Green Couch Counseling, LLC

6400 Manatee Ave West, Suite L 101
Bradenton, Florida 34209
(941) 500-3600
greencouchcounseling.org

New Client Information

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Client Name:_____ Today's Date:_____
Social Security #:_____ Age:_____ Date of Birth:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Employer/School:_____ Location:_____
Home Phone:_____Cell#:_____
Person Responsible for Payment:_____
Address if Different:_____
Referred By:_____

****

Household Members

Name	Birth date	Relationship	Are you Legal Guardian?
_____	_____	_____	YES _____ NO_____
_____	_____	_____	YES _____ NO_____
_____	_____	_____	YES _____ NO_____
_____	_____	_____	YES _____ NO_____

****

Personal History

Highest level of education:_____
School Attended:_____
Leisure Activities/Hobbies:_____
_____
Alcohol Use: Never___ Occasional___ Weekly___ # of drinks/week___
Cigarette use: No___ Yes___ # of packs/day___

****

What concern(s) brought you to counseling? _____
_____
_____
_____

What changes would you like to see as a result of counseling?_____
_____
_____
_____

Revised: 10.22.22

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Medical History

Doctor's involved in your health care Specialty Frequency seen
_____
_____
_____

Please list any current health problems or
concerns_____
_____
_____

Are you currently taking any medications? Yes___ No___

Prescription Medication(s)	Dosage	How Often	Reason for Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Non Prescription Medication	Dosage	How Often	Reason for Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been hospitalized in the past? Yes___ No___
If yes, was it Medical_____ Psychiatric_____ Chemical Dependency____

Dates	Reasons	Hospital/Facility
_____	_____	_____
_____	_____	_____

Have you had past counseling, EA., or chemical dependency services? Yes____ No____
If yes, please list:

Therapist/Facility Name	Dates seen	Reason	Helpful?
_____	_____	_____	Yes__ No__
_____	_____	_____	Yes__ No__

****

How may I contact you? (Please check all that are ok)
Home Phone ___ Work Phone___ Cell Phone___ By mail at home___

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Consent for Treatment

I, the undersigned, hereby voluntarily request to receive clinical services from Green Couch Counseling, LLC.

I understand that these services may include individual, group, and/or family therapy. I acknowledge that no guarantees have been made to me as to the effect of therapeutic assessments, therapy, treatment or care of my condition. I further understand that before beginning any treatment procedure, I will be given an explanation of the nature and purpose of such treatment and any probable risks involved. I may refuse any and all treatment at any time.

I understand that the information I share with the therapist will be held in the strictest confidence with the exception of the following reasons as outlined by Florida Statues: 1) You consent in writing, 2) Someone's life or safety is seriously threatened, 3) Disclosure is required by law, and 4) You file a benefit claim and the claims payer requires information.

I understand that I am responsible for the full payment of all services. In addition, I understand that if I do not attend a scheduled appointment and do not give at least twenty four hours cancellation notice, I will be responsible for the full payment of the session.

Signature:_____ Date:_____

Revised: 10.22.22

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Office Policies & General Information Agreement for Psychotherapy Services

This form provides you (client) with information that is additional to that detailed in the Notice of Privacy Practices.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions **are confidential** and may not be revealed to anyone without your written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form.

WHEN DISCLOSURE IS REQUIRED BY LAW: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent, or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Notice of Privacy Practices Form.)

WHEN DISCLOSURE MAY BE REQUIRED: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me. In couple and family therapy, or when different family members are seen individually, confidentially and privilege do not apply between the couple or among family members. Green Couch Counseling, LLC will use clinical judgment when revealing such information. Green Couch Counseling, LLC will not release records to any outside party unless she is authorized to do so by all adult family members who were part of the treatment.

EMERGENCIES: If there is an emergency during your work together, or in the future after termination, where Green Couch Counseling, LLC becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she can within the limits of the law, to prevent you from injuring yourself or others and to insure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided on the biographical sheet.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier of HMO/PPO/MCO/EAP in order to process the claims. If instructed by you, only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly, the psychotherapy notes will not be disclosed to your insurance carrier. Green Couch Counseling, LLC has no control or knowledge over what insurance companies do with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility

to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will be reported to the congress-approved, National Medical Data Bank. Accessibility to companies' computers or to National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-in's and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies: therefore, you are in a vulnerable position.

CONFIDENTIALITY OF E-MAIL, CELL PHONE AND FAXES COMMUNICATION: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify Green Couch Counseling, LLC at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not send an e-mail for emergencies or appointment cancellations.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on a Green Couch Counseling, LLC therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Green Couch Counseling, LLC, will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc.. Green Couch Counseling, LLC may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. During the course of therapy, Green Couch Counseling, LLC is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These

approaches include behavioral, cognitive-behavioral, solution focused, family systems, developmental (adult, child, family), or psycho-educational.

