LIFE SKILLS RESOURCE GROUP
Licensed Counselors, Life & Executive Coaching
7758 Wallace Road, Suite VI & VII, Orlando, FL 32819
407-355-7378 www.lifeskillsresourcegroup.com

CLIENT INFORMED CONSENT

Life Skills Resource Group is an association of independently practicing mental health professionals who share certain expenses and administrative functions. While the members share a name and office space, each clinician is completely independent in providing his/her clinical services and each is fully responsible for those services. He/she practices according to his/her own background, training, and expertise. Based on the information provided by you, he/she will determine the appropriate scope, means, manner, and method of your treatment. Clinical records are separately maintained by each clinician and no member of the group can have access to them without your specific, written permission.

I consent to receive counseling/therapy from_____, who is a_____. I acknowledge that I am here voluntarily and that I may terminate treatment at any time. I understand that, as with all effective treatments, there are benefits as well as possible risks to counseling/therapy. I understand that benefits will depend on the treatment goals that I establish together with my therapist. I understand that risks may include problems temporarily worsening or the conflict/problem not being resolved or changed. I realize that there is no guarantee of improvement in my condition. I acknowledge that any treatment will be a cooperative effort between me and

_____. I agree to actively participate in our counseling/therapy sessions. I further acknowledge that the counseling/ therapy session is only one part of the process of change. Following through with the activities and trying the new behaviors agreed upon between sessions in most cases has a two-fold effect; increasing the opportunity for success and decreasing the number of sessions needed to begin to feel relief and see the desired change.

The following are the basic rights of individuals participating in counseling/therapy:

- The right to be informed of the various steps and activities involved in receiving services
- The right to confidentiality under federal and state laws
  **I cannot speak even in general to anyone about my clients, i.e. "I saw this person today and you can't believe what they told me…" –this is against the law and the ethics of my field.*
  **We may live in the same community and even find ourselves in social settings together. In these cases, I will not greet you in order to preserve your confidentiality, as others know what I do for a living. If you choose to greet me, I will follow your lead.*
- The right to humane care and protection from harm, abuse and neglect.
- The right to make an informed decision regarding whether to accept or reject treatment.
- The right to contact and consult with and select practitioners of my choice and at my expense.

I understand that confidentiality of records or other information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand that the confidentiality of my record may be breached under the following circumstances:

1. If I sign a waiver requesting release of information.
2. If a court orders the release of my records.
3. If a mental status or competency should arise in a legal proceeding.
4. Refer to LIMITS OF CONFIDENTIALITY form for details on confidentiality limits specific to the field of Mental Health Counseling, Social Work, and Marriage and Family Therapy.
5. If Counselor should become unavailable due to serious illness or death. This would only be for the purpose of finding client contact information.

LIFE SKILLS RESOURCE GROUP
Licensed Counselors, Life & Executive Coaching
7758 Wallace Road, Suite VI & VII, Orlando, FL 32819
407-355-7378 www.lifeskillsresourcegroup.com

CLIENT INFORMED CONSENT (Continued)

I understand that if I or anyone else, with proper release of information, ask my counselor to prepare paperwork for an outside party, I will be charged $75 for each document. I also understand that if my counselor is asked to attend any court hearings or meetings, I will be charged $150 per hour for every hour outside of the office to include travel time, with a minimum of four hours or $600. The minimum fee will be paid in advance, and any balance due will be billed to credit card provided at the time of the subpoena.

- When the documents/testimony is involving children seen by a counselor, both parents must consent.
- When the documents/testimony is regarding anything involving sessions with more than one person, all persons present in the sessions must consent.

