Dianne Brown, MA, LMHC
P: 407-476-8955
Orlando, Apopka,
Winter Park & Lake Mary

GENERAL INFORMATION

Date (*Fecha*): _________________ How did you hear about us? (*Como supiste de nosotros*) ______________________ May we send a thank you gift? (*Podemos enviarte un regalo de agradecimiento)*_________________________

Full Name (*Complete Nombre)* : □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. ____

Nick Name (*Apodo*) :_______________________________ Name You Prefer (*Nombre que prefiera):* __________________________________

Age (*Edad*): ____________ Date of Birth (*La fecha de nacimiento*): ________________________________ Sex: □ Male □ Female

Race: □ White □ Black □Hispanic □ Asian □ Other: ____

Parent/Guardian (Padre/Madre): ____________________________________ Relationship (Relacion) ______________________________

CONTACT INFORMATION

Street Address: ____ Suite/Apartment Number: ________________

City: _____________________________________ State: __________ Zip Code: _________________ May We Send Mail Here: □ Yes □ No

Mailing Address or Post Office Box: ____

City: _____________________________________ State: __________ Zip Code: _________________ May We Send Mail Here: □ Yes □ No

Home Phone: (__________) ____ May We Leave a Message Here: □ Yes □ No

Mobile Phone: (_________) ____ May We Leave a Message Here: □ Yes □ No

Work Phone: (__________)____ May We Leave a Message Here: □ Yes □ No

Email Address: ____ May We Send Email Here: □ Yes □ No

I would like to be added to Total Life Counseling Newsletter to receive free articles, tips and resources: □ Yes □ No

I prefer to be □ texted □ emailed □ phone call □ none for appointment reminders.

EMERGENCY CONTACT

Name:____ Relationship: ____

Home Phone: (__________) _____________________________________ Mobile Phone: (_________) _______________________________

EMPLOYMENT INFORMATION

Employer:____ Length of Employment: _______________________________

Occupation:____ Average Hours Worked Per Week: _________________________

Average Annual Salary: □ $0 to $10,000 □ $20,001 to $40,000 □ $50,001 to $60,000 □ $80,001 to $100,000
□ $10,001 to $20,000 □ $40,001 to $50,000 □ $60,001 to $80,000 □ More than $100,000

EDUCATION INFORMATION

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ 1 □ 2 □ 3 □ 4 □ Other: _____________________

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Are You Currently in School: ☐ Yes ☐ No. If Yes, What School: ____

RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No. If No, Briefly Explain: ______________________________________

If Married, How Long: ______________________ Number of Previous Marriages for You: ____________ For Your Partner: __________

If Separated or Divorced, How Long: ___________________________ If Widowed, How Long: _________________________________

Partner's Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ____

How Long Have You Known Your Partner: _______________________ Age: _______________ Preferred Name: _________________

Partner's Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: ___________________________________ Partner's Sex: ☐ Male ☐ Female

Partner's Occupation: ____ Average Hours Worked Per Week: _____________________

Last Year of School Partner Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: ____________

What Words Would You Use to Describe Your Partner: ____

Is Your Partner Supportive of You Seeking Counseling: ☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _________________

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of	Relationship to You (*e.g. Biological, Adopted,*)	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: ☐ Yes ☐ No. If Yes, When: ____

Have You Ever Had a Miscarriage or Medical Abortion: ☐ Yes ☐ No. If Yes, When: ____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You (*e.g. Mom, Dad, Sibling,Step*)	Occupation	Describe Him/Her

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Do You Have a Personal Support System: ☐ Yes ☐ No. If Yes, Who: ____

MEDICAL INFORMATION

Primary Physician: ____ Phone: (________) ________________________

Address: ____ City: ____________________ Zip: ____________

Specialty *(e.g. Family Practice, OB/GYN, Internal Medicine)*: ____

Are You Currently Receiving Medical Treatment: ☐ Yes ☐ No. If Yes, Please Specify: ______________________________

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had *(Use Back if Necessary):* _________

____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: ____________________________ Dosage: ____________ ☐ Improves ☐ Prevents ☐ Controls: ______________

Medication: ____________________________ Dosage: ____________ ☐ Improves ☐ Prevents ☐ Controls: ______________

Are You Taking these Medication(s) According to Your Doctor's Recommendations: ☐ Yes ☐ No

If No, Briefly Explain: ____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches………...☐ Past Visual Trouble…… ☐ Past Weakness………… ☐ Past Difficulty Breathing..☐ Past Change in Appetite. ☐ Past Hearing

☐ Present
☐ Present
☐ Present
☐ Present
☐ Present
☐ Present

Dizziness…………. ☐ Past Sleep Trouble…….. ☐ Past Tension…………….☐ Past Intestinal Trouble….☐ Past Tiredness…………..☐ Past

