



William Brislin, LMHC
Client Intake Form

CLIENT INFORMATION

DATE: _____ *Please print.*

NAME: _____ **DATE OF BIRTH:** _____
FIRST MI LAST

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ **RELATIONSHIP TO INSURED:** _____
NUMBER STREET

CITY STATE ZIP CODE

PHONE NUMBERS: _____
HOME

Leave message: Yes No

MOBILE

Leave message: Yes No

WORK

Leave message: Yes No

Referred by : _____

Person to contact in the event of an emergency:

NAME: _____ **PHONE:** _____

I agree to pay William Brislin, LMHC a fee of \$90 per 45-50 minute session for counseling services, if insurance is unavailable or denied. Cancelled or missed sessions are subject to a \$40 charge, unless 24 hours notice is given.

CLIENT'S SIGNATURE

DATE

THERAPIST'S SIGNATURE

DATE

CLIENT CONSENT FORM

I hereby authorize William Brislin, LMHC and his colleagues to provide, directly or through consultation, mental health counseling, which may or may not include hypnotherapy or EMDR (Eye Movement Desensitization and Reprocessing), to me now or at a later date. I realize that these services do not guarantee improvement or cure of any mental disorder or distress.

In connection with the foregoing, I understand that any information asked of me now or in the future shall be kept in my records and/or files. Any information in these records or files will be used to provide me with counseling and will not be made available to individuals or agencies without my written consent. I also understand that William Brislin and his colleagues are required to keep all information related to my case completely confidential.

Information necessary to carry out the official responsibilities of a grand jury, or other court, law enforcement agency or Legislative Investigation Committee will be released when requested by subpoena or court order, after consultation with a legal advisor.

I agree to pay for or make arrangements for payment of services. I realize that treatment may be discontinued if my account is delinquent by an excess of three sessions.

CLIENT'S SIGNATURE

DATE

LIMITS OF CONFIDENTIALITY

Information discussed in the therapy setting is held confidential and will not be disclosed without written permission except under the following conditions:

- The client threatens suicide.
- The client threatens to bring harm to another person(s), including murder, assault, or other physical harm.
- The client reports suspected child abuse, including but not limited to physical beatings and sexual abuse.
- The client reports suspected abuse or exploitation of an aged person or disabled adult.
- Records are requested through court order and signed by a judge.

Florida State law mandates that mental health professionals must report these situations to the appropriate persons and/or agencies.

Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of the State of Florida.

Having read and understood the above, I agree to these limits of confidentiality.

CLIENT'S SIGNATURE

DATE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) outlines specific rights that you have as a patient. The following are your rights as a patient under HIPAA

- 1. Right to inspect you own health information and obtain a copy (excluding psychotherapy progress notes).**
- 2. Right to request an amendment to health information ((excluding psychotherapy progress notes.)**
- 3. Right to receive an accounting of disclosures for purposes other than treatment, payment and healthcare operations.**
- 4. Right to request that uses and disclosures of health information is restricted, unless prohibited by court order or mandated abuse reporting.**
- 5. Right to file a privacy complaint with your provider and to have that complaint reviewed by an objective reviewer.**

As your provider, I am legally required, under Federal Law and HIPAA, to protect your health data and to release only the minimum necessary information for the purpose of treatment, payment, or healthcare operations, unless otherwise specifically authorized by you.

I have read and understand my privacy rights as a patient:

Client initials _____



William Brislin, LMHC
1417 N. Semoran Blvd.; Suite 201
Orlando, FL 32807

INSURANCE CONSENT FORM

407-242-1025
FAX 407-658-2002

Insurance Company _____

Insurance Phone Number _____

Co-pay \$ _____

Policy or ID Number _____

Group Number _____

Authorization Number _____

of Sessions Authorized _____

Authorized from _____ **to** _____.

