Counseling FL.com

William Brislin, LMHC
New Client Packet

CLIENT INFORMATION

Please print.

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

ADDRESS: _____
NUMBER STREET

_____
CITY STATE ZIP CODE

PHONE NUMBERS: _____ Leave message: Yes □ No □
HOME

_____ Leave message: Yes □ No □
MOBILE OK to text RE Apts: Yes □ No □

_____ Leave message: Yes □ No □
WORK

Referred by: _____

Person to contact in the event of an emergency:

NAME: _____ **PHONE**: _____

I agree to pay William Brislin, LMHC a fee of $120 per 45-minute session for counseling services. If utilizing insurance, I will pay the appropriate co-payment or full fee if insurance is denied. I will provide the courtesy of 24 hours' cancellation notice to avoid a $40 late cancellation/missed appointment charge.

_____ _____
CLIENT'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 therapy (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. Agreed on fees are evaluated and updated each calendar year. I realize that treatment may be discontinued if my account is delinquent by an excess of three sessions.

William Brislin makes every effort to fit active clients into his calendar. After 90 days, clients who have not had an appointment are considered "inactive." Every effort will be made to accommodate returning clients and fees will be updated to the current standard charges.

_____ _____

CLIENT'S SIGNATURE DATE

Your signature signifies that you understand the above information and grant consent for services.

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 HIPPA

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

Counseling FL.com

INSURANCE CONSENT FORM

Most clients perfer to self-pay due to privacy concerns. However, if you choose to use insurance, please complete this form.
Bill is no longer a participating provider in any insurance networks.
If your plan includes out-of-network benefits and you wish him to file for you, please complete this form.

Insurance Company _____

Employer or Group Name _____ 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)*_____ Relationship to Insured _____

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 behavioral health 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

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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 practioner? *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.

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

- □ Manage stress?
- □ Relax?
- □ Change mood?
- □ Sleep
- □ Loosen inhibitions?

Are you or people close to you concerned about your alcohol/drug use?

- □ Not concerned
- □ Slightly concerned
- □ Very concerned
- □ I am in recovery
- □ Lapsed recovery

What goals do you have for therapy?

_____

_____

_____