I understand that my clinician does not provide emergency services. When my clinician is unavailable, I understand that I will be able to leave messages through the administrative staff. I understand that my clinician or administrative staff will make every effort to return my call within 24 hours, with the exception of weekends and holidays. I understand that if I am in crisis and am unable to wait for my clinician to contact me, I should go to the nearest emergency room or call 911. I understand that I may also call the Lifeline of Central Florida, the 24-hour crisis hotline, at 407-425-2624 for immediate assistance. I understand that if my clinician will be unavailable for an extended period of time (e.g. vacation), he/she will provide me with the name of a colleague to contact, if necessary. **Initial: _____**

I have read and understood the above:

_____
Parent or Guardian of Client Under 18

_____	_____	_____
Client Signature	Counselor Signature	Parent or Guardian of Client Under 18

LIFE SKILLS RESOURCE GROUP
Licensed Counselors, Life & Executive Coaching
7758 Wallace Road, Suite VI & VII, Orlando, FL 32819
407-355-7378 www.lifeskillsresourcegroup.com

LIMITS OF CONFIDENTIALITY

Therapy is considered a confidential relationship. Neither verbal information nor written records about a client can be shared with another party without the client's written consent. **The following are EXCEPTIONS:**

Duty to Warn and Protect

When a client expresses intentions or a plan to harm another person, mental health professionals are required by law to warn the intended victim and to report this information to law enforcement. In the case of a client who discloses a plan for suicide, the mental health professional is required to make reasonable attempts to notify the family or significant other of the client. In both cases, it is the duty of the mental health professional to assure the client or victim's safety. This may include using the Baker Act in the State of Florida, which allows for up to 72 hours of involuntary commitment to a mental health facility for those deemed a danger to themselves or others by a qualified mental health professional.

Abuse of Children or Vulnerable Adults

If a client states or suggests that he or she is abusing a child or vulnerable adult (or has recently done so), or indicates knowledge of a child or vulnerable adult being in danger of abuse; the mental health professional is required to report this information to the appropriate social service and or law enforcement authority.

Prenatal Exposure to Controlled Substances

Mental health professionals are required to report admitted ongoing prenatal exposure to controlled substances.

Minor/Guardianship

Parents and legal guardians of non-emancipated minor clients have the right to access the clients' records.

Administrative Staff

Administrative staff are employed and other mental health professionals are practicing within this office. In most cases, the need to share protected information with these individuals is for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside the practice.

Personal Electronic Devices and Email

It is important to note that personal electronic devices (such as cell phones, tablets, etc.) as well as emails are not considered 'secure'. While we make every effort to make them as secure as possible (encryption, etc.) they still pose their own unique risks. Land lines and faxes are considered secure and HIPAA compliant.

Insurance Providers, Employee Assistance Programs, and Other Payers

If you choose to use insurance, an Employee Assistance Program (EAP), or another third-party payer, you should be aware that these payers require your mental health professional to provide information about the services provided to you in order to approve payment of claims. Your mental health professional must provide the name of the client, the date of service, a clinical diagnosis, and a procedure code. Your mental health professional may also be required to provide additional clinical information such as progress notes, treatment plans, summaries, or copies of your entire clinical record. Your mental health professional will make every effort to release only the minimum information necessary for the purpose requested. All information provided to these third-party payers becomes a permanent part of their files and your medical record. In some cases insurance companies may share the information with a national medical information databank. Your mental health professional will provide you with a copy of any report submitted, per your request.

YOUR SIGNATURE BELOW INDICATES YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.
I agree to the above Limits of Confidentiality and understand their meanings and ramifications.

_____	_____	_____	_____
Client Signature (Parent/Guardian if under 18)	Date	Parent/Guardian if under 18	Date

LIFE SKILLS RESOURCE GROUP
Licensed Counselors, Life & Executive Coaching
7758 Wallace Road, Suite VI & VII, Orlando, FL 32819
407-355-7378 www.lifeskillsresourcegroup.com

GENERAL AND FINANCIAL POLICIES

INSURANCE REIMBURSEMENT POLICY

Our office will provide the courtesy of verifying your insurance. However, the initial information provided to us by the insurance company may not be accurate and the actual coverage provided by your insurance company cannot be determined until a detailed Explanation of Benefits is received with the insurance payment. At your request, we are happy to provide a super bill that you can file with your insurance, but we cannot accept responsibility for collecting or for negotiating a settlement of a disputed claim. It is important that you also determine exactly what mental health services your insurance policy covers. If you have any questions about the coverage, call your plan administrator.

