Counseling Services of Miami, PLLC.

Welcome to our office! We are pleased to be able to offer you and your family mental health services. As therapists, our responsibility lies in offering you the needed diagnostic and therapeutic services for the emotional and behavioral difficulties you and/or your family are currently experiencing. Enclosed you will find some forms that will aid us in assisting you more effectively. Our professional staff will be glad to discuss with you our services, charges, insurance billing, appointments, as well as any other questions you may have.

Individual, family, couples, and hypnotherapy sessions are 45-50 minutes in length. The fee will be assessed on a prorated basis should the session exceed 50 minutes.

If you cannot attend a scheduled appointment, kindly notify us as soon as possible. We rely upon our clients keeping their appointments because another client could be scheduled for that time slot. Please be aware that you will be charged **the full session fee** for any appointment that is not cancelled at least twenty-four (24) hours in advance. If you are more than twenty (20) minutes late for an appointment without advising us that you are coming late, your appointment will be cancelled and you will be charged **the full session fee** for that appointment.

Our office prefers payment to be made by check or cash, but we also accept credit cards. **Checks are to be made payable to Counseling Services of Miami, PLLC.** There is a $25.00 service charge for a check that is returned from the bank. We require all clients to leave a credit card on file, should there be a fee for a missed appointment.

Confidentiality is of primary importance in the mental health practice. Consequently, we adhere to very strict standards regarding the release of records and/or information related to you or your family for your own protection. All communications between us is confidential and privileged, with the following exceptions:

1. In staff supervision and with consultants, as needed, in order to challenge and/or confirm decisions about diagnosis, treatment, and medication.

2. By statutory law, "DUTY TO WARN", outweighs the limits of confidentiality and privilege in case of a reported act, which may endanger yourself or others, as further explained in the attached Confidentiality and Consent Form.

****

I hereby consent to the psychotherapeutic evaluation and treatment. I have read and agree with the terms stated herein.

_____ _____

Client's Signature Therapist's Signature

_____ _____

Parent/Guardian's Signature Date

95 Merrick Way
Suite 420
Coral Gables, Florida 33134
(305) 814-5375
www.counselingservicesmiami.com

Counseling Services of Miami, PLLC.

INTAKE INFORMATION

PATIENT INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ ◯ okay to call

CELL PHONE: _____ ◯ okay to call

EMAIL: _____ SS#: _____

SEX: M____ F____ AGE: _____ DATE OF BIRTH: _____

MARITAL STATUS: MARRIED____ SINGLE____ DIVORCED____

SEPARATED____ WIDOWED____

LIVING WITH SOMEONE ____

HOW DID YOU HEAR ABOUT US?:

_____

EMPLOYER/SCHOOL: _____

OCCUPATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

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EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATION TO YOU: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PRESENT HOUSEHOLD

NAME	AGE	RELATIONSHIP	OCCUPATION

OTHER SIGNIFICANT FAMILY MEMBERS NOT LIVING IN YOUR HOME

NAME	AGE	RELATIONSHIP	OCCUPATION

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MEDICAL HISTORY:

ILLNESS/MEDICAL CONDITIONS:

_____

_____

PRESCRIPTION/OTC DRUGS: _____

_____

ALLERGIES AND MEDICATIONS: _____

_____

TOBACCO, ALCOHOL, DRUG USE HISTORY: _____

_____

PREVIOUS PSYCHOTHERAPY/HYPNOTHERAPY TREATMENT? YES _____ NO _____

WITH WHOM: _____

HOW LONG: _____

PRIMARY CARE PHYSICIAN:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

REASON FOR VISIT _____

_____

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CONFIDENTIALITY AND INFORMED CONSENT

I understand that my right to privacy is protected by federal and state laws and that I am the holder of a privilege within the client/clinician setting. I understand that this means information discussed during treatment at Counseling Services of Miami, PLLC is confidential and that no information can be released to anyone outside of Counseling Services of Miami, PLLC without prior authorization from me, with certain exceptions, as outlined below:

1) I understand and give permission for my clinician to consult with other professionals and employees at Counseling Services of Miami, PLLC since they are members of Counseling Services of Miami, PLLC's own in-house treatment team, or another therapist who is seeing other members of my family. It may be necessary at times to share routine information with a physician, nutritionist, psychiatrist, school counselor, or other professional in the community who is treating or involved with you in some way. These disclosures will be discussed with you in advance and you will be asked for a signed consent prior to any such disclosure. You clinician may also speak with his or her supervisor about your case in order to discuss the best course of treatment.

