Lotus Counseling & Wellness Center

Feather Sound Square
2325 Ulmerton Road, Suite 11C
Clearwater, FL 33762
Tel. 727-744-2559

Client Information

Date:			
Name:		Social Security #	
Address:	City:	State:	Zip:
E-mail address:		May we contact you by e-mail?	
Cell Phone:	Home Phone:		
Marital: M S W D DP SEP	Race:	DOB:	Age:
Occupation:	Employer:		
Employer's Address:		Office Tel:	
Spouse:		How long together?	
Occupation:	Employer:		
If client is a minor - Parent / Guardian Information:		N/A	
Guardian Name:		DOB:	
Guardian Address *(if different from above)*:			
City:	State:	Zip:	
Minor's School:		Grade:	
Name of Emergency Contact:		Phone:	
Address:	City:	State:	Zip:
Relationship to Client:		Consent/Release Form: Yes / No	
Name of Primary Physician:		Phone:	
Address:	City:	State:	Zip:
Consent/Release Form: Yes /No	If no, briefly explain why:		
Name of Psychiatrist:		Phone:	
Address:	City:	State:	Zip:
Consent/Release Form: Yes /No	If no, briefly explain why:		
How were you referred to our office?			
Reason for Seeking Services:			
Purpose of this appointment:			

Lotus Counseling & Wellness Center

Feather Sound Square
2325 Ulmerton Road, Suite 11C
Clearwater, FL 33762
Tel. 727-744-2559

Have you ever had the same or a similar issues/condition? ____ Yes ____ No

If yes, when, and describe:

What total percentage of time during the day (at home and at your job) do you spend:

Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%
**total should add up to 100%*

NO SYMPTOMS/STRESS EXTREME SYMPTOMS/STRESS

|_____|

(Please place an "X" on the line above to indicate level of problem.)

What are your hobbies / what do you do for fun?

What medications or drugs are you taking? *(below list name / dosage / prescribing doctor):*

Other Family / Household Members: **Relationship to client, ie.child, sister, roommate, father, cousin etc.*
***attach an additional page if needed*

Name:	Age:
Relationship:	Willing to Participate? Yes / No
Name:	Age:
Relationship:	Willing to Participate? Yes / No
Name:	Age:
Relationship:	Willing to Participate? Yes / No
Name:	Age:
Relationship:	Willing to Participate? Yes / No
Name:	Age:
Relationship:	Willing to Participate? Yes / No

Client's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Therapist/Coach's Signature _____ Date:_____

Lotus Counseling & Wellness Center

Feather Sound Square
2325 Ulmerton Road
Suite 11C
Clearwater, FL 33762

Tel: 727-744-2559

Gayle@Lotuscwc.com
www.Lotuscwc.com

Office Policies & Procedures

Welcome to Lotus Counseling and Wellness Center! We thank you for choosing us and entrusting us with the care of you and your family members.

Please complete the New Client Packet and bring it with you to your first appointment. The New Client Packet consists of: *Client Information Form, Informed Consent for Services, Credit Card Authorization/ Financial Agreement Form, HIPAA Privacy Practices, Release of Information (if needed), and this form, Office Policies and Procedures.* These forms are available on our website for you to download, print, and fill out, or you can request them via email or fax and we will be happy to send them to you. It is important to take the time and complete these forms to the best of your ability *prior* to your first schedule appointment. You will not be able to receive services at your initial appointment without having the New Client Packet fully completed. ***Please note**, the signed Credit Card Authorization/ Financial Agreement is required to hold your scheduled appointment time.*

Sessions: The number or length of sessions will depend on the issues to be addressed and your commitment to the process. For the best outcome, you are expected to attend all scheduled sessions (reschedule when you cannot attend), be actively involved in sessions, voicing your thoughts, feelings, and opinions honestly and openly whether positive or negative, setting goals, completing any homework assignments, trying new behaviors and skills learned in sessions, and implementing my crisis plan (if needed). A successful outcome depends to a large degree on the amount of effort you put into this process. If at any time you feel the process is not working for you or you would like to make changes, please discuss this with us to identify potential solutions and make changes to your service plan. You are free to terminate our services at any time.