Insured's Name _____

Insured's Date of Birth _____

Insured's Social Security Number _____

Patient's Name (If different) _____

Patient's Date of Birth _____

Patient's Social Security Number _____

I hereby authorized the release of any information necessary to process my insurance claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signed _____ **Date** _____

I hereby authorize payment of mental health and/or EAP benefits to William Brislin, LMHC, for psychological services rendered.

Signed _____ **Date** _____

Party responsible for payment, if other than client:

NAME: _____ **RELATIONSHIP TO CLIENT:** _____
FIRST MI LAST

ADDRESS: _____
NUMBER STREET
CITY STATE ZIP CODE



William Brislin, LMHC
Leawood Business Center
1417 N. Semoran Blvd.; Suite 201
Orlando, FL 32807

The following information is needed to best help you. It may also help to meet assessment requirements for you insurance company. Please clearly print your response to each question. This will help save time during your first session. If you are unable to complete some parts, or prefer to discuss them first, leave them blank and you will have a chance to complete them with your counselor. Counseling records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Name _____ Age _____ Circle Gender: *M F Other*

SECTION II: MEDICAL HISTORY

Name and location of physician _____

Approximate date of last physical exam: _____

Please list any significant illnesses, hospitalizations, and injuries:

Have you ever received treatment by a psychiatrist, psychologist, or counselor? *Y N*

Briefly state problem and any helpful information such as: Duration of therapy? Was it helpful? Was medication prescribed?

Are you currently seeing a psychiatrist or psychiatric nurse practitioner? *Y N* For what reason? _____

SECTION III: DESCRIPTION OF PRESENTING PROBLEM

Please state why you decided to come for counseling/therapy:

How long has this been a problem? _____ How do you estimate the severity of this problem: *Mild Moderate Serious Severe*

What symptoms are related to this problem? Check **all** that apply.

- | | | | | |
|--------------------------------------------------------|----------------------------------------------------|---------------------------------------------------|---------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Overeating | <input type="checkbox"/> Restless | <input type="checkbox"/> Rapid heart rate | <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Taking drugs |
| <input type="checkbox"/> Fears/phobias | <input type="checkbox"/> Odd behavior/thoughts | <input type="checkbox"/> Crying | <input type="checkbox"/> Trembling / shaking | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Low motivation | <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Distrust | <input type="checkbox"/> Social withdrawal | <input type="checkbox"/> Aggressive behavior |
| <input type="checkbox"/> Family problems | <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Dizzy or lightheaded | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Can't fall asleep | <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Experienced a traumatic event | <input type="checkbox"/> Frequently angry | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Low appetite |
| <input type="checkbox"/> Abusing alcohol | <input type="checkbox"/> Abusing drugs | <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Fatigue/loss of energy | <input type="checkbox"/> Recent weight gain |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Outbursts of temper | <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Problems with work |
| <input type="checkbox"/> Jumpy | <input type="checkbox"/> Sweating | <input type="checkbox"/> Hearing Voices | <input type="checkbox"/> Racing Thoughts | |

SECTION IV: MEDICATIONS AND SUBSTANCES USED

– If applicable please list all medications and dosages you are now taking or have taken in the past three months.

If applicable, amount of **caffeinated** beverages per day: coffee _____ soda _____ espresso _____ tea _____

If applicable, amount number of cigarettes smoked per day: _____ If applicable, how often do you use marijuana per week? _____

Consider a typical week during the past month. Describe your alcohol use during that week: _____

Do you use alcohol or drugs to (check all that apply): Are you or people close to you concerned about your alcohol/drug use?

- | | |
|----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Manage stress? | <input type="checkbox"/> Not concerned |
| <input type="checkbox"/> Relax? | <input type="checkbox"/> Slightly concerned |
| <input type="checkbox"/> Change mood? | <input type="checkbox"/> Very concerned |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> I am in recovery |
| <input type="checkbox"/> Loosen inhibitions? | <input type="checkbox"/> Lapsed recovery |

What goals do you have for therapy?
