Lynne Brackett, M.S., L.M.H.C.

 Counseling Psychology

108 Robin Road, Suite 1006 Altamonte Springs, FL 32701 (407) 657-9433

Information Sheet:

Date:		-					
Name:		SS	#:	D.O.B.:	D.O.B.:		
		SS	#:	D.O.B.:	_ D.O.B.:		
Address:							
	(Street)	(City)		(State)	(Zip)		
How May We Con	tact You?						
Home Phone:	Iome Phone:Office Phone:			Cell:			
Email Address:							
If you are employed	d, what is the name	of your employer?					
Name of Insurance Name of Physician: List any medication	s you are currently	taking:		olicy Number:			
Who referred you to	o this office?						
Have you sought co	ounseling previously	?					
If yes, please explai	in:						
Briefly describe you	ur concern:						

Please Note

Payment for professional services is made following each counseling session. If you cannot make it to your appointment, you must contact the office 48 hours in advance, otherwise you will be charged for the session.

Fees

Individual sessions are \$125.00 an hour. Insurance claims can be filed through this office.

(Client's Signature)

(Client's Signature)



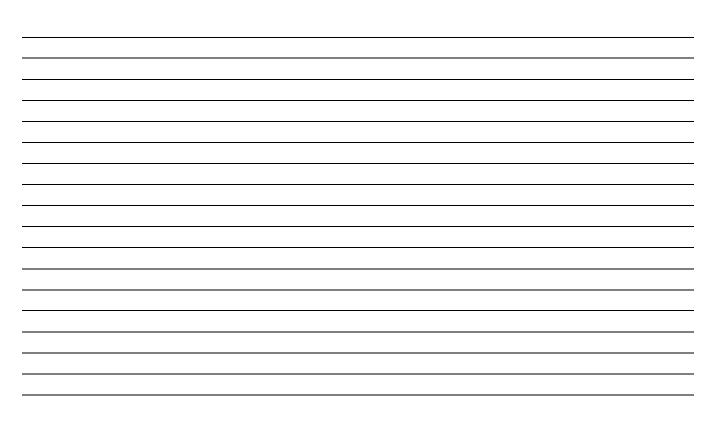
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Symptoms

Please check the behaviors and symptoms that occur to you more often than you would like them to take place:

Aggression	Fatigue	Sexual Difficulties
Alcohol Dependence	——— Hallucinations	Sick Often
Anger	Heart Palpitations	Sleeping Problems
Antisocial Behavior	——— High Blood Pressure	Speech Problems
Anxietyh	——— Hopelessness	Suicidal Thoughts
Avoiding People	Impulsivity	Thoughts Disorganized
Chest Pain	Irritability	Trembling
Depression	Judgement Errors	Withdrawing
Disorientation	Loneliness	Worrying
Distractibility	Memory Impairment	Other (Specify)
Dizziness	Mood Shifts	
Drug Dependence	Panic Attacks	
Eating Disorder	Phobias / Fears	
Elevated Mood	Recurring Thoughts	

Please give examples of how each of the symptoms you checked impair your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.





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In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the follow	ving manner (check all that apply):		
Home Telephone:	-		
Written Communication	O.K. to mail to my home address		
O.K. to leave message with detailed information	O.K. to mail to my work/office address		
Leave message with call-back number only	O.K. to fax to this number		
Work Telephone:	_		
O.K. to leave message with detailed information	Other:		
Leave message with call-back number only			
Patient Signature	Date		
Print Name	Birth date		
The Privacy Rule generally requires healthcare providers to take re PHI to the minimum necessary to accomplish the intended purpose, pursuant to an authorization requested by the individual.			

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type Key: T = Treatment Resource; P = Payment Information; O = Healthcare Operations

(3) Enter how disclosure was made: F = Fax; P = Phone; E = Email; M = Mail; O = Other



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Consent for Treatment / Fee Agreement

As a client of Lynne Brackett, M.S., L.M.H.C., I voluntarily agree to participate in psychological treatment with the undersigned counselor.

I understand that all information and records maintained are considered confidential, and shall not be released unless I give my written authorization, except for cases of suspected abuse or neglect, legitimate court orders, and requirements in accordance with Florida Statutes.

I understand that a session is 50 minutes in length and is payable at the time services are provided. I understand my agreed fee arrangement is \$ per session.

If I am unable to keep an appointment, I agree to pay charges for the time reserved, unless I give notice to cancel the appointment at least 48 hours prior to the scheduled session.

Signature of Client

Parent or Guardian

Signature of Therapist

Date

Date

Date