the Happy Mind Company

4700 Millenia Blvd
Suite 175
Orlando, FL 32839

Telephone: 407-704-1461
Fax: 407-987-2354
www.happymindcompany.com

Counseling Confidential Information

Client Information: Date of Birth: _____

1. Client Name: _____
(Last) (First) (Middle)
2. Address (street): _____
3. City: _____ State: _____ Zip: _____
4. Home Phone: _____ Cell: _____
5. E-mail Address: _____
6. Sex: M F
7. Place of Employment: _____
8. Student/School: _____
9. Is the client currently on any medication? If so what/how much? _____

Parental Information: (If client is a minor)

10. Parents Name: _____
11. Parents' Marital Status: Single Married Divorced Separated
12. If parents are divorced or separated, who has primary custody? Mom Dad Other: _____
13. Both parents must consent and sign the "Treatment Consent Form" prior to meeting with the counselor
14. Home Phone: _____ Cell: _____
15. E-mail Address: _____

In Case of Emergency:

16. Relative or friend not residing with client: _____
17. Relationship to Client: _____
18. Address: _____
19. Phone Number: _____

In the unfortunate event that this account is assigned to any attorney for collection and/or suit, the prevailing party shall be entitled to any and all attorney's fees and costs of collection. Also, an additional fee of 40% of the amount owed will be added for collection charges.

Please be sure to review and acknowledge The Happy Mind Companies *Financial*, *Medication* and *Practice Policies*, found at the end of this packet.

IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE GIVE 48 HOURS NOTICE
A $75.00 CHARGEWILL BE IMPOSED FOR THE TIME RESERVED.

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Confidential Client Intake

(This form to be filled out by patient or legal guardian for patient)

Please fill out as much of the following information as possible. It will greatly aid your counselor in understanding and assisting you. If you feel uncomfortable about a particular question, leave it blank and speak to your counselor about it.

Date: _____ Client Name: _____ Sex: _____

Partner's name: _____ His/Her Birthday: _____
How long have you been in the relationship: _____
Are you a blended Family: _____

Names of your children:

_____ DOB _____ Sex _____
_____ DOB _____ Sex _____
_____ DOB _____ Sex _____
_____ DOB _____ Sex _____
_____ DOB _____ Sex _____

Presenting Problem: State in your own words the nature of the issues which brought you to counseling:

_____
_____
_____
_____
_____

When did your problem(s) begin? Give dates as best as you can remember: _____

_____
_____
_____
_____
_____

Work \ School:

What is your present occupation / school: _____
How long have you been at the place of employment / school: _____
How do you feel about your work or school? ( ) Hate it ( ) Tolerate it ( ) Like it

_____

What are your hopes or aspirations? _____

_____
_____
_____

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Client Name: _____

Family Information:

Your parents: Mother _____ Father _____
Are parents deceased: _____

Brothers/Sister: _____ Age _____

Brothers/Sister: _____ Age _____

Brothers/Sister: _____ Age _____

Brothers/Sister: _____ Age _____

Spouse's Parents: Mother _____ Father _____
Are parents deceased? _____

Brothers/Sister: _____ Age _____

Brothers/Sister: _____ Age _____

Brothers/Sister: _____ Age _____

Brothers/Sister: _____ Age _____

Counseling:

Have you ever been treated by a professional therapist (Psychiatrist, psychologist, mental health counselor, social worker) Yes ___ No ___
When and with whom: _____

Are you on any medication? Yes ___ No ___ What? _____
_____

Any inpatient treatment? Yes ___ No ___
If so where and when? _____
_____

Any illegal drug use? Yes ___ No ___
If so, when, what, and how much? _____
_____

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Client Name: _____

Behavior:
Check any of the following that apply to you, your partner or client if a minor

#1		#2	#1		#2
_____	Overeat	_____	_____	Suicide attempt	_____
_____	Vomiting	_____	_____	Repeat actions over & over	_____
_____	Odd behavior	_____	_____	Withdraw from people	_____
_____	Work too hard	_____	_____	Sleep disturbance	_____
_____	Often put things off	_____	_____	Phobic (fear) avoidance	_____
_____	Act impulsively	_____	_____	Lazy	_____
_____	Loss of control/behavior	_____	_____	Aggressive behavior	_____
_____	Crying	_____	_____	Loss of appetite	_____
_____	Sexual problem	_____	_____	Hurt self	_____
_____	Quit jobs	_____	_____	Often over sleep	_____
_____	Easily agitated	_____	_____	Day dream	_____

Feelings:
Check any feelings that apply to you:

_____	Anger	_____	Guilty	_____	Unhappy	_____	
_____	Annoyed	_____	Happy	_____	Bored	_____	
_____	Sad	_____	Confused	_____	Restless	_____	
_____	Depressed	_____	Regretful	_____	Lonely	_____	
_____	Anxious	_____	Hopeless	_____	Contented	_____	
_____	Fearful	_____	Hopeful	_____	Excited	_____	
_____	Panicky	_____	Helpless	_____	Optimistic	_____	
_____	Energetic	_____	Relaxed	_____	Tense	_____	
_____	Envy	_____	Jealous	_____	Ashamed	_____	
_____	Loss	_____	Grief				

Any other information you wish to share at this time: _____

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INSURANCE WAIVER AGREEMENT

I, _____,
(Printed name of patient or parent/guardian)
understand that I am responsible for any charges for psychiatric, psychological or psychotherapy services provided by The Happy Mind Company according to the financial policy.

