High Expectations Counseling
407-967-1327
1456 E. Michigan Street
Orlando, Florida 32806

NEW CLIENT REGISTRATION FORM

Please complete the information requested based on the person/s who will be receiving counseling:

The client is a: (please circle) **Adult** **Child/Adolescent** **Couple** **Family**

Date: ________________________

Please circle the form of services you are interested in: **Skype** **In office Session** **Phone** **Email** **Residential (Please fill out the information as it relates to the clients that will be involved in the therapeutic process. (family, couples, adolescents)**

Clients First Name _________________ Middle Initial______ Last Name______________________

Client's First Name _______________ Last Name_______________Email________________

Clients First Name _________________ Middle Initial______ Last Name__________________Email_______________

Home Address: ____

City: ____________________________ State: ________________ ZIP Code: __________________

Home Phone: __________________ Cell Phone:______________ Sex: ______ Age:____________

D.O.B: ___________________

Referred By: ____

Person to contact in case of emergency: ___________________________ Phone: _________________

Employer: ____Phone: _________________

Email Address: ____

Please list below any relevant information pertaining to any other numbers, email addresses, etc. of those involved in sessions that will be helpful in the therapeutic process. Also provide the **best method of communicating** for appointment reminders, and confidentiality purposes.

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Informed Consent for Therapy Services

CLIENT SERVICE AGREEMENT

Welcome to HEC (High Expectations Counseling). This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. It is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them prior to services rendered. For all types including those in office, residential, out of state, and online services, the intake packet, **must contain a credit card on file that is confidential**. **This ensures that the space has been reserved for cancellations.**

THERAPEUTIC SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of Therapy often requires discussing the unpleasant aspects of your life. However, Therapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Therapy requires a **very active effort on your part**. In order to be most successful, **you will have to work on things we discuss outside of sessions.**

The first session will involve a comprehensive evaluation of your needs. This process will be between 90 to 120 min in length. By the end of the first session, I will be able to offer you some initial impressions of how our work will be most beneficial and include collaboratively how we will approach therapy. It is important that you make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments run an average of 90 minutes in duration, once per week or at a time we agree on. Some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with a **24 hour notice**. If you miss a session without cancelling, **my policy is to collect the payment in full for the time reserved.** (Unless we both agree that you were unable to attend due to circumstances beyond your control.) I will assist to schedule another time for the appointment. In addition, you are responsible for coming to your session on time. My approach is very different than the typical 50 minute therapy session. Please be respectful as I have blocked off an hour and half segment of time for you to use should you need it. I do not prorate for the extra time as most therapist. You will pay an agreed upon flat rate for session.

PROFESSIONAL RECORDS

I will keep appropriate records of the therapeutic services that I provide. Your records are maintained in a secure and locked location in the office. I keep brief records noting that you were in session, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discuss, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement is essential at important times throughout treatment. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern. It is my goal to work with the entire family and keep all involved and updated on progress.

CONTACTING OUTSIDE OF BUSINESS HOURS

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. I will however get back to you within the end of the business day. At these times, you may leave a message on my confidential voice mail. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please go to your Local Hospital Emergency Room, call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences. You may also reach me via email at sally@highexpectationscounseling.com or text at 407-967-1327

OTHER RIGHTS

If you are unhappy with your progress in therapy, I hope you will talk with me so that I can respond to your concerns. Comments are taken seriously and handled with care and respect. You may also request that I refer you to another therapist at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

CONSENT TO THERAPY Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to these terms.

____________________________ ____________
Signature of Client Date

____________________________ ____________
Signature of Client Date

____________________________ ____________
Signature of Parent/Guardian Date

____________________________ ____________
Signature of Mental Health Practitioner Date

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PROFESSIONAL FEES AND INSURANCE POLICY

FEE

In Office Session 90 minutes $130

Online Face to Face Sessions 60 minutes $80

Telephone Sessions 30 min-60 min $30 (30 min) $60 (60 min)

I am very interactive with my clients and make it a point to go above and beyond between sessions should you need the support. If it is suggested that we do a phone session before your next in office session, an agreed upon $40.00 will be charged for that time

- Please note that I can do on an individual basis a sliding scale. If this was discussed prior to session at a different rate please record agreed upon amount and initial. $_________ Initial ____________

-Sliding scale is available and can be discussed at time of phone consultation.

