



Suellen Fagin-Allen, MA, NCC, LMHC

Licensed Mental Health Counselor

Leawood Professional Center

1417 N. Semoran Blvd., Suite 201, Orlando, FL 32807

(407)242-2956 phone – (407)282-0552 fax - Suellen@counselingfl.com

CLIENT INFORMED CONSENT FOR TREATMENT, NOTICE OF PRIVACY PRACTICES, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT GUARANTEE

Welcome to the counseling, coaching and consulting practice of Suellen Fagin-Allen, LMHC!
Below is some general information I hope you will find helpful.

Description and Length of Services: Many insurance, managed care and employee assistance plans authorize a limited number of services. I can request more sessions if you and I feel they are medically necessary. Otherwise, depending on your needs and insurance and the objectives we agree upon, services may range from crisis debriefing and management, employee assistance (brief therapy and referral), counseling, long term psychotherapy, life coaching (clarifying goals and establishing accountability for making progress on them) or consultation (identification and strategizing to solve your own specific problems, or to help someone else with theirs).

No Guarantee. Treatment will be tailored to your needs and the time we have available. However, I can't guarantee when you will feel better. In fact, you may feel worse for a time before you feel better. That's because in sessions we're often recalling painful memories and discussing hurtful experiences. You may get better faster if you are willing to do "homework" between sessions and take a very active role in your recovery. Please let me know if a particular treatment strategy or protocol is not working for you so that we can consider modifying it.

Length of Sessions: An initial intake session usually lasts one hour and others will last from 45 to 50 minutes. Please make every effort to get here on time: if you are more than 15 minutes late, I may have to ask you to reschedule. Please note: If you have not been seen within 15 minutes after your scheduled time, please feel free to come knock on my door or call me.

Fees for Services: My standard hourly fee is \$100, payable at the time of service in cash, by check or with major credit cards through Paypal. (Note: a sliding fee scale may apply in your case; however, this must be arranged in advance of your session.) Sessions cancelled with less than 24 hours' notice or "no-shows" will be charged the full fee. There is a \$30 charge for checks returned for insufficient funds. I reserve the right to terminate services for non-payment of fees: if I do this, I will make appropriate referral arrangements.

Insurance: Insurance coverage is available ComPsych, Cigna, MHN, MHNet, Humana LifeSynch and Value Options (Military OneSource claims). Your health insurance may have benefits for out-of-network providers. Check with your agent, employer or insurance carrier for more information. I will bill your insurance for covered sessions, with the exception of health savings accounts. You are responsible for all deductibles and co-pays at the time of service.

Availability: Appointments are scheduled from 10 am until 7 pm Monday, Wednesday and Friday. In emergencies, appointments may also be scheduled on other days. Telephone access is during the normal business week, Monday through Friday from 9 am until 7 pm. I will return non-emergency calls within one business day. In the event of an emergency, please call 911 or 211 (the United Way crisis hot-line). I will let you know in advance of any extended absences and how you can access help at those times.

Social Media Policy: I respect your privacy and do not connect with or "friend" clients through any social media such as Facebook, LinkedIn or Twitter.

Confidentiality: Treatment records are governed by Federal and State confidentiality laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its amendments, the Code of Federal Regulations, 42 CFR Parts 160 and 164, and Chapter 391 of the Florida Statutes.

I routinely share your protected health information only as follows:

1. In order to get paid by insurance, managed care and EAP companies for covered services. I may hire clerical employees or contract with a billing service for this purpose.
2. In supervision or peer consultation, so that I can get ideas from colleagues as to how I can better help you. Your name will never be used under these circumstances.

However, I will be legally required to release your information if one of the following occurs:

1. You are thinking about, planning or threatening suicide.
2. You are planning to harm another person.
3. You are reporting the abuse of a child or vulnerable adult.
4. You are involved in a court case in which I am called to produce treatment records or testify.
5. Your employer has required that you undergo EAP counseling, in which case I am normally required to discuss your treatment progress with your employer's representatives.

Otherwise, I will not release any information about you unless you authorize me to do so in writing.

NOTE: If you are working on a relationship issue and we decide that it would be helpful for you to invite the other person (such as a family member or partner) into a session, I of course cannot guarantee what that other person will do with the information you reveal in the session.

Please also understand that I have no control over confidential information once it is released under any of the conditions mentioned above.

_____ ***I have read, discussed with my counselor, and understand the information provided above. I further understand the limitations on confidentiality of records related to my treatment and I release Suellen Fagin-Allen, LMHC, NCC from liability for any damages that I may incur due to the unauthorized disclosure of such information by third parties.***

_____ ***I also authorize Suellen Fagin-Allen, LMHC, NCC to release protected health information regarding my care and treatment to my insurance, managed care company or employee assistance plan representatives in order to facilitate claim processing.***

_____ ***I hereby authorize payment of medical, managed care, or EAP benefits for my care and treatment directly to Suellen Fagin-Allen, LMHC. I agree to pay any applicable fees for services, deductible or coinsurance amounts at the time services are rendered.***

***I have received a copy of this information for my records. _____ OR
I do not need a copy of this information for my records. _____***

Date Signed

Client Signature

Date Signed

Parent Signature (if client under age 18)

Date Signed

Counselor Signature

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NEW CLIENT INFORMATION SHEET

Date: _____

Name: _____

Street Address: _____

City and Zip: _____

Phone: (Home) _____ (Work) _____ (Other) _____

Where do you prefer to be contacted? _____

Gender: _____ Date of Birth: _____

Relationship Status: _____ Racial/ethnic identity: _____

Occupation _____ Highest level of education _____

Children (names and ages) _____

Other individuals in your household (names, relationship and ages)

Person we may notify in the event of an emergency:

Name: _____ Relationship: _____

Telephone: _____ Alternate telephone: _____

Please briefly describe what has brought you here today:

What symptoms have been most noticeable or distressing to you?