☐ Present
☐ Present
☐ Present
☐ Present
☐ Present
☐ Present

Stomach Trouble….☐ Past
Trouble Relaxing….☐ Past
Rapid Heart Rate… ☐ Past
Hearing Noises……☐ Past
Pain…………………☐ Past
Other………………. ☐ Past

☐ Present
☐ Present
☐ Present
☐ Present
☐ Present
☐ Present

Your Height: ________________ Your Weight: ______________ How has Your Weight Change in the Last 2-3 Months: ____________

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress……………… ☐ Past Panic……………….
Guilt……………….. ☐ Past
Recent Death…….. ☐ Past
Inferiority Feelings.. ☐ Past
Shyness…………… ☐ Past
Marriage……………☐ Past
Emotional Abuse….☐ Past
Temper……………. ☐ Past Bad Dreams……….☐ Past Unwanted Thoughts☐ Past Impulsive Behavior. ☐ Past Sexual Problems….☐ Past Legal Matters……...☐ Past Drug

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Nervousness………☐ Past
Unhappiness………☐ Past
Apathy……………...☐ Past
Grief……………….. ☐ Past
Defective Feelings.. ☐ Past
Fears……………….☐ Past
Communication……☐ Past
Verbal Abuse…….. ☐ Past
Anger……………….☐ Past
Concentration…….. ☐ Past
Memory…………….☐ Past
Self-Control………..☐ Past
Pregnancy………… ☐ Past
Trauma……………. ☐ Past
Alcohol Use………. ☐ Past

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Anxiety…………….. ☐ Past
Depression………...☐ Past
Terminal Illness…... ☐ Past
Hopelessness……..☐ Past
Loneliness………… ☐ Past
Friends……………..☐ Past
Physical Abuse…… ☐ Past
Sexual Abuse…….. ☐ Past
Aggressiveness…...☐ Past
Racing Thoughts….☐ Past
Loss of Control…… ☐ Past
Compulsivity……….☐ Past
Abortion…………… ☐ Past Eating Problems…. ☐ Past Trouble with Job…..☐ Past Making

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Children…………… ☐ Past ☐ Present
Recent Loss……….☐ Past ☐ Present
Being a Parent…….☐ Past ☐ Present
Disaster…………….☐ Past ☐ Present
Finances…………...☐ Past ☐ Present
Smoke Cigarettes…☐ Past ☐ Present

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1 = Very Little Distress; 10 = Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: ☐ Yes ☐ No. Have You Experienced Them in the Past: ☐ Yes ☐ No

Have You Ever Attempted Suicide: ☐ Yes ☐ No. If Yes, When and How: ____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: ☐ Yes ☐ No

If Yes, When and Who: ____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e. What Are Your Issues, Problems?)*: ____

____

Why Have You Decided to Come for Counseling Now: ____

____

What Do You Hope to Gain or Change by Coming for Counseling: ____

____

How Long Do You Believe Counseling Should Last: ____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary)*:

Therapist: ____________________________ Location: _______________________ Dates: _________________ Reason: __________________

Therapist: ____________________________ Location: _______________________ Dates: _________________ Reason: __________________

RELIGIOUS BACKGROUND

Please describe your religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of?

____

ACTIVITIES, INTERESTS, & STRENGTHS

What do you do in your spare time? ____ _______________________________

What do you do well? ____

TERMS OF SERVICE

I hereby give Dianne Brown, LMHC permission to provide counseling services for the client mentioned above:

Signed: ____ Date: _______________________________

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Victimization History

Abuse:
Physical:

____

____

Sexual:

____

____

Mental:

____

____

Neglect:

____

____

Domestic Violence:

____

____

Past C.P.S. Involvement:

____

____

Potentially Abusive Behavior:

Substance	Onset	Current	Highest	Most Recent	Tolerance/Withdrawal
Alcohol					
Marijuana					
Cocaine					
Depressants					
Amphetamines					
Hallucinogens					
Opiates					
Inhalants					
K2, Bath salts, spice					
Other					
Tobacco					
Caffeine					

DIANNE BROWN, MA, LMHC
PO BOX 682214 ORLANDO, FL 32868

Authorization of Release Form

As a therapist it may be helpful to consult with your attorney, doctor, previous therapist, psychologist, psychiatrist, school, or applicable parties regarding treatment. In order to consult we need your authorization. If applicable, please complete on for each contact.

I ___________________________________, hereby authorize Dianne Brown, MA, LMHC

PO Box 682214 Orlando, FL, 32868 to:

Release information of ____ ______________

Name of Client Date of Birth

To/From:
(family, doctors, psychologist, schools, etc.)

____

____

Phone/email ____

(Please specify if you only want to authorize for appointments and payments.)