Any checks returned to the office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay the fee, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, consultations which you have requested, or the time required to perform any other service which may be requested of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

I am not an in network provider for insurance plans. I will supply you with a receipt of payment for services, an itemized invoice with all clinical diagnostic requirements which you can submit to your insurance company for third party reimbursement. Please note that not all insurance companies reimburse for out-of-network providers but most will work with me to assist you in getting reimbursed. Payment must be collected up front for therapy.
-By initialing I have read and understand the above fees and insurance information: _____________ (Initial)

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AUTHORIZATION FOR TREATMENT

There are several important issues regarding our work together, which you will need to understand and consent to. *Please take the time to read the following. If you have any questions or need further clarification, please ask before signing.*

1. **AUTHORIZATION AND CONSENT FOR TREATMENT:**

I, ______________________________, an applicant for therapeutic services,

-or-

I, ______________________________, a representative or guardian for

______________________________, an applicant for therapeutic services.

_______A. Authorize Sally High, LMHC to administer therapy.
(Initial)

2. **CONFIDENTIALITY**

The therapeutic relationship is held in the strictest confidence, records nor will information be released to anyone without your informed and signed consent. There are certain legal limits to confidentiality which include:

-If the client or guardian indicates a desire to hurt themselves or another person, the therapist has a duty to ensure others safety, and thus confidentiality will have to be waived.

-If a minor client, elderly client, or disabled client indicate they have been physically or sexually abused or neglected, the therapist is required by Florida law to report this to the appropriate authorities. Also if a judge issues a court order for release of records or information.

3. **CONSENT TO USE UNECRYPTED EMAIL, Distance Therapy or TEXT:I**t is very important that you are aware that computer e-mail, texts, and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies through your provider may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. All Data on HEC laptop is encrypted including e-mails and efaxes. It is always a possibility that e-faxes, texts, and e-mail can be sent erroneously to the wrong address and computers. Unencrypted e-mail or texts provide as much privacy as a postcard. You should not communicate any information to your health care provider that you would not want to be included on a postcard that is sent through the Post Office. E-mail messages on your computer, your laptop, IPad, phone or other devices have inherent privacy risks – especially when your e-mail access is provided through your employer or when access to your e-mail messages is not password protected. HEC laptop is equipped with a firewall, a virus protection and a password, and all confidential information from the computer is backed up on a regular basis onto an encrypted hard-drive. Please, note that e-mails, faxes, and texts are all part of your clinical records. Also, be aware that phone messages are transcribed and sent to HEC via unencrypted e-mails if your phone, email, etc. is not protected. Please notify Sally High, LMHC if you decide to avoid or

limit, in any way, the use of email, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, it will be assumed that you have evaluated the risks and made an informed decision. HEC will view it as your agreement to take the risk that such communication may be intercepted, and your desire to communicate on such matters will be honored. Please do not use texts, e-mail, voicemail, or faxes for emergencies unless you are comfortable with such use after understanding the above stated risks.

-When you select online counseling via online, you will be asked to set up a free account with Virtual Therapy Connect. This is a secure messaging system that provides unparalleled privacy protection. Using the Secure Sockets Layer protocol and server encryption, Virtual Therapy Connect offers the highest possible protection for face to face therapy sessions via the computer.

-You must allow yourself 10 min before session to prepare for login, allow billing to be confirmed and paid prior to start of session. **Payment must be made before session can begin and will be confirmed before session begins or at time of scheduling.**

-You must make sure you are in a place where others are not able to hear your conversations. I can ensure HIPPA compliance on my end as I am in my office but in order for you to get the security you need, find a location that is away from others.

Thank you for seeking treatment with Sally High, LMHC. I am committed to providing you with the best possible care. I look forward to our work together.

I/We, the undersigned, have read and understand the above, have had all questions answered to my/our satisfaction, and agree to comply with all stipulations.

______________________________	____________
Signature of Client	Date
______________________________	____________
Signature of Parent/Guardian	Date
______________________________	____________
Signature of Mental Health Practitioner	Date

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CREDIT CARD ON FILE

Information to be completed by the Cardholder:

The undersigned agrees and authorizes High Expectations Counseling to charge the credit card indicated below for any account balances which include, but are not limited to fees for no show appointments. A receipt will go to your preferred email address upon completion of therapy services for your records.
________ (initial)

Preferred email address for receipt; ____

Type of Credit Card: MasterCard Visa Discover American Express other: ____________

Card Number: # ________ -_______-_______-_______ -

Expiration Date: ______________ (month/year)

Security Code: _________________ (last 3 numbers on back of card)

I, ____ authorize High Expectations Counseling LLC to process the above credit card as "Signature on File" for any balance due on my account. I understand this authorization will expire upon conclusion of care.

________________________________ ___________________________________
Cardholder's Signature Date

________________________________ _____________________________________
Signature of Mental Health Practitioner Date

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SELF HARM AGREEMENT

Client Name: ___________________________

I agree to refrain from harming, injuring, and/or endangering myself in any way including attempting suicide while I remain in therapy with Sally High, LMHC.

I agree to seek the assistance of my therapist immediately or call 911 if or when I have thoughts of self-harm and/or harm to others, regardless of the time of day or night.

______________________________ ______________________

Client Signature Date

________________________________ ______________________

Signature of Mental Health Practitioner Date