What major areas of your life have been affected by this issue?

Please describe any previous treatment for this issue, including outcome.

In the past 30 days, have you experienced **any** of the following?

Feeling hopeless, guilty, listless, lack of motivation, wanting to give up _____

Crying excessively , over- or under-eating or sleeping _____

Suicidal ideas or plans _____

Inability to relax, tense, uptight _____

Nervous, agitated, jumpy, easy to startle _____

Nightmares, flashbacks _____

Losing track of significant periods of time, "spacing out", feelings of unreality _____

Angry to the point of losing control, violent urges _____

Homicidal ideas or plans _____

Seeing, hearing or feeling things that weren't really there _____

Persistent, troubling thoughts or ideas that you couldn't get rid of _____

Feeling the need to perform "rituals" to prevent bad things from happening _____

"Blacking out", binge drinking or using, drinking or using to "medicate" negative feelings _____

People expressing concern about your drinking or using behavior _____

Drinking or using first thing in the morning _____

Drinking or using and then forgetting important obligations _____

Who is your primary medical care provider? _____

Provider address: _____ Phone: _____

Current medical treatment for _____

Please provide name, dosage and frequency of any currently prescribed medications, herbal preparations or supplements taken.

Please describe any significant past medical history: _____

Any family history of mental or emotional disorders, physical health issues, substance abuse or other addictive disorders? _____ Yes _____ No

Has that ever placed you in the role of caretaker? _____ Yes _____ No

How has that affected you, if at all? _____

History of abuse? _____ Verbal _____ Emotional _____ Physical/Sexual

If yes, please briefly describe any treatment received, and outcome. _____

Caffeine use per day? _____ Tobacco? _____ Alcohol? _____

Sleep per typical night? _____ Exercise per day? _____

Spiritual/religious beliefs _____ How satisfactory? _____

Hobbies? _____ How satisfactory? _____

Preferred learning style: _____ Hearing _____ Seeing _____ Hands-on

You prefer: _____ Thinking _____ Feeling _____ Doing _____ Being _____

Please describe your goals for the counseling process: _____

Is there anything else you'd like to tell me that would help me understand you or your situation better? If so, please feel free to share.

THANK YOU!

**Suellen Fagin-Allen, NCC, LMHC
Licensed Mental Health Counselor**

**EFFECTIVE JUNE 1, 2010, UNDER THE HEALTH INSURANCE PRIVACY
AND ACCOUNTABILITY ACT, YOU HAVE THE RIGHT TO:**

1. Inspect and copy your protected health information, except for psychotherapy notes or information compiled in anticipation of a civil, criminal or administrative proceeding.
2. Request a restriction on the release of your protected health information for the purposes of treatment, payment or our operations. You may also request that part or all of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes. Your request must state the specific restriction requested and to whom you want the restriction to apply.
3. Request to receive confidential communications from me by alternative means or at an alternative location. We will accommodate reasonable requests, but we do have the right to ask you for information as to how payment for services will be handled or to specify an alternative address or other method of contacting you.
4. To request that we amend your protected health information, as long as we maintain your records. We may deny your request, but you have the right to file a statement of disagreement with us and we may provide a rebuttal to your statement and will give you a copy if you request one.
5. To have an accounting of certain disclosures we have made, if any, of your protected health information for purposes other than treatment, payment or health care operations. This right does not extend to disclosures we may have made to you, to family members or friends for notification purposes if you authorized us to do so, for national security or intelligence, or for law enforcement or correctional facilities (as provided in the HIPAA privacy rule). You have the right to receive specific information regarding these disclosures made after April 14, 2003.
6. To receive a paper copy of this notice from us.
7. To file a complaint to us or to the United States Secretary of Health and Human Services if you believe we have violated your privacy rights. You may also file a complaint directly against us, by notifying Suellen Fagin-Allen, NCC, LMHC. We will not retaliate against you for filing a complaint.

Patient Signature _____ Date _____

Parent Signature (if patient is a minor) _____ Date _____

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
(SHORT FORM - HIPAA COMPLIANT)**

I hereby authorize the release of my HIPAA - protected health information by Suellen Fagin-Allen, Licensed Mental Health Counselor as follows:

_____ Release to no one other than to me.

_____ Release to the following individual(s):

Name	Relationship	Telephone
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Name	Relationship	Telephone
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The purpose of this release will be only to schedule or reschedule my appointments.

You may contact me by telephone in the following manner:

_____ Leave callback message on voicemail/answering machine. (Only caller's name and telephone number and time of call will be left.)

_____ Leave detailed message on voicemail/answering machine.

_____ Leave callback message with one of the above-specified individuals.

_____ Leave detailed message with one of the above-specified individuals.

You may contact me by e-mail at the following address: _____
_____ (PLEASE NOTE: The CounselingFL.com web mail is **not** on a secure server.)

I understand that this authorization will expire one year from the date of my signature, unless I specify an earlier date here: _____.

I have received a copy of this release. ____ **OR** I do not need a copy of this release. ____

Date	Client Signature
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Date	Parent Signature (if client under age 18)
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