disclosed within sessions and the written records pertaining to those sessions **are confidential** and may not be revealed to anyone without your (patient's) written permission, except where disclosure is required by law. Most provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form along with Informed Consent during your initial appointment. **WE WILL NOT RELEASE ANY PSYCHOTHERAPY PROGRESS NOTES TO THE CLIENT OR HIS/HER GAURDIAN UPON THEIR REQUEST.** We will gladly provide the client or guardian with a **Case Summary**.

**When Disclosure Is Required By Law:**  Some of the circumstances where disclosure is required by law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled (for more details, see also Notice of Privacy Practices form).

**When Disclosure May Be Required:** Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant **MAY** have the right to obtain the psychotherapy records and/or testimony of the therapist. In couple's and family therapy or when different family members are seen individually, confidentiality and privilege do **NOT** apply between couple or among family members. Ms. Williams will use her clinical judgment when revealing such information. Ms. Williams will **NOT** release records to any outside party unless she is authorized to do so by all adult family members who were part of treatment.

**Emergencies:**  If there is an emergency during our work together, or in the future after termination, where the therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, we will do whatever we can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, we may also contact the person whose name you have provided on the biographical sheet.

**Health Insurance & Confidentiality Records:** Disclosure of confidential information may be required by your health carrier or HMO/PPO/MCO/EAP in order to process the claims, if you so instruct our office, only the minimum necessary information will be communicated to the carrier. Unless authorized by you, explicitly the Psychotherapy Notes, will not be disclosed to your insurance carrier. However, insurance carriers are bound to confidentiality (see their term) and by HIPPA laws. We have no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies’ computers and soon will also be reported to the,

Congress-approved, National Medical Data Bank. Accessibility to companies’ computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

**Confidentiality of E-mail, Cell Phone and Faxes Communication:** It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentially of such communication can be compromised. E-mail’s, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify Ms. Williamsat the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies.

**Social Media Statement:** CW Holistic Counseling LLC has a Facebook page. This is not to be used for any personal information. Any misuse of this will result in being blocked from our Facebook page.

**Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making full disclosure with regard to many matters which may be confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your provider to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

**Consultation:** We consult regularly with other professionals regarding her clients; however, the client’s name or other identifying information is never mentioned. The client’s identity remains completely anonymous, and confidentiality is fully maintained.

* Considering all of the above exclusions, if it is still appropriate, upon your request, our office will release information to any agency/person you specify unless your provider concludes that releasing such information might be harmful in any way.

**TELEPHONE & EMERGENCY PROCEDURES**: If you need to contact your provider between sessions, please leave a message with the answering service (850) 243-0095 and your call will be returned as soon as possible. Messages are checked a few times a day, unless we are closed. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the Suicide Hotline (800) 273-8255 or Emergency Services (911) and 988 Suicide and crisis Lifeline. You should contact your physician and/or psychiatrist immediately if it is an emergency.

**PAYMENTS & INSURANCE REIMBURSTMENT:** Clients are expected to pay the standard fees (see contract/fee schedule) at the beginning of each session. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify our office if any problem arises during the course of therapy regarding your ability to make payments. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance companies. Unless agreed upon differently, we will provide you with a copy of your receipt on a monthly basis, which you can submit to your insurance company for reimbursement, if you so choose. As was indicated in the section, *Health Insurance & Confidentiality of Records*, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is **your** responsibility to verify the specifics of your coverage.

**MEDIATION & ARBITRATION**: All disputes arising out of or in relation to the agreement to provide psychotherapy services shall first be referred to mediation, before and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Ms. Williams and client(s). The cost of such mediation, if any shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Okaloosa County, FL and Walton County, FL in accordance with the American Arbitration Association which are in effect at the time the demand arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Ms. Williams can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney’s fees. In the case if arbitration, the arbitrator will determine that sum. Outstanding balances that are overdue 3-months (190-days), will automatically be forwarded to collections (unless otherwise arranged).

**THE PROCESS OF THERAPY/EVALUATION:**  Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you seek therapy. Working towards these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Ms. Williams will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feeling of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Ms. Williams may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Ms. Williams is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), psycho-educational, dialectical behavior therapy, Christian counseling, play therapy, Crisis intervention, Internal Family Systems (IFS), EMDR and client centered.