I further acclaim that I do NOT have mental health insurance coverage, **OR** if I do, have chosen NOT to disclose this to The Happy Mind Company of my own accord. If the latter is true, then I understand that my insurance company may not reimburse me for any or all of my fees, and The Happy Mind Company would NOT be responsible for any charges that are not reimbursed by my insurance company.

_____ _____
Name of Patient Patient Date of Birth

_____ _____
Signature of Patient or Parent/Guardian Date

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TREATMENT CONSENT FORM

*This form must be completed by ALL PATIENTS- ADULTS and MINORS and signed by **both parents** if a minor is being seen and parents are divorced or separated prior to meeting with the professional staff at The Happy Mind company!*

Name:_____ Date:_____

Date of Birth:_____ Social Security Number:_____

Explanation of Consent Form:
This treatment consent form covers all procedures and testing that are not of a nature to require a special consent, and it provides protection for the procedures and testing performed by the professional staff of The Happy Mind Company. This form documents that the patient has consented to treatment at The Happy Mind Company, including but not limited to medicine management, psychotherapy, psychological testing, counseling and coaching. This allows the professional staff at The Happy Mind Company to provide services to you.

This form provides evidence that no guarantee is made by any professional at The Happy Mind Company concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at The Happy Mind Company. If you have any questions concerning this or any other matters, it is your responsibility to ask your psychiatrist, psychologist, or therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment:

I, _____, for _____,
(Print Your Name as a Consenting Adult) *(Print Name of Patient)*

Do hereby voluntarily consent to care and treatment by The Happy Mind Company, assistants and/or designees. I am aware that the practice of medicine psychiatry, clinical psychology, clinical social work and therapy is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the counseling process and that I share responsibility for my treatment. My responsibilities in treatment include informing the psychiatrist, coach or therapist of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

_____ _____
Signature *Date*

_____ _____
Witness Signature *Date*

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TELEMENTAL HEALTH INFORMED CONSENT

I (name of self or parent/guardian), _____, hereby consent to participate, or allow my minor child _____ to participate in telemental health services with providers at The Happy Mind Company as part of psychiatry and psychotherapy services. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different geographic areas.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2. I understand that there are benefits (including but not limited to easier access to care and the convenience of meeting from a location of my choosing), risks, and consequences (including but not limited to disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized person(s), and/or limited ability to respond to emergencies) associated with telemental health. I understand that my health care provider or I can discontinue the telehealth visit if it is felt that the videoconferencing connections are not adequate for the situation. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits have been addressed.

3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to the confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding; an insurance audit mandates disclosure of progress notes).

5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call the office at 407-704-1461 to discuss, since we may have to reschedule. If you are unable to reach the office, please know that we will make every effort to reach you by phone as soon as possible.

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7. I understand that my therapist or doctor may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

EMERGENCY PROTOCOLS

Your therapist or doctor needs to know your location in case of an emergency. You agree to provide the address where you are at the beginning of each session. An emergency contact person is also required to be listed, and only contacted on your behalf when your safety is called into question, and/or during a life-threatening emergency. I authorize providers at The Happy Mind Company to contact this person in an emergency situation. My emergency contact person's name, address and phone number are:

_____
_____
_____

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Signature of Client/Parent/Legal Guardian _____

Date _____

Effective 12/03/20

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company **to Receive** PHI	Name and Address of Individual/Facility **to Disclose** PHI
_____	_____
_____	_____
_____	_____

Information authorized for use or disclosure, or to be obtained ***(Please circle items that should be disclosed)***:

History & Physical Discharge Summary Operative Report ER Record Consultation Lab reports

Progress Notes **X**-ray reports Other _____

Medical information between _____ to _____

The information will be obtained, used, or disclosed for the **following purpose** only ***(Please circle appropriate item(s) below)***:

Insurance Continued treatment Legal At the request of the patient or patient's representative

Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be eighteen (18) months from date of signature or upon occurrence of the following event: _____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released, unless prohibited by law and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

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ACKNOWLEDGEMENTS

Patient or Client Name: _____ **Date:** _____

By initialing each of the following and then signing below, I am acknowledging that I have read and understand as well as agree to adhere to the following, and have received copies of each to keep in my possession:

NAME OF POLICY	INITIALS
Financial Policy - The Happy Mind Company	_____
Practice Policy - The Happy Mind Company	_____
Medication Policy - The Happy Mind Company	_____

* A copy of each policy is available to read/review on our website*

https://happymindcompany.com/forms-policies/