COUNSELING INTAKE FORM

Demographic Information:

Name:_____ Date:_____ Age:_____

Date of Birth:_____ Phone:_____ Email:_____

Mailing Address:_____City_____Zip_____

Current Employer:_____ Job Title:_____

Emergency Contact Name:_____

Emergency Contact Phone Number: _____

How did you hear about Patty Mohler Counseling? _____

Hello, Patty Mohler Counseling requires credit card information for balances and missed appointments. You may continue to pay with check or cash, however; we will require holding the following information. If you have any questions, please do not hesitate to ask.

I authorize Patty Mohler Counseling to charge outstanding balances on my account on the following card:

Visa☐ Mastercard ☐Health Savings Card ☐Discover☐

Name on card (please print):_____

Account Number: _____

Expiration Date: _____

CVV Number (last 3 number on back of card) _____

Billing Address: _____

Billing Zip code: _____

Signature: _____ Date:_____

CANCELLATION POLICY: To cancel an appointment please call 24 hour prior to scheduled appointment or you will be charged the full amount of your appointment time. Patty Mohler Counseling requires credit card information to be held on file to take care of balances and missed appointments

Initial_____

Patty Mohler COUNSELING

EMPOWER • MOTIVATE • INSPIRE

CONSENT FOR TREATMENT

The goal at Patty Mohler Counseling, LMHC is to provide excellent mental health care and quality customer service. Every individual is encouraged to take an active part in their treatment. The following are the office policies. Please place your initials once you have read the following:

_____ I understand that payment is due at the time of service.

_____ 491.0147 Florida Confidentiality Statue-Any communication between any person licensed or certified under this chapter and his/her patients or client shall be confidential. Information will not be released without your written consent. This confidentiality may be waived under the following conditions:

1. If there is reason to believe that a child, elderly person, or person with a disability is being abused or that abuse has occurred.
2. When danger to self or others (such as a threat to serious bodily harm) requires disclosure.
3. In the event of a medical emergency.
4. Or as otherwise stated by state law.

_____ I understand that if I have forms/paperwork that needs to be completed by my clinician, fees are determined by length and complexity of form. The fee will be calculated based on a rate of $100.00 per hour.

_____ I understand that the office may contact me by phone regarding confirmation of my appointment time and billing issues and may leave a message or text. REMINDER CALLS ARE A COURTESY. I AM RESPONDSIBLE FOR KEEPING TRACK OF MY SCHEDULED APPOINTMENTS.

_____ **CANCELLATION POLICY: To cancel an appointment please call 24 hours prior to scheduled appointment or you will be charged the full amount of your appointment time. Patty Mohler Counseling requires credit card information to be held on file to take care of balances and missed appointments. Text reminders are a courtesy, and you are still responsible for your appointment. Monday appointments may only be cancelled by Friday at 5:00 pm.**

I voluntarily give my consent for evaluation and counseling services to be provided by Patty Mohler Counseling. I understand I may withdraw myself (or the client) at any time from treatment and refuse any treatment offered. I acknowledge, understand, and agree to the terms and policies listed above. I voluntarily give my consent for evaluation and counseling to be provided by Patty Mohler.

Client's signature _____ Date_____

If under 18, Parent's signature_____ Date_____

Patty Mohler Counseling, LMHC
408 4th St. N Jacksonville Beach, FL 32250
patty@pattymohlercounseling.com 904-699-TALK (8255)

Patty Mohler COUNSELING

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NOTICE OF PRIVACY PRACTICES
SUMMARY OF NOTICE
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Patty Mohler Counseling keeps medical information about you. This information is personal and private. I need to use this information in many ways. First, I use the information when I treat you or refer you for treatment. Second, I use the information to pay bills for your medical care. Finally, I use this information for health care operations and quality assurance.

Under the law, each patient has certain rights to the medical information kept at the Patty Mohler Counseling. The rights are:

- Access. You can ask to look at your information.
- Restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- Accounting. You may request a list of the disclosures of your mental health information that have been made to persons or entities other than for treatment or health care operations.
- Amending. You can ask to change medical information if it is wrong.

A client has the right to file a complaint regarding privacy with the Secretary of Health and Human Services.
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Washington, D.C. 20201 Toll Free: 1-877-696-6775

Florida Statutes: Florida statutorily grants patients the right of access to medical records maintained by health care practitioners. The disclosure of patient information by providers is generally prohibited without the patient's consent, subject to specified exceptions. Florida also has numerous laws protecting the confidentiality of health information held by a variety of entities and government agencies.

_____ _____

Patient Signature Date

408 4th St N Jacksonville Beach, FL 32250
(904) 699-8255
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patty@pattymohlercounseling.com