Debbie Miller Soul Care INTAKE PACKET

Contact and Household Information

Date: _____________

Client Name: ____

Age: ______ D.O.B: ________________________________ Last 4 digits of SSN.: ______________

Home Address: ____

____

Mobile Phone: __________________________ Secondary Phone:_______________________

Preferred email address: ____

Permanent Address: Same as above ❒ Yes ❒ No If no, please provide:

____

May we leave a message for you at: Mobile Number: ❒ Yes ❒ No

Secondary Number: ❒ Yes ❒ No

May we contact you via text to discuss scheduling/other issues? ❒ Yes ❒ No

May we contact you via email to discuss scheduling/other issues? ❒ Yes ❒ No

How did you hear about our practice? ____________________________________

If applicable, may we thank your referral source? ❒ Yes ❒ No

Emergency Contact: ____

Phone Number:____

Your Occupation: ____

Work Status: Full-time ❒ Part-time ❒ _____________ avg. hours/week

Employer/School:____

Average Annual Gross Household Income: ____________________________________

Marital status:
Married ❒ Remarried ❒ Single ❒ Widow(er) ❒
Divorced ❒ Separated ❒ Other ❒ ____________________________________

If applicable, Spouse's Name: ____

Do you have children? ❒ Yes ❒ No

If yes, names and ages ____

____

Who lives in your home? ____

History, Current Status & Counseling Goals

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? ❒ Yes ❒ No
If yes, when? ____

Please briefly list the reasons: ____

____

____

Are you currently taking any medications? ❒ Yes ❒ No If yes, explain:

____

____

____

What brings you to counseling today? What goals would you like to accomplish?

____

____

____

____

____

____

____

What is your current level of distress? Please mark an "X" on the scale below;
(1 = very little distress; 10 = extreme distress):

____

1 2 3 4 5 6 7 8 9 10

Are you currently having suicidal thoughts? ❒ Yes ❒ No If yes, briefly describe:

____

____

____

Have you experienced them or attempted suicide in the past? ❒ Yes ❒ No
If yes, briefly describe:

____

____

____

____

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Personal Beliefs and Support System

What words would you use to describe yourself? ____

____

How important is spirituality/faith to your life? Please mark an "X" on the scale below:
(1 = not important at all; 10 = extremely important):

____

1 2 3 4 5 6 7 8 9 10

If God were to describe you, what do you imagine that God would say?

____

Briefly describe the spiritual/religious environment of your home growing up:

____

____

Complete this thought: "God is ____

____

Do you regularly attend a place of worship? ❒ Yes ❒ No If yes, where?

____

Do you have a personal support system? ❒ Yes ❒ No If yes, please describe:

____

____

Have you completed any of the following inventories or assessments? (Check all that apply; if you know the results, please list them.)

- ❒ Myers Briggs Type Indicator Results: ____
- ❒ Enneagram Results: ____
- ❒ StrengthsFinder 2.0 Results (top 5): ____

  ____
- ❒ Spiritual gifts inventories: Results: ____

  ____

Terms of Service

I have read, understood, and agree to comply with the Policies and Procedures of Debbie Miller LLC. I attest that the information provided here is accurate as of this date. I will promptly notify my therapist of any changes to this information.

Signature: ____ Date: ________________

Printed Name: ____

INFORMED CONSENT AND RELEASE OF LIABILITY

Debbie Miller, LLC, doing business as Debbie Miller Soul Care, offers professional mental health counseling services by Christian practitioners who have earned a Master's Degree from an accredited graduate program, and who have been licensed as Licensed Mental Health Counselors or provisionally licensed as Registered Mental Health Counselor Interns by the State of Florida.

The completion of an intake questionnaire and an informed consent and release of liability form are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent at fees to be determined.

In order to initiate counseling, please read the following agreement; your signature attests that you both understand and agree to the terms contained herein.

1) I, ____, understand that my counselor is a Licensed Mental Health Counselor or a Registered Mental Health Counseling Intern working under the supervision of a Licensed Mental Health Counselor, as specified by Florida law.
2) I understand that my counseling records are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession.
3) In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Debbie Miller, LLC and the Debbie Miller Soul Care counseling practitioners from any and all claims, demands, damages, actions or causes of action whatsoever related to the counseling process.

