OLIVE BRANCH COUNSELING, LLC

Kelli Hauer-Skorman and Associates
9100 Conroy Windermere Road, Windermere, FL 34786
407-612-5808 www.olivebranchcounselingorlando.com

HEALTH INFORMATION PRACTICES

Receipt and Acknowledgement of Notice

Client Name: _____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the OLIVE BRANCH COUNSELING, 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 at 407-612-5808.

Signature of client: _____ Date: _____

Signature of Parent, Guardian (if under 18): _____ Date: _____

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Olive Branch Counseling, LLC is an association of independently practicing mental health professionals. Each associate is completely independent in providing his/her clinical services and is each fully responsible for those services. He/she practices according to his/her own background, training and expertise. Clinical records are separately maintained by each clinician and no other member of the group has access to those records.

I consent to receive counseling/therapy from _____, who is a _____. I acknowledge that I am here voluntarily and I may terminate treatment at any time. I understand that, as with all effective treatments, there are benefits and well as possible risks to counseling/therapy. I understand that the benefits will depend on the treatment goals that I establish together with my therapist. I understand that risks may include problems, temporary worsening or the conflict/problem not being resolved or changed.

I realize 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 counseling /therapy session is only one part of the process of change.

- 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.

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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.

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 _____

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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.

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****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. 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.

Cardholder Name (please print): _____

Cardholder Signature: _____

Card Type: VISA __ MASTERCARD__ AMEX__ DISCOVER__

Card Number: _____

Exp. Date (MM/YY): __ / __ Security code: _____ Billing Zip: _____

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

Date Parent/Guardian if under 18 Date Initials:_____

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): _____

Telephone:_____ Is it ok to leave a message? Yes / No

Email: _____ Is it ok to send email if needed? Yes / No

How did you learn about OLIVE BRANCH COUNSELING?

_____

_____

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