17862 Hunting Bow Circle Lutz, Fl. 33556
www.SolutionsFamilyTherapy.com
(727) 612-4077

Personal Information

Name: _____ Birth Date: _____
Address: _____
City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____
Email: _____ Occupation: _____
Current Health Problems: _____
Medications: _____

Spouse Information

Name: _____ Birth Date: _____
Address: _____ (if different from above)
City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____
Email: _____ Occupation: _____
Current Health Problems: _____
Medications: _____

Children Information

Name: _____ Age: ___ Name: _____ Age: ___
Name: _____ Age: ___ Name: _____ Age: ___
Name: _____ Age: ___ Name: _____ Age: ___

Other

What do you hope to change or accomplish with Solutions Family Therapy?

_____

_____

How did you hear about us? _____

Signature: _____ Date: _____

Signature: _____ Date: _____

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Terms of Service

Cancelation

We request at least 24 hours' notice if the client needs to cancel or reschedule. A fee of $75 will be charged for a late cancellation or not showing up for a scheduled appointment.

Outcomes

The greatest outcomes of therapy depend on clients doing the work outside of sessions. You will be given work to do between sessions to assist in making changes that will lead to better results. You determine the nature and amount of change you wish to make.

Payment for Services

The fee for a regular session of 55 min. is $175. Payment is due at the time of service. Cash, check, or credit cards are accepted.

Payment arrangements are as follows:

- ❑ Self Pay
- ❑ Bill Insurance- ID #: _____
  DOB of Insured Person: _____
  DOB of Client (if different than Insured Person): _____
  Ref # for EAP: _____
- ❑ Other: _____

Signature: _____ Date: _____

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Authorization for Release

I authorize Solutions Family Therapy to disclose my health information to the persons listed below. This includes any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational, or psychological conditions.

I can revoke this agreement at any time by sending a written notice to the Solutions Family Therapy office where I am receiving services.

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by Solutions Family Therapy confidentiality rules.

I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

This authorization is valid until three months after my file is closed at Solutions Family Therapy.

Insurance Company: _____ Client's Initial: _____

Name: _____ Client's Initial: _____

Name: _____ Client's Initial: _____

Name: _____ Client's Initial: _____

Name: _____ Client's Initial: _____

Client's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Witness: _____ Date: _____

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HIPAA Notice of Privacy Practices

Please read through the information below carefully and sign at the bottom indicating that you have read and understood the information contained in this notice.

Federal law requires us to give you this notice, and it is known as the Health Insurance Portability and Accountability Act (HIPAA).

This notice will tell you about the ways in which Solutions Family Therapy may use and disclose health information about you and will describe your rights and our obligations regarding the use and disclosure of that information.

Your Health Information:

This notice applies to the information and records we have about your health, health status, and the health care services you receive.

This information and record relates primarily to counseling services you will receive from Solutions Family Therapy.

How We May Use and Disclose Health Information About You:

For Treatment

Solutions Family Therapy may use or disclose health information about you to facilitate counseling and other health treatment. For example, we may disclose information about you to another therapist to determine the most appropriate care for you.

For Payment

Solutions Family Therapy may use or disclose information about you in order to be paid by you, or any other party paying any portion of the fee for our services provided to you.

For Operations

Special Situations

Solutions Family Therapy may use or disclose health information without your permission for several reasons. These reasons include:

- Disclosing your health information as required by law to prevent injury or suspected abuse or neglect
- Disclosing your health information as required by federal, state, or local law
- Disclosing your health information in response to court order, subpoena, warrant, summons, or similar process

Other Uses and Disclosures of Health Information

Except where otherwise required or authorized by law, Solutions Family Therapy will not use or disclose your health information for any purpose without your written authorization. If you authorize Solutions Family Therapy to use or disclose health information about you, you may revoke your authorization, in writing, at any time. If you revoke your authorization, Solutions Family Therapy will no longer use or disclose your health information for the reasons covered by your written authorization, but we cannot take back any uses or disclosures we have already made with your permission.

Your Rights Regarding Your Health Information:

You may inspect and copy your health information, with certain exceptions.

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information.

You may obtain an accounting of our disclosures of your health information. This is a list of all our disclosures of your health information for purposes other than treatment, payment, and healthcare operations.

You may request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

You have the right to receive a paper copy of this notice.

If you want to exercise any of these rights, please let your therapist know with a written request at any time.

Solutions Family Therapy has the right to change this notice. If done so, the new notice will apply to the health information we may already have about you and to the health information that we receive in the future. We are required to abide by the most current notice that is in effect. You are entitled to receive a copy of the most current notice.

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

Signature: _____ Date: _____