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.: _____

Name of Partner: _____ SS#: _____ D.O.B.: _____

Address: _____

(Street) (City) (State) (Zip)

How May We Contact You?

Home Phone: _____ Office Phone: _____ Cell: _____

Email Address: _____

If you are employed, what is the name of your employer? _____

Please provide the Following Medical Information

Name of Insurance Company: _____ Policy Number: _____

Name of Physician: _____

List any medications you are currently taking: _____

_____

_____

Who referred you to this office? _____

Have you sought counseling previously? _____

If yes, please explain: _____

_____

_____

Briefly describe your 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 following manner (check all that apply):

Home Telephone: _____

____ Written Communication
____ O.K. to leave message with detailed information
____ Leave message with call-back number only
____ O.K. to mail to my home address
____ O.K. to mail to my work/office address
____ O.K. to fax to this number

Work Telephone: _____

____ O.K. to leave message with detailed information
____ Leave message with call-back number only
____ Other: _____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made 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 releassed 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 Date

_____ _____

Parent or Guardian Date

_____ _____

Signature of Therapist Date