Initials: _____

CANCELLATION POLICY

Cancellations must be made 24 hours or more before your scheduled appointment or you will be charged your full session fee, as we will be unable to fill our hour on short notice. If your counselor is Cindy Fabico or Amy Smith, please call the main office number at 407-355-7378 with schedule changes during business hours (Monday to Thursday 10:00am to 4:00pm and Friday 10:00am to 2:00pm). Outside of business hours, please send your counselor a text message to cancel. For counselors other than Cindy Fabico or Amy Smith, we request that you contact your therapist directly and not the main office number when making schedule changes. **NO EMAIL CANCELLATIONS, PLEASE.**
Thank you for your consideration regarding this important matter. We appreciate the opportunity to work with you.

Initials: _____

PAYMENT POLICY

I authorize my counselor,_____, to charge my card for all services provided and for any appointments for which I cancel within 24 hours or fail to show up.
For clients of Cindy, your credit card information will be kept on file through ProPay, which securely stores customer payment information in ProPay's Industry compliant data storage solution from the Online Terminal.

Cardholder Name (please print) _____

Cardholder Signature _____

Card Type: VISA ___ MASTERCARD ___ AMEX ___ DISCOVER ___

Card Number _____

Exp Date _____ Security Code _____ Billing Zip Code _____

Initials: _____

_____ _____ _____ _____
Client Signature (Parent/Guardian if under 18) Date Parent/Guardian if under 18 Date

Initials: _____

LIFE SKILLS RESOURCE GROUP
Licensed Counselors, Life & Executive Coaching
7758 Wallace Road, Suite VI & VII, Orlando, FL 32819
407-355-7378 www.lifeskillsresourcegroup.com

CLIENT RECORD OF COMMUNICATION

In general, the HIPPA privacy rules give the individual the right to request confidential communications or that communication be made by alternate means. We wish to clarify how you do and *do not* wish for us to communicate with you.

I GIVE PERMISSION TO BE CONTACTED IN THE FOLLOWING MANNER

(PLEASE CHECK ALL THAT APPLY FOR YOU AND CIRCLE YOUR PREFERRED METHOD):

Name (please print):_____

_____Home Telephone: (_____)_____
_____Ok to leave a message with detailed information
_____Leave a message with call back number only

_____Written Communication
_____OK to mail to my home address
_____OK to fax to this number: (_____)_____

_____Cellular Phone: (_____)_____
_____Ok to leave voice message with detailed information
_____Ok to text detailed information
_____Leave a message with a call back number only

_____Work Phone: (_____)_____ext: _____
_____Ok to leave a message with detailed information
_____Leave a message with call back number only

_____Email:_____
_____Ok to send email with follow-up information from sessions
_____Ok to Email Newsletter from LIFE SKILLS RESOURCE GROUP

CLIENT RECORD OF REFERRAL

We would really appreciate if you would take just a moment to answer a few questions about where you learned of us or how you were referred to LIFE SKILLS RESOURCE GROUP.

Please check <u>all</u> that apply:

_____Internet Search: What was the *first* link the internet search took you to?
_____Psychology Today, Find-A-Therapist
_____Life Skills Resource Group Website
_____UCF Referral Directory
_____Other (Please describe): _____

_____Family, Friend, or Physician _____
Can we thank them for the referral? Yes_____No_____(please initial) _____

_____Advertisement: Newspaper, Magazine _____

LIFE SKILLS RESOURCE GROUP
Licensed Counselors, Life & Executive Coaching
7758 Wallace Road, Suite VI & VII, Orlando, FL 32819
407-355-7378 www.lifeskillsresourcegroup.com

HEALTH INFORMATION PRACTICES
RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

CLIENT NAME: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND HAVE BEEN GIVEN AN OPPORTUNITY TO READ A COPY OF THE LIFE SKILLS RESOURCE GROUP, LLC NOTICE OF HEALTH INFORMATION PRACTICES. I UNDERSTAND THAT IF I HAVE ANY QUESTIONS REGARDING THE NOTICE OF MY PRIVACY RIGHTS, I CAN CONTACT MY COUNSELOR OR THE LIFE SKILLS RESOURCE GROUP MANAGING MEMBER, CINDY FABICO, AT 407-504-2133.

Signature of Client:_____**Date:** _____

Signature of Parent, Guardian, or Personal Representative:

_____**Date:** _____

_____**Date:** _____

Note: If you are signing this as a personal representative, please describe your legal authority to act for this individual and provide a copy of the documentation of same.