For the purpose of:

☐ Outpatient/Inpatient Counseling ☐ Coordination with schools

☐ Coordination with MD/Psychologist/OT Therapist/Therapist

☐ Coordination with other family members

I understand state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire one year from the date signed.

____ _________________

Client, Parent, Guardian Date

____ ________________

Witness Date

P: 407-476-8955

Financial Policy

Payment & Fee Policy:
We are committed to providing you with the best possible care. Payment for services is due at the time of service. I accept cash, checks, Master Card, and Visa. Our fees:
Individual, Family and Marriage Sessions intake is _______ per hour, follow up sessions are______ per hour, or if paid by cash or check _____ per hour.
Payment methods: Checks and cash must be received before the session if sent via mail, cash app or certified check. If payment has not been received, the session must be rescheduled.
Counselor Administrative Services: Treatment Summary Requests, Professional Letters, and Phone/Conference calls will be billed, if requested, at the individual therapeutic rate for a minimum of 30 minutes.
Court Appearances and Depositions are double the therapeutic hourly rate. This would include travel expenses and time away for the office. Payment is to be made in advanced and any unused funds will be refunded. The retainer is a minimum of 4 hours and we will need a credit card on file in the event the court hearing goes over.
A cancellation fee is charged for appointments with **credit/debit only** that are no show or canceled without **2-business days** <u>advance notice</u> unless there is an emergency or illness. The no-show fee is equivalent to your normal session fee.
Returned checks are subject to a $45 fee
If a patient's appointments are being covered by PIP, we must have a credit card on file in the event that your claims are denied, or benefits are exhausted. Please note that any charges not covered by the third party will be the patient's responsibility.
Disclosure:
Please be aware if for any reason we do not receive payment, your information may be used during a debt collection.
To secure your appointments, please enter credit card information below. I authorize Dianne Brown to place my credit card information on file to charge for any applicable/outstanding fees.

(Required) CC# ____ Exp: _______ CVC: ________

Policy on Insurance Reimbursement: If you have medical Insurance that provides coverage for mental health counseling, we want to help you receive your maximum allowable benefits. We will be happy to help you process your insurance claim form for your reimbursement. A completed insurance form must accompany any such request at each visit. You are responsible for mailing it to the insurance company and tracking your reimbursement. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:
1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, called "Usual, Customary and Reasonable" (UCR). Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.
5. I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance. By signing below, I agree to the terms listed above.

Signature ____ Date ___________

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Please do not write in space below. For office use only

Issues	Descriptions & Objectives	Interventions

Diagnostic Impressions:

Axis I: ____

____

DIANNE BROWN, MA, LMHC
PO BOX 682214 ORLANDO, FL 32868

Informed Consent & Release of Liability

Name: (please print): ____

I understand the following:

1. Counseling services are provided by practitioners who have earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and who have been licensed by the state of Florida as Mental Health Counselor
2. Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
3. Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
4. This counselor is not providing an emergency service; therefore, at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance.
5. Regular attendance will produce maximum results, but I am free to discontinue treatment at any time. A final closure/summary session is highly recommended to get the greatest benefits.
6. I understand that my counseling records & conversations with the counselor are kept confidential, except where disclosure is required by law (i.e. abuse of a child, elderly or disable person; potential harm or threat to self or others and specific information subpoenaed by a court of law.)
7. I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.
8. I acknowledge that I may be given the option for telehealth when in-office sessions are not available and my counselor is maintaining confidentiality. I understand that it is my responsibility to make sure I maintain my own confidentiality while doing a virtual session.

All group members agree if the therapist is sued for breach of confidentiality, the client who breached confidentiality will hold the therapist harmless from any damages including attorney fees. Consequences of breaching confidentiality may result in pressed charges by another client. Although confidentiality agreements have been signed by all group members, this does not guarantee that confidentiality will not be breached by fellow group members.

My signature below indicated that I grant informed consent for Dianne Brown, MA LMHC to provide counseling services to myself and or minor members of my family.

Signature: ____________________________ Date:_ ____________________________

Notice of Privacy Practices

This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identif..... health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

• *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

• *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

• *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

• The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations outside of treatment, payment and health care operations.

• The right to obtain a paper copy of this notice for us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Dianne Brown
PO Box 682214 Orlando, FL
32868
(407) 476-8955

For more information about HIPAA or to file a complaint:
The U.S. Department of Health
& Human Services
Office of Civil Rights
200 Independence Avenue,
S.W. Washington, D.C. 20201
877.696.6775 (toll-free)

P: 407-476-8955

Acknowledgement of Receipt: Privacy Practice Notice

I, _ _____________________________ have received a copy of Dianne Brown, MA, LMHC's Notice of Privacy Practices.

Street Address: . ____

City: _________________________ State: ____________ Zip: __________________

Client Signature: _____________________________________ Date: _______________

Witness: ____ Date: _______________

Witness Signature: ____

____

____