2) I understand that there are several exceptions to the client/clinician privilege. Your clinician is obligated under law to report the following:
    a. Child abuse
    b. Elder abuse
    c. Abuse of disabled or mentally ill persons
    d. When required by court order
    e. Harm or potential harm to self or others ("Duty to Warn")

3) Because privacy in treatment is often crucial to successful progress, I understand and agree that treatment for children and adolescents may require that the parents or guardians waive their right to their children's records. We will provide parents/guardians with general information about the progress of the child's treatment and attendance at sessions. If we feel, however, that the child is in danger or is a danger to someone else, we will notify the parents of this concern.

4) I understand that communications and web-based scheduling over the internet and/or using an electronic email system is not always encrypted, not a confidential system, and is inherently insecure. There is no assurance of confidentiality when communications are done in this way. Nevertheless, I agree to its use in my treatment as a means of communication and sharing of treatment information. I agree to communication in this manner and accept full responsibility for messages to my email address(s) and/or other information transmitted via the internet.

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5) I understand that neither Counseling Services of Miami, PLLC nor my clinician provides supervision for minors who are in the building where Counseling Services of Miami, PLLC has its offices. Arrangements for their supervision will be made by me in advance and their supervision is my responsibility.

INFORMED CONSENT AND AUTHORIZATION FOR TREATMENT

I am aware that the Notice of Privacy Practices for Protected Health Information (PHI) is in the waiting room and was made available to me. I have read and understand the information contained on the prior pages of this form. My signature below indicates my understanding and agreement to this information, and I hereby consent to the professional procedures deemed appropriate for evaluation and treatment; and where treatment is for a minor, I am authorized to consent for his/her treatment.

_____ _____

Client's Signature Parent/Guardian's Signature

_____

Parent/Guardian's Signature

_____ _____

Clinician's Signature Date

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FINANCIAL AGREEMENT

I, _____, agree that the responsibility for the hourly charge of $ _____ at Counseling Services of Miami, PLLC is mine. If at any time I terminate therapy and have an outstanding balance, I agree to pay that balance in full.

Because time has been reserved exclusively for me and/or my family members, I understand that a twenty-four (24) hour notice of cancellation of an appointment is required. In the event that such advance notice is not provided, I understand that I will be charged **the full session fee** for the reserved appointment. If I am more than twenty (20) minutes late for an appointment without advising my therapist that I will be coming late, my appointment will be cancelled, and I will be charged **the full session fee** for that appointment.

Should it be necessary for Counseling Services of Miami, PLLC to obtain the services of a collection agency and/or an attorney to collect an overdue balance, the undersigned agrees to pay all reasonable attorney's fees, collection expenses, and court costs incurred in any such action. Balances that have been outstanding over thirty (30) days will begin accruing interest at a rate of 1.5% per month. Interest will continue to accumulate on a monthly basis and will be added to the balance until the entire bill is paid in full.

_____ _____

Client's Signature Print Name

_____ _____

Date Address

_____

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CREDIT CARD AUTHORIZATION FORM

Our office prefers payments to be made by check or cash. However, in an effort to avoid difficulties with your account, please provide credit card information in the space below.

This information will only be used in processing a payment due to one or more of the following: regular session fees, returned bank checks, or missed or late cancelled appointments.

Thank you for your cooperation.

CREDIT CARD: ◯ VISA

◯ MASTERCARD

◯ DISCOVERCARD

NUMBER:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CVV: ☐☐☐☐

EXPIRATION DATE: ☐☐/☐☐

BILLING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SIGNATURE: _____

PRINT NAME: _____

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