Fees: Therapy and Coaching sessions are 45-50 minutes on average, but can vary depending on your needs and our recommendations for best care. Initial sessions for both services are scheduled for 90 minutes to allow us time to complete the initial paperwork, get to know each other, and develop rapport to move forward. In the course of your care, longer sessions are often needed/recommended based on the issues being addressed. Group sessions generally range between $20-$45 per session. Telephone and internet/video sessions are available and will be charged to your credit card on file prior to the scheduled session. Discounts are offered when multiple sessions are pre-paid in advance. Please refer to the specific program Fee Summary which will provide detailed fees for the services you have selected and package pricing available. Please note that payment is due at the time of service and will be collected prior to your session.

Cancellations: All cancellations require a 24 hour notice. Please remember, if you no-show or cancel your scheduled appointment without giving 24 hours' notice of the cancellation, your credit card on file will be charged for the full cost of the missed appointment.

Emergencies: Voicemails are checked several times per day. We generally do not return calls after business hours, on the weekends, or on major holidays. In the case of an emergency please do not leave a voicemail. Instead, please call 911 for police / emergency medical assistance. If for some reason you are unable to reach/wait for 911 response, please go to the nearest hospital emergency room for immediate care. For less urgent situations that may improve through competent, professional phone intervention or to obtain 24hr resource and referral information, call First-Call-For-Help by dialing 211 from any phone.

Confidentiality & Privacy: The HIPAA Notice of Privacy Practices is provided in your New Client Packet and is also available on our website. Please be assured that all information received from you will be kept *strictly confidential* as required by law. No information will be released to another party without your written authorization and consent, except for the mandates and limitations as required by law, which were explained and agreed to, by you on the Informed Consent Form. Lotus will keep all information we originate by phone or email confidential; however, we cannot guarantee this for phone or emails that we do not originate that is up to the sender to ensure your confidentiality is protected.

If you have any questions or concerns, please let us know. At Lotus Counseling & Wellness Center our goal is to Motivate for Change and Encourage a Better You!

By signing below, you agree that you have read, understood and accept the above information.

_____	_____	_____
Client Name	**Client Signature**	**Date**
_____	_____	_____
Guardian Name ***(if client is a minor)***	**Guardian Signature**	**Date**

Lotus Counseling & Wellness Center

Feather Sound Square
2325 Ulmerton Road
Suite 11C
Clearwater, FL 33762

Tel: 727-744-2559

Gayle@Lotuscwc.com
www.Lotuscwc.com

Credit Card Authorization / Financial Agreement

Client Name:_____ DOB: _____

I, _____, authorize Lotus Counseling & Wellness Center to keep my signature on file and to charge my credit or debit card for the balance of charges related to all transactions not paid in full at the time services are rendered, to cover any / all insufficient fund/check issues, for co-payments and/or any amounts not paid by my insurance company.

I, _____, authorize Lotus Counseling & Wellness Center to charge my credit/debit card for the following professional services:

- Recurring charges for services provided, not paid in full at the time services were rendered.
- Charges for a telephone or video/internet sessions, not paid for in advance of the session.
- If payment is made by check and a check is returned due to insufficient funds, the owed amount will be charged to the credit card plus a $35 returned check fee.
- If I no-show or cancel my scheduled appointment without giving 24 hours' notice of the cancellation, the credit card will be charged for the full cost of the missed appointment.
- Any co-payments not paid at the time services are rendered.

To save time during your sessions you can authorize us to charge your payment to the credit card information you have on file.

_____ Initial here to authorize Lotus CWC to automatically charge your credit card after each session. This consent must be revoked in writing to discontinue automatic charges.

Card Type (circle one): Visa Mastercard American Express Discover

Credit / Debit Card (circle one) #: _____ Exp. Date: _____

Verification / Security Code: _____
*Verification /Security Code can be found * MC/Visa/Discover: 3 digit # on back of card by signature line; *Amex: above card number, upper right-hand side.

Name Printed on Card: _____

Billing Address: _____

Billing City: _____ State: _____ Zip: _____

Billing Phone Number: _____

Authorized Signature: _____ Date: _____

**I understand and agree that I authorize by my signature above, any/all charges as listed above. I also agree that this form is valid for the duration of my treatment and/or services received at Lotus Counseling & Wellness Center. I agree not to dispute any charges or institute any charge backs for sessions and/or services that I have received or appointments that I have failed to cancel within 24 hours, according to the policy listed above.*

Lotus Employee Signature: _____ Date: _____

Lotus Counseling & Wellness Center

Feather Sound Square
2325 Ulmerton Road
Suite 11C
Clearwater, FL 33762

Tel: 727-744-2559

Gayle@Lotuscwc.com
www.Lotuscwc.com

HIPAA - NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act - Effective date: March 25, 2007

Client Name:_____ DOB: _____

This Notice describes how medical and other information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

The privacy and confidentiality of your health information is very important, and we are committed to protecting it to the extent that we can, consistent with federal and state laws and ethics of the counseling profession. Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow the disclosure of your health information for these purposes.

Uses and Disclosures for Treatment, Payment, and Health Care Operations: We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent.

To help clarify these terms, here are some definitions:

**"PHI"* refers to information in your health record that could identify you.
**"Treatment, Payment and Health Care Operations"* Treatment refers to when a Lotus CWC provides, coordinates, or manages your
health care and other services related to your health care. An example of treatment would be when Lotus CWC consults with another health care provider, such as your primary care physician or another therapist/ life coach on your behalf. Payment is when Lotus CWC obtains reimbursement for your healthcare. Examples of payment are when Lotus CWC discloses your PHI to your health
Insurer to obtain reimbursement for your health care or to determine eligibility or coverage. Health Care Operations are activities that relate to the performance and operation of Lotus CWC. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. ·
**"Use"* applies only to activities within Lotus CWC such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.·
**"Disclosure"* applies to activities outside of Lotus CWC such as releasing, transferring, or providing access to information about you to other parties.

I. Uses and Disclosures Requiring Authorization

Lotus CWC may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Lotus CWC is asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes and/or other private information contained in your file. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Lotus CWC has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

II. Uses and Disclosures with Neither Consent nor Authorization

Lotus CWC may use or disclose PHI without your consent or authorization in the following circumstances:

*Child Abuse: If we know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that we report such knowledge or suspicion to the Florida Department of Child and Family Services.

Feather Sound Square
2325 Ulmerton Road
Suite 11C
Clearwater, FL 33762
Tel: 727-744-2559
Gayle@Lotuscwc.com
www.Lotuscwc.com

*Adult and Domestic Abuse: If we know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, we are required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

*Health Oversight: If a complaint is filed against Lotus CWC or any of its providers with the Florida Department of Health on behalf of the Board Mental Health, the Department has the authority to subpoena confidential mental health information from Lotus CWC relevant to that complaint.

*Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and Lotus CWC will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have not informed Lotus CWC that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
.

*Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, we may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

*Worker's Compensation: If you file a worker's compensation claim, we must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

III. Patient's Rights and Psychotherapist's Duties

Patient's Rights:

*Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Lotus CWC is not required to agree to the 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. (For example, you may not want a family member to know that you are seeing a provider at Lotus CWC, so upon your request, we will send correspondence to another address.)

*Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, we will discuss with you the details of the request as it is processed.

*Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may, however, deny your request. On your request, we will discuss with you the details of the amendment process.

*Right to an Accounting – In general, you have the right to receive an accounting of disclosures of your PHI. On your request, we will discuss with you the details of this process.

*Right to a Paper Copy – You have the right to obtain a paper copy of the notice from Lotus CWC upon your request, even if you have previously agreed to receive the notice electronically.

Psychotherapist's Duties:

We at Lotus CWC are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless and until, we notify you of such changes, however, we are required to abide by the terms currently in effect.

Feather Sound Square
2325 Ulmