Being Unlimited Counseling Center
Amy Arnold-Sirmans MS, LMHC
407.897.3387

Thank you for taking this important step to pursue counseling for you and/or your family. Please find in this packet several important documents to ensure you receive the best professional treatment possible. This includes the **Confidential Client Information Form**, **Statement of Counseling Policies and Procedures**, and **Informed Consent and Release of Liability**.

In addition, this packet includes a copy of our **Notice of Privacy Practices**. This is in compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPPA). This Federal law requires that all healthcare professionals notify patients of how their health information is protected and how it may be used.

Florida law regarding psychotherapy is much stricter than Federal guidelines. HIPPA allows stricter state laws to prevail where conflict between the two may exist.

To best serve you, please take the time to review the attached documents, complete the necessary information, and sign the **Acknowledgement of Receipt of Privacy Practices, Statement of Counseling Policies and Procedures,** and **Informed Consent and Release of Liability.**

If you have questions regarding HIPPA or our privacy practices, please do not hesitate to contact us.
Phone: 407.897.3387
Email: amy@joyofbeingunlimited.com

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Confidential Client Information Form

GENERAL INFORMATION
Date: _____
Referred by:_____ May we thank them? _____

Full Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr.
_____

Nick Name:_____ Name You Prefer: _____

Age: _____ Date of Birth: _____
Race: □ White □ Black □Hispanic □ Asian □ Other:
_____ Sex: □ Male □ Female

CONTACT INFORMATION
Street Address: _____
Suite/Apartment Number: _____
City: _____ State: _____ Zip Code: _____
May We Send Mail Here: □ Yes □ No
May We Leave a Message Here: □ Yes □ No
Mobile Phone: (_____) _____
May We Leave a Message Here: □ Yes □ No
Email Address: _____
May We Send Email Here: □ Yes □ No

EMERGENCY CONTACT
Name: _____
Relationship: _____
Phone: (_____) _____

EMPLOYMENT INFORMATION
Employer: _____
Length of Employment: _____
Occupation: _____
Average Hours Worked Per Week: _____

EDUCATION INFORMATION
Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ 1 □ 2 □ 3 □ 4 □
Other: _____
Are You Currently in School: □ Yes □ No. If Yes, What Level: _____
Degree Pursuing: _____

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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.
_____
How Long Have You Known Your Partner: _____ Age: _____
Partner's Race: □ White □ Black □ Hispanic □ Asian □ Mixed □ Other: _____
Partner's Sex: □ Male □ Female
Partner's Occupation: _____
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 Death**	**Relationship to You** *(e.g. Natural, Adopted, Step)*	**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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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: _____
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 □ Present
Dizziness □ Past □ Present
Stomach Issues □ Past □ Present
Vision Issues □ Past □ Present
Sleep Issues □ Past □ Present
Trouble Relaxing □ Past □ Present
Weakness □ Past □ Present
Tension □ Past □ Present
Rapid Heart Rate □ Past □ Present
Breathing Issues □ Past □ Present
Intestinal Issues □ Past □ Present
Hearing Noises □ Past □ Present
Change in Appetite □ Past □ Present
Tiredness □ Past □ Present
Pain □ Past □ Present
Hearing Voices □ Past □ Present
Seeing Things □ Past □ Present
Other _____ □ Past □ Present

Your Height: _____ Your Weight: _____
How has Your Weight Change in the Last 2-3 Months: _____

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CURRENT STATUS

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

Stress □ Past □ Present
Nervousness □ Past □ Present
Anxiety □ Past □ Present
Panic □ Past □ Present
Unhappiness □ Past □ Present
Depression □ Past □ Present
Guilt □ Past □ Present
Apathy □ Past □ Present
Terminal Illness □ Past □ Present
Recent Death □ Past □ Present
Grief □ Past □ Present
Hopelessness □ Past □ Present
Inferiority Feeling □ Past □ Present
Defective Feeling □ Past □ Present
Loneliness □ Past □ Present
Shyness □ Past □ Present
Fears □ Past □ Present
Friends □ Past □ Present

Marriage □ Past □ Present
Communication □ Past □ Present
Physical Abuse □ Past □ Present
Emotional Abuse □ Past □ Present
Verbal Abuse □ Past □ Present
Sexual Abuse □ Past □ Present
Temper □ Past □ Present
Anger □ Past □ Present
Aggressiveness □ Past □ Present
Bad Dreams □ Past □ Present
Concentration □ Past □ Present
Racing Thoughts □ Past □ Present
Unwanted Thoughts □ Past □ Present
Memory □ Past □ Present
Loss of Control □ Past □ Present
Impulsive Behavior □ Past □ Present
Self-Control □ Past □ Present
Compulsivity □ Past □ Present
Sexual Problems □ Past □ Present
Pregnancy □ Past □ Present
Abortion □ Past □ Present

Legal Matters □ Past □ Present
Trauma □ Past □ Present Eating
Problems □ Past □ Present
Drug Use □ Past □ Present
Alcohol Use □ Past □ Present
Trouble with Job □ Past □ Present
Career Choices □ Past □ Present
Ambition □ Past □ Present
Making Decisions □ Past □ Present
Children □ Past □ Present
Being a Parent □ Past □ Present
Finances □ Past □ Present
Recent Loss □ Past □ Present
Disaster □ Past □ Present
Other □ 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:

_____

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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: _____

ETHNIC/CULTURAL/RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself:

_____

What Words Describe What You and Your Family Value:

_____

Briefly Describe the Environment of Your Home as You Were Growing Up:

_____

_____

Do You Regularly Attend Church: □ Yes □ No. If Yes, What Denomination:

_____

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

_____

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STATEMENT OF COUNSELING POLICIES AND PROCEDURES

COUNSELING SESSIONS
Counseling Sessions can be done in person or through telehealth counseling. Videoconferencing through technology is an option for counseling services. It is recommended that headphones be used for privacy.

FEES
Private counseling rates are $125 per session. Receipts can be provided for you to be reimbursed for out-of-network providers. Talk to your therapist about insurance co-pays and your out of pocket expenses. We are willing to work with you and your provider to provide affordable health care.

RESCHEDULING APPOINTMENTS
It is our policy to schedule you for a "standing appointment". Your appointment will be confirmed for next week at the end of each appointment. If your appointment needs to be changed, please do so as soon as possible. Please be aware that repeated cancellations or no-shows will result in the loss of your standing appointment.

CANCELLATIONS / NO SHOWS
If you must cancel your appointment, please call your therapist at least 24 hours in advance of your scheduled time. Their confidential voicemail is available 24 hours a day. Failure to do so will result in you being charged the $50 cancellation fee. Advance cancellations allow us to make the most efficient use of therapist time and office space. If there is a repeat cancellation or no show, a charge for a full session will be required before scheduling a new appointment.

PAYMENT ON FILE
Due to the option of telehealth, it is required to have a payment method on file in order to be able to utilize this method of counseling. You will be charged at the end of every session and for late cancellations and no shows.

I have read and understand the policies regarding payment, cancellations, "no-shows", and fees.

_____ Date: _____

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Informed Consent and Release of Liability

Counseling services are provided by independent professionals who have earned a Master's Degree, or higher, from an accredited graduate program, and who have been licensed by the State of Florida or provisionally licensed by the State of Florida as registered interns as defined in and governed by Chapter 491, Florida Statutes.

To begin counseling services, the completion of an intake questionnaire and the signing of an Informed Consent and Release of Liability form are required. While I expect benefits from treatment:

I fully understand that such benefits and particular outcomes cannot be guaranteed.

I understand that because of the treatment, I may experience emotional strain, feel worse during treatment, and make life changes, which could be distressing.

I also understand regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so I will notify the provider at least two weeks in advance so that effective discharge planning can be implemented.

I understand that the contents of all therapy sessions are considered confidential. Both verbal information and written information about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

- When a client discloses intentions or a plan to harm self or another person, the mental health professional is required to notify legal authorities and those people who may be impacted.
- If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
- When a mental health professional is made aware of prenatal exposure to controlled substances that are potentially harmful, a report must be made to the appropriate authorities.
- Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.
- Insurance companies (when applicable) and other third-party payers are given information that they request regarding services to clients, such as types of service, dates/times of service, diagnosis, treatment plan, progress of therapy, case notes, and summaries.

The clinical records are the property of the mental health professionals of Being Unlimited Counseling Center and as such, are deemed records of confidential sessions between counselors and clients. Other than as required by law, these records will only be released subject to the following paragraph and with the advanced written consent of the client and Being Unlimited Counseling Center.

I waive any right I may have otherwise to seek to use my counselor records with Being Unlimited Counseling Center except as may otherwise be agreed upon in writing, in any judicial proceeding or to compel the testimony of any mental health professional outlined in Chapter 491, Florida Statutes or supervisors providing counseling with Being Unlimited Counseling Center. If testimony is required, I agree to pay twice the normal hourly rate for any, and all, of these individuals for their testimony, and preparation therefore.

In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release and forever discharge and covenant not to sue or hold legally liable Being Unlimited Counseling Center; the licensed counselors; the licensed therapists; the registered interns; the supervisors; or the staff from any and all claims, demands, damages, actions or causes whatsoever related to the counseling process.

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I have read and understood the preceding information and agree to the terms and conditions of Being Unlimited Counseling Center as stated.
I understand that this agreement is a prerequisite to receiving and continuing counseling services through Being Unlimited Counseling Center.
Signed: _____ Date: _____
Witnessed: _____ Date: _____

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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. PLEASE REVIEW CAREFULLY. The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable 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. Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request, except to the extent that we have already taken actions relying on your authorization. You may contact our Privacy Officer in writing to invoke your following rights:

• You may request in writing that we restrict using and disclosing your PROTECTED HEALTH INFORMATION to family members and relatives, friends, or others you identify. We reserve the right to deny this request. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• You may request an amendment to your PROTECTED HEALTH INFORMATION.

• You may request alternative means or locations in which you receive confidential communications.

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• You may request an accounting of disclosures of PROTECTED HEALTH INFORMATION beyond treatment, payment, and health care operations.
•The right to obtain a paper copy of this notice from us upon request.
We are required by law to protect the privacy of your PROTECTED HEALTH INFORMATION and to abide by the terms of the Notice of Privacy Practices. We will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request. You may file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated. For more information regarding our Privacy Practices, please contact:
Amy Arnold Sirmans MS
LMHC #16372
1212 Mt Vernon Ave
Orlando, FL 32803
407.897.3387

For more information about HIPPA or to file a complaint, please contact:
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)

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Acknowledgement of Receipt of Privacy Practices

I, _____ have received a copy of Being Unlimited Counseling
(Full Name)

Center's Notice of Privacy Practices.
Print Name of Client: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Signed: _____ Date: _____
Witnessed: _____ Date: _____