**Discussion of Treatment Plan:** Within a reasonable period of time after the initiation of treatment, Ms. Williams will discuss with you (client) her working understanding of the problem, treatment plan, therapeutic objectives, and her view of possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Ms. Williams’s expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that Ms. Williams does not provide, she has an ethical obligation to assist you in obtaining those treatments. She is more than happy to help find the appropriate resources.

**Termination:** As set forth above, after the first couple of meetings, Ms. Williams will assess if she can be of benefit to you. Ms. Williams does not accept clients who, in her opinion, she cannot help. In such a case, she will give you a number of referrals that you can contact. If at any point during psychotherapy, Ms. Williams assesses that she is not effective in helping you reach the therapeutic goals she is obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, she would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, Ms. Williams will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional’s opinion or wish to consult with another therapist, Ms. Williams will assist you in finding someone qualified, and, if she has written consent, she will provide her or him with essential information needed. You have the right to terminate at any time. If you choose to do so, Ms. Williams will offer to provide you with names of other qualified professionals whose services you might prefer.

**Dual Relationships:** Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Ms. Williams’s objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. Ms. Williams will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. The Fort Walton Beach and Miramar Beach areas are towns and many clients know each otherand Ms. Williams from the community. Consequently you may bump into someone you know in the waiting room or into Ms. Williams out in the community. Ms. Williams will never acknowledge working therapeutically with anyone without written permission. Many clients choose Ms. Williams as their therapist because they knew her before they enter into therapy with her and/or are aware of her stance on the topic. Nevertheless, Ms. Williams will discuss with you the often-existing complexities, potential benefits, and difficulties that may be involved in such relationships. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it and it is often impossible to know that ahead of time. It is **your**, the client’s, responsibility to communicate to Ms. Williams if the dual relationship becomes uncomfortable for you in any way. Ms. Williams will always listen carefully and respond accordingly to your feedback. Ms. Williams will discontinue the dual relationship, if she finds it interfering with the effectiveness of the therapeutic process or the welfare of the client and, of course, you can do the same at any time.

**CANCELLATION:** Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24-hours (1 Day) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, a fee will be charged for sessions missed without notification and after first warning. Most insurance companies do not reimburse for missed sessions.

**A copy of Office Policies and Procedures will be provided to you at your request.**

**Patient statement of Understanding and Informed Consent**

**I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them. I have also received a copy of the Notice of Privacy Practices as well as the Florida Patient Bill of Rights.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Name (print) Date Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Name (print) Date Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian (print) Date Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist Date Signature**

**Notice of Privacy Practices**

Patient Notice of Privacy Practices

**CW Holistic Counseling LLC**  
**Christina Williams, LMHC**

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPAA) Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments.

**This notice describes how health information about you may be used and disclosed, and how you can get access to this information.**

**PLEASE REVIEW THIS NOTICE CAREFULLY**

**If you have any questions about this notice or if you need more information, please contact**

**CW Holistic Counseling LLC**  
**Attn: Office Management**  
**850-240-0095**

**907 Marwalt Dr. Ste 2022**

**Fort Walton Beach, FL 32547**

**ABOUT THIS NOTICE**

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at all divisions of **CW Holistic Counseling LLC.** We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements.  This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information.  We are required by law to follow the terms of this Notice that is currently in effect.

**WHAT IS PROTECTED HEALTH INFORMATION (“PHI”)**

**PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:**

•   Your past, present, or future physical or mental health or conditions,

•   The provision of health care to you, or

•   The past, present, or future payment for your health care.

**HOW WE MAY USE AND DISCLOSE YOUR PHI**

We may use and disclose your PHI in the following circumstances:

**•   Treatment.** We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

**•   Payment.** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.  For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

**•   Health Care Operations.** We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

**•  Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.**We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

**•    Minors**.  We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. Mental Health providers have the right to NOT disclose any psychotherapy progress notes and can, instead, provide their parents or guardians with a case summary.

**•   Research.** We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst **CW Holistic Counseling LLC** providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

**•   As Required by Law.** We will disclose PHI about you when required to do so by international, federal, state, or local law.