   I waive any right I may otherwise have to seek to use the record of my counseling with Debbie Miller, LLC/Debbie Miller Soul Care as evidence in any judicial proceeding or to compel the testimony of any licensed counselor, registered mental health counseling intern, or supervisor providing counseling to me through Debbie Miller LLC/Debbie Miller Soul Care.

I have read and understood the preceding information and agree to the policies of Debbie Miller, LLC, as stated. I understand that these comments are prerequisite to my receiving and continuing counseling through the Debbie Miller Soul Care practice.

Signed: ____ Date: ____________

Witnessed: ____ Date: ____________

Policies and Procedures

Please read and initial each section of the policies and procedures to indicate that you understand and accept the policies and procedures as stated.

APPOINTMENTS

Counseling sessions are typically 50-60 minutes long. During COVID-19, all counseling and coaching services are being provided by phone or Zoom. Please call in or log-on on time so that you can benefit from a full-length session. Sessions are by appointment only. We prefer to schedule your counseling sessions at a set time on a weekly, bi-weekly or monthly basis as agreed upon with your therapist.

Initial Here __________

CANCELLATIONS

24 hour notice is expected when canceling an appointment. You will be charged your full fee for no-shows or cancellations made with less than 24 hours' notice. Emergencies and extreme circumstances are taken into consideration. If you fail to show up for an appointment and have not notified your counselor at least 24 hours in advance, it is your responsibility to contact your counselor before your next session to confirm your next appointment.

Repeated no shows or cancellations may be grounds for terminating your counseling or coaching relationship with Debbie Miller LLC/Debbie Miller Soul Care. By reading and signing this document, you agree to be liable for any balance due for therapeutic or coaching sessions conducted or missed without proper notification.

Initial Here __________

CONFIDENTIALITY

Maintaining a safe, ethical and professional counseling and coaching environment is important to us at Debbie Miller, LLC/Debbie Miller Soul Care. Except as noted, your therapy and coaching sessions are held with the strictest ethical standards to honor your confidentiality.

By law, your therapist/coach is required to report:

- Suspected past or present abuse and/or neglect of children, dependent adults, and elders to the appropriate authorities based on information provided by a client or collateral sources (other individuals involved in a client's psychotherapy or coaching, such as parents, guardians, spouses); and
- Information that may help to avert danger to a client or to others, e.g., imminent risk of suicide or homicide.

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Selected information may also be released in the following circumstances:

- When you or a legal guardian have submitted written authorization for information be released to designated parties;
- When financial information is released to a collections agency, attorney, or small claims court for delinquent client accounts; or
- When significant clinical aspects of your case are presented for peer consultation or supervision as part of providing you with the best care. Your confidentiality is still honored strictly during supervision or consultation. If you have any questions or concerns regarding your confidentiality and clinical supervision, please make sure to address these concerns with your therapist.
- Where otherwise required or compelled by State, federal or local laws.

The following information is protected as confidential: the acknowledgment of your presence in therapy/coaching, documentation you give to your therapist, and your therapist or coach's clinical notes (except as required by law).

Initial Here _________

COMMUNICATIONS

You may leave a voice mail on your therapist's voicemail at any time. At the discretion of your therapist, you may also communicate via text or email. Under normal circumstances, you will receive a response within 24 to 48 hours.

IMPORTANT: If you have a life-threatening or urgent situation, please call 911.

Any phone calls with your therapist/coach longer than 10 minutes will be treated as a therapy/coaching session, and you will be expected to pay your normal session rate.

Email communication is also appropriate for brief questions or communications to your therapist/coach and will be discussed at your next session. It is important to note that email is not 100% secure. Any emails relevant to your treatment will be kept in your file.

Initial Here _________

FEES AND PAYMENT ARRANGEMENTS

Payment is due at the time services are rendered. Payment for phone or Zoom appointments may be required in advance. Payments may be made by Check or Credit Card. Professional service fees are $145 per session (50-60 minutes). Checks should be made payable to "Debbie Miller."

Consultations with other professionals and reports prepared on your behalf will be charged a pro-rated fee, calculated in 15 minute increments. Assessment testing is charged on a per-instrument basis. A $25 charge is made for any check returned to us as non-payable for any reason. Accounts over 90 days past due may be sent to collections and additional fees may be applied.