_____**HC Surrogate** _____**HC Proxy** _____**POA** _____**_ DPOA**

_____**Client refuses to acknowledge receipt**

Signature of Staff: _____

LIFE SKILLS RESOURCE GROUP
Licensed Counselors, Life & Executive Coaching
7758 Wallace Road, Suite VI & VII, Orlando, FL 32819
407-355-7378 www.lifeskillsresourcegroup.com

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AND SIGN INDICATING THAT YOU HAVE READ AND UNDERSTAND THE NOTICE.

Understanding Your Health Record/Information

Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- **Basis for planning your care and treatment**
- **Means of communicating among the many health professionals who contribute to your care**
- **Legal document describing the care you received**
- **Means by which you or a third party payer can verify that services billed were actually provided**
- **A tool in educating health professionals**
- **A source of information for public officials charged with improving the health of the nation**
- **A source of data for facility planning and marketing and**
- **A tool with which we can assess and continually work to improve the care we render and the outcome we achieve**

Understanding what is in your health record and how your health information is used helps you to:

- **Ensure its accuracy**
- **Better understand who, what, when, where and why others may access your health information**
- **Make more informed decisions when authorizing disclosure to others**

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. Privacy Rules (PR) specify that you have the right to:

- **Request a restriction on certain uses and disclosures of your information as provided by PR 164.522**
- **Obtain a paper copy of the notice of information practices upon request**
- **Inspect and copy your health record as provided for in PR 164.524**
- **Amend your health record as provided in PR 164.528**
- **Obtain an accounting of disclosures of your health information as provided in PR 164.528**
- **Request communications of your health information by alternative means or at alternative locations**
- **Revoke your authorization to use or disclose health information except to the extent that action has already been taken**

PLEASE NOTE: The Final HIPPA Privacy Rule defines *psychotherapy notes* as an official record, created for use by the mental health professional for treatment, "recorded in any medium…documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session that are *separate from the rest of the individual's medical record*…" 45 C.F.R. 164.501 (65 Fed. Reg. at 82805) (emphasis added). According to the American Psychological Association (APA), "This kind of information is not typically needed by anyone other than the treating [Mental Health Professional] to care for the patient, and is not needed for payment or health-care operations." Therefore, "…these notes about communication in psychotherapy, when kept separately from the rest of the record and not disclosed to anyone, would remain private under the Rule."

-taken from *Psychotherapy Notes Provision of HIPPA Privacy Rule*; APA Doc. Ref. No. 200201

Additionally, please be aware that we do employ a receptionist during business hours, who answers phones, books appointments, makes referrals, bills insurance, etc. This person is either a Masters level Counselor or a Counselor in training. He/she was carefully screened upon being hired and is held to the same ethical standards as anyone in our Practice.

Our Responsibilities:

This organization is required to:

- **Maintain the privacy of your health information**

- **Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you**
- **Abide by the terms of this notice**
- **Notify you if we are unable to agree to a requested restriction**
- **Accommodate reasonable requests you may have to communicate health information by alterative means or at alternative locations**

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information, or to Report a Concern:

If you have questions and would like additional information, you may contact the Manager, Cindy Fabico at 407-504-2133.

If you believe your privacy rights have been violated, you can file a complaint with the Managing Member of Life Skills Resource Group, LLC. There will not be retaliation for filing a complaint.

Examples of Disclosure for Treatment, Payment and Health Operations

- **We will use your health information for treatment. For example: Information obtained by your mental health counselor will be recorder in your record and used to determine the course of treatment that should work best for you. Your counselor will document in your record his/her expectations of your treatment.**
- **We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis.**
- **We will use your health information for regular health operations. For example: Members of the counseling staff may use information in your health records to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the counseling services we provide.**

Other Uses and Disclosures

***Notification*: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.**

***Communication with Family*: Counselors in best judgment may disclose to a family member, or other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.**

***Marketing*: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.**

***Workers' Compensation*: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.**

***Public Health*: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.**

***Law Enforcement*: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena.**

There are specific exceptions to confidentiality as provided in state and federal law, where a counselor can release information without your consent. These exceptions include possible threat of harm to self, harm to others, child abuse and neglect situations, aging adult abuse and neglect.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.