**•   To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others.  But we will only disclose the information to someone who may be able to help prevent the threat.

**•   Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

**•   Military and Veterans.**If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.

**•   Workers’ Compensation.** We may use or disclose PHI for workers’ compensation or similar programs that provide benefits for work-related injuries or illness.

**•   Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration (“FDA”) for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**•   Abuse, Neglect, or Domestic Violence.** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

**•   Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**•   Data Breach Notification Purposes.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

**•   Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.

**•    Law Enforcement.** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

**•   Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials, so they may carry out their legal duties under the law.

**•   Coroners, Medical Examiners, and Funeral Directors.** We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

**•   Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

**•   Uses and Disclosures That Require Us to Give You an Opportunity to Object and opt Out**

**•   Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

**•   Payment for Your Care.**Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.

**•   Disaster Relief.** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

**•   Fundraising Activities.** We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

**Your Written Authorization if Required for Other Uses and Disclosures**

The following uses and disclosures of your PHI will be made only with your written authorization:

**•**Most uses and disclosures of psychotherapy progress notes; Mental Health providers have the right to NOT disclose any psychotherapy progress notes and can, instead, provide their clients or guardians with a case summary.

**•**Uses and disclosures of PHI for marketing purposes; and

**•**Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

**Your Rights Regarding Your PHI**

You have the following rights, subject to certain limitations, regarding your PHI:

**•    Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We will give you a reasonable time frameto make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.  You can only direct us in writing to submit your PHI to a third party not covered in this notice.  We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

**•   Summary or Explanation.** We can also provide you with a summary of your PHI, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

**•   Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity.  If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.

**•   Receive Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.

**•  Request Amendments.**If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**•  Accounting of Disclosures.**You have the right to ask for an “accounting of disclosures,” which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to Christina Williams. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

**•   Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to Christina Williams. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.

**•   Request Confidential Communications.**You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

**•   Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by contacting the **CW Holistic Counseling** office you are receiving services from.

**•  Changes to This Notice**

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office.

**•   Complaints**

If you believe your privacy rights have been violated, you may file a complaint with the **CW Holistic Counseling LLC, OFFICE MANAGER**, at the address listed at the beginning of this Notice or with the Secretary of the Florida Department of Health and Human Services. To file a complaint with the Secretary, mail it to:  Secretary of the Florida Department of Health and Humans Services, 221 Hospital Drive NE, Fort Walton Beach, FL 32548.  Call (850) 833-9240 (or toll free (877) 696-6775 or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. **You will not be penalized for filing a complaint.**

Notice Effective 9/23/2018

**CW Holistic Counseling LLC**

**ACKNOWLEDGEMENT OF RECEIPT OF**

**PATIENT NOTICE OF PRIVACY PRACTICES**

I acknowledge that I read and/or received a copy of the **CW Holistic Counseling LLC** Patient Notice of Privacy Practices effective September 23, 2018.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. (or Guardian, if applicable)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Informed Consent for Telehealth Services**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Introduction**

Online psychotherapy, also known as telemental health service (‘telehealth”), involves a therapist or counselor providing psychological counseling and support over the internet through email, video conferencing, online chat, or phone calls. The information may be used for diagnosis, therapy, follow-up and/or education.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

**Expected** **Benefits**:

* Improved access to mental health services by enabling the client to remain in his/her home or other remote site.
* Mental health services are more accessible and convenient –increasing mental health treatment outcomes.
* More efficient evaluation and community of mental health services.

**Possible Risks:**

There are potential risks associated with the use of Telehealth services. These Risks include, but may not be limited to:

* In rare cases, information transmitted may not be sufficient to allow for appropriate decision making by the counselor/therapist;
* Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
* In very rare instances, security protocols could fail, causing a breach of privacy of personal information;

Signature Date

**Credit Card Authorization Form**

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

|  |
| --- |
| **Credit Card Information** |
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX  □ Other |
| Cardholder Name (as shown on card): |
| Card Number: |
| Expiration Date (mm/yy): CVV: |
| Cardholder ZIP Code (from credit card billing address): |

I, , authorize Sonshine Counseling to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account, including appropriate appointment co-pays and missed appointment fees when applicable.

Customer Signature Date