Initial Here _________

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INSURANCE

Debbie Miller LLC/Debbie Miller Soul Care therapists/coaches are not on any insurance panels. If you have PPO insurance and you would like to receive reimbursement from your insurance plan, you will be provided a super bill that will have the necessary information for you to submit to your insurance company. Please review your plan with your insurance carrier to see if they offer partial reimbursement for out-of-network mental health care providers.

Should your insurance company, disability provider, or healthcare agency require reporting, copies of treatment plans, or other paperwork, you will need to authorize release of that information. Administrative fees to respond to the requests will be calculated based on your normal counseling fee, pro-rated in 15-minute increments. Administrative fees will be collected at the next client session following the request or billed to your credit card.

Initial Here _________

PARTIAL SCHOLARSHIPS

Upon completing a scholarship application, clients with demonstrated financial need may quality for a partial scholarship of up to $25 per session. Scholarships are awarded for up to a six-month period and a client's eligibility must be re-evaluated at that time.

By accepting a scholarship, you commit to the following:

- Promptly notifying your therapist/coach if your financial situation improves;
- Completing all homework assigned between sessions; and
- Showing up for counseling/coaching ready to engage in the therapeutic/coaching process.

Initial Here _________

PROFESSIONAL CONDUCT

As with any professional relationship, the psychotherapeutic relationship requires high standards of moral, ethical, and appropriate conduct on the part of the therapist. Specifically, any form of sexual intimacy between a therapist and a client is never appropriate.

Initial Here _________

TERMINATING COUNSELING

If you feel that you would like to terminate counseling before your counselor suggests, we ask that you do so with one full session available to process your reasons for discontinuing, progress you have made, and suggested next steps.

Initial Here _________

CREDIT CARD ON FILE AGREEMENT

I acknowledge my credit card information will be kept on file to be used for session fees in which I do not provide payment (unless other arrangements have been made with my therapist/coach). Charges for missed appointments not cancelled with 24 hours advanced notice, returned check fees plus the amount of the

check that did not clear, unpaid administrative fees for consultation or reporting, and overdue balances of more than 30 days will be billed to my account.

My credit card will only be used under these circumstances or when I have not provided payment in another form (i.e. cash or check).

By signing below and providing my credit card information, I authorize Debbie Miller, LLC or my individual Debbie Miller Soul Care therapist/coach to charge my credit card.

Signature: ____ Date: __________

Printed Name: ____

Name on Credit Card: ____

Billing Address on Card: ____

____

Credit Card Number: ____

Expiration Date: __________________________ CVV (3 digit code on back): _________

Billing Zip Code: ____

Phone Number on record with Card:____

Credit Card Type: ❑ Visa ❑ MasterCard

CLIENT ACCEPTANCE

I have read and understand (or have asked for clarification about) the information presented in this form, and consent to treatment within these guidelines.

Client Signature: ____ Date: _________

Printed Name: ____

NOTICE OF PRIVACY PRACTICES (for your records)

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc. In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services.

We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law. You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that we restrict using and disclosing your PROTECTED HEALTH INFORMATION to family members and relatives, friends, or others you identify. We reserve the right to deny this request.
- You may request an amendment to your PROTECTED HEALTH INFORMATION.
- You may request alternative means or locations in which you receive confidential communications.
- You may request an accounting of disclosures of PROTECTED HEALTH INFORMATION beyond treatment, payment, and health care operations. We are required by law to protect the privacy of your PROTECTED HEALTH INFORMATION and to abide by the terms of the Notice of Privacy Practices. We will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request. You may file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated. For more information regarding our Privacy Practices, please contact: Debbie Miller, LMHC 9860, Debbie Miller, LLC, 7890 Saint Andrews Circle, Orlando, FL 32835, (407) 342-3559. For more information about HIPAA or to file a complaint, please contact: The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, (877) 696-6775 (TOLL FREE).

PLEASE PRINT AND RETAIN FOR YOUR RECORDS.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have received a copy of Debbie Miller, LLC/Debbie Miller Soul Care Notice of Privacy Policies.

Name: ____

Street Address: ____

____

City: ____ State: __________

Zip Code: ____________________

Signed: ____ Date: __________

Parent/Guardian:____________________________________ Date: __________