DISCUSSION OF TREATMENT PLAN: Within a reasonable period of time after the initiation of treatment, Green Couch Counseling, LCC will discuss with you (client) the working understanding of the problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Green Couch Counseling's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that she does not provide, she has an ethical obligation to assist you in obtaining those treatments.

TERMINATION: As set forth above, after the first couple of meetings, Green Couch Counseling, LLC will assess if the therapist can be of benefit to you. The therapist does not accept clients who, in our opinion, we cannot help. In such a case, the therapist will give you a number of referrals that you can contact. If at any point during psychotherapy, Green Couch Counseling, LLC sees that therapy is not effective in helping you reach the therapeutic goals, the therapist is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, the therapist would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, the therapist will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, the therapist will assist you in finding someone qualified, and, if the therapist has your written consent, the therapist will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, you will have the option of being provided with the names of other qualified professionals whose services you might prefer.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your Green Couch Counseling therapist between sessions, please leave a message on the voice mail at (941) 500-3600 and your call will be returned within 24 hours. If an emergency situation arises, please call 911 (emergency services) or go to the nearest Emergency Room.

PAYMENTS AND INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $140.00 per 45minute session at the end of each session (or agreed upon fee via the sliding scale rate). Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate unless indicated and agreed upon otherwise. Please notify your Green Couch Counseling, LLC therapist if any problem

arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, you will be provided with a copy of your receipt on a monthly basis which you can then submit to your insurance company for reimbursement if you so choose. As indicated in the section *Health Insurance & Confidentiality of Records,* you must be aware that submitting mental health invoices for reimbursement carries a certain amount of risk. Not all issue/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

DUAL RELATIONSHIPS: Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs therapist's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. Green Couch Counseling, LLC will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Manatee/Sarasota is a small community and many clients know each other. Consequently, you may bump into someone you know in the waiting room. Green Couch Counseling, LLC will never acknowledge working therapeutically with anyone without his/her permission. Nevertheless, the therapist will discuss with you, her client(s), the often existing complexities, potential benefits, and difficulties that may be involved in such relationships. Dual or multiple relationships can enhance effectiveness but can also detract from it and often it is impossible to know ahead of time. It is your, the client's, responsibility to communicate to your therapist if the dual relationship becomes uncomfortable for you in any way. Your Green Couch Counseling therapist will always listen carefully and respond accordingly to your feedback. The dual relationship will be discontinued if it is found to be interfering with the effectiveness of the therapeutic process or the welfare of the client.

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, ***a minimum of 24 hours (1 day) notice is required for re-scheduling or canceling an appointment***. This must be done by reaching Green Couch Counseling, LLC by phone or by leaving a voice mail message at her office at (941) 500-3600. E-mail messages are not an acceptable way to cancel or re-schedule an appointment. *Unless a different agreement is reached,* ***the full fee will be charged for sessions missed without such notification***. Most insurance companies do not reimburse for missed sessions.

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them.

Client Name (print)	Date	Signature

Client Name (print)	Date	Signature

Therapist	Date	Signature

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Privacy Policy

This notice describes how information about you may be used and disclosed and how you get access to this information. Please review carefully.

Green Couch Counseling, LLC is committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes how she may use and disclose your protected health information to carry out treatment, payment, or health operations and for other purposes that are permitted or required by law and is effective on April 15, 2003. It also describes your rights as they relate to your protected health information.

"Protected Health Information" means health information including demographic information, collected from the patient and created or receive by the practitioner, another health care provider, a health plan, patient's employer or a health care clearing house. This protected information is related to your past, present, or future physical or mental health or condition that identifies you.

Use and Disclosure of protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent authorizing the practitioner to use and disclose your protected health information for treatment, payment, and health care operations. By refusing to sign this consent or by revoking this consent, this organization may refuse to treat you as permitted by Section 165.506 of the Code of Federal Regulations.

I will use your health information for treatment: I will use and disclose your protected health information, coordinate, or manage your health care and any related service. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information such as a Home Health Agency that provides care to you.

I will use your health information for payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

I will use your health information for regular health operations: I may use or disclose, as-needed, your protected health information as necessary, for your practitioner's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff and licensing.

I may use or disclose information to notify or assist in notifying a family member, personal

representative, or another person responsible for your care, your location, and general condition. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

I may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your practitioner. I may call you by name in the waiting room when your practitioner is ready to see you. I may use or disclose your protected health information as necessary, to contact you to remind you of an appointment via phone confirmation and/or a post card mailed to the address you have provided.

I may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services, collection agency, etc.) for the practice.

I may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

You must contact my office in writing to request that any of the above items not be performed in relation to your care.

Uses and Disclosure of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revise this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object

I may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

I may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive information. The disclosure will be made for the purposes of controlling disease, injury, or disability.

I may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting a communicable disease or condition.

I may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefits program, other government regulatory programs and civil rights laws.

I may disclose your protected health information to a public health authority that is authorized by law to

receive reports of child abuse or neglect. In addition, I may disclose your protected health information if I believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal state laws. I may disclose health information for law enforcement purposes required by law or in response to a valid subpoena.

In conclusion:

I am required to abide by the terms of this Notice of Health Information Practices. I reserve the right to change the terms of our notice, at any time, and to make the new provisions effective for all protected health information I maintain. Upon your request I will provide you with any revised Privacy Policy at your next appointment or by mail with written notice.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

Please contact us for more information:

For more information about HIPPA
Or file a complaint:

The U.S. Department of Health & Human Service
Office of Civil Rights
200 Independence Avenue. SW.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

I have received a copy of Green Couch Counseling, LLC's privacy policy.

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Client Signature Date

Green Couch Counseling, LLC

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AUTHORIZATION TO RELEASE INFORMATION

1. I authorize Green Couch Counseling, LLC to disclose and share my protected health information for the limited purpose of sharing information with my parent or guardian.

_____ _____
Name of Patient Date of Birth

_____ _____
Name of Counselor Name of Parent or Guardian

2. I authorize the following information to be shared:
(please check a box)

☐ Complete copy of the medical record.

☐ Synchronous and asynchronous sessions between myself and my counselor related to relevant issues that I am seeking counseling for.

☐ Other (please specify)_____

3. I understand and agree that this Authorization will be valid and in effect until my treatment with my counselor named above terminates or until I otherwise revoke this consent.

4. I understand that I can revoke or cancel this Authorization at any time by sending notice to my counselor named above. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

_____ _____
Signature of Patient Date

_____
Signature of Guardian Date

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CREDIT CARD AUTHORIZATION FORM

Please Note:

The information provided herein will be used ONLY after each session and/or service as well as in the event of a cancellation without a 24 - hour notice.

This information is kept STRICTLY CONFIDENTIAL in Green Couch Counseling, LLC file and is only accessible by authorized staff. In the event that you are no longer with Green Couch Counseling, LLC, this information will not be kept and be properly destroyed.

I, _____ hereby acknowledge and authorize the use of this Credit Card information provided below to be used for payment of any services or products provided by Green Couch Counseling, LLC.

On this date ___/___/_____, I authorize the approval for the following Credit Card for the above noted transactions. This authorization will remain in effect until canceled in writing.

Name on card: _____

Credit card number: _____

Expiration Date: _____

CVV: _____

Billing Address: _____

City: _____

State: _____

Zip: _____

Signature of Cardholder: _____ Date: _____

PAYMENT POLICY

Thank you for choosing Green Couch Counseling as your health care provider. We are committed to working with you to make your treatment successful. Part of your commitment to that success is the prompt payment of your bill. Please read and sign the following statement thereby indicating your understanding of my payment policy.

Therapist:_____

REGARDING PAYMENT: Clients are expected to pay the standard fee of $140.00 per 45minute session at the end of each session (or agreed upon fee via the sliding scale rate). Please notify your Green Couch Counseling, LLC therapist if any problem arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, you will be provided with a copy of your receipt on a monthly basis which you can then submit to your insurance company for reimbursement if you so choose.

REGARDING REPORT WRITING: You will be charged for preparation of reports or letters which may be required at any time during your psychotherapy process. These charges are based on time and are equal to my normal fee for in person psychotherapy and cannot be billed to your insurance company and will be billed in full to you.

REGARDING COURT AND LEGAL FEES: Clients are discouraged from having Green Couch Counseling/therapists subpoenaed or requesting records for the purpose of litigation. Even though you (the client) are responsible for the testimony fee, it does not mean that testimony will be solely in your favor. Green Couch Counseling therapists will only testify to the facts of the case and to professional opinion. A minimum of $500 charge for a court appearance. Additional fees will be rendered for court depositions, travel, and reports, etc. Please contact your therapist for Green Couch Counseling's court fee agreement.

MISSED APPOINTMENTS: Unless canceled **at least 24 hours in advance,** my policy is to charge $140 for missed appointments. This charge cannot be billed to your insurance company and will not show up on a Superbill. Please help me serve you by keeping scheduled appointments.

COLLECTIONS: If you fail to uphold your agreement to pay for your counseling services in a timely manner, your account may be forwarded for legal collection proceedings. At that time your name and other necessary information may be released to my agents for the purpose of collecting monies owed and additional cost of collection may be added to your balance due.

I have read the Payment Policy and I understand and agree to its contents:

_____ _____

Signature of Client or Parent if Client is a Minor *Date*

_____ _____

Signature of Co-Responsible Party *Date*

Revised: 10/22/2022