NEW PATIENT REGISTRTION FORM

PRN#:____________________

Today's Date:____________________

Social Security #:____________ **Email**:____________________

Last Name:____________________ **First**:__________ MI:__________

Nickname/Maiden Name____________________

Address:____________________

Apt/Unit#:____________

City:____________ State:__________ Zip Code:__________

Home Phone:__________ Work Phone:__________ **Cell Phone**:__________

Age:______ DOB:__/__/____ Marital Status: ☐Single ☐Married ☐Divorced ☐Other

Gender: ☐F ☐M

Race: **(Optional)** ☐Black ☐White ☐Asian ☐Hispanic ☐Other

Employer:____________________

Occupation:____________________

How did you hear about us? ☐Personal Reference____________________

☐Physician ☐Internet ☐Yellow Pages ☐Newspaper/Magazine/Television

☐Other____________________

EMERGENCY CONTACT

Name:____________________ Relationship:__________

Home Phone:__________ Work Phone:__________ Cell Phone:__________

Patient consent to text and voice messaging

I provide express consent to receive automated text, voice and email messages at the phone number(s) and/or email above.

_______ *(Initials)*

Supplemental Intake Form

Date: ____________________

Name: ____

Highest grade completed: ____

Describe the childhood: ___Happy ___Turbulent ___ Traumatic ___ Painful ___ Uneventful

Describe any traumatic experiences in the childhood: (List the age when they occurred)

____

Childhood Family Household composition:

Name: Age: Relationship to client:

____
____
____
____

Family History of Mental Health Issue (which relative and which mental illness):

____
____
____

Current household members composition:

Name: Age: Relationship to client:

____
____
____

Previous Counseling or Mental Health Treatment:

____
____

Known medication allergies: ____

Physician: ____

Current Medications: ____

Current medical conditions: ____

State briefly the reason you are seeking counseling: ______________________________

____
____

Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment*** – I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations with Yantra Psychiatric Services. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

Informed Consent for Treatment

Client Name: ______________________________________ DOB: _______________________________

I, __________________________________, am voluntarily seeking treatment from Becky Razaire, LMHC.
(responsible party)

1. I understand that what I talk about in sessions with my therapist is considered confidential and that my therapist will not disclose that information to anyone without a release of information, except for situations as required by law as described in HIPAA. ________(Initial)
2. I also understand that my therapist, in keeping with generally accepted standards of practice, may seek confidential clinical supervision regarding my treatment plan. The purpose of such consultation is to assure quality of care. ________ (Initial)
3. I understand that I and my therapist alone are responsible for my treatment and that no other therapist sharing office space or in affiliation with my therapist will be responsible for my on-going treatment. ________ (Initial)
4. I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" ,late cancellations, and/or failure to follow my treatment plan in any form may be ground for termination of services________ (Initial).
5. My therapist will recommend a specific type of treatment for me and will explain the advantages and risks. It is my responsibility to ask questions if I am not clear about my treatment plan. ___________ (Initial)
6. It may be recommended that I participate in Accelerated Resolution Therapy (ART). I have received a brochure on ART and understand the risks and benefits of this therapy.________ (Initial)
7. I understand that I may leave a message with my therapist or Yantra Psychiatric in the event of an urgent situation. A return call will be given within 12 hours. Should an emergency situation arise (wanting to hurt oneself or another), I will call 911 first. __________ (Initial)
8. I understand that it is my responsibility to pay for services (or copay) when rendered that are not covered under insurance or EAP. _________ (Initial)
9. I understand that if I have a scheduled appointment and need to cancel it, I will do so at least 24 hours in advance or more if possible. If I do not provide 24 hour notice, I will be charged $125.00 for the appointment. _________ (Initial)
10. I **authorize** Yantra Psychiatric or Becky Razaire, LMHC or her representatives who have information as to diagnosis, treatment and prognosis with respect to any mental condition and/or treatment of me or my dependents to give the group policyholder, third party administrator, my third party carrier or its legal representative, any and all such information.
11. I **understand** the information obtained by this authorization will be used to determine eligibility for insurance, and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim or claims submitted by Becky Razaire, LMHC or as may be otherwise lawfully required or as I may further authorize.
12. I **authorize** that payment of services be made to Becky Razaire, LMHC or Yantra Psychiatric listed on any claim submitted for any services furnished me by that practitioner or organization.
13. I acknowledge that I have received a copy of the Health Insurance Portability Accountability Act (HIPAA),Client Rights & Therapist Duties disclosure.

____ _______________________________
Client Signature (or Legal Guardian if client is a minor) Date

____ _______________________________
Becky Razaire, LMHC Date

Authorization for Release of Information

I, ____, whose date of birth is _________________________,
(Client name)

authorize Yantra Psychiatric Services, Inc. or Compass Counseling and Consulting, LLC to disclose to and exchange information from

____ the following information:
(name of person/title/organization)

Description of information to be disclosed: (Patient should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Discharge/Transfer Summary
_____ Progress in Treatment
_____ Demographic Information
_____ Other ____________________

_____ Medical Information
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____Presence/Participation in treatment
_____ Other _______________________

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and, when appropriate, coordinate treatment services.
If other purpose, please specify: ____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Yantra Psychiatric Services, Inc. or Compass Counseling and Consulting, LLC 1014 S. Florida Ave Ste. 200 Lakeland, FL 33803 . I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires on the following date: __________________________
or as otherwise indicated: ____

Form of Disclosure
Unless specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any matter that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Redisclosure
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

____
(Signature of Client) (Date)

____
Becky Razaire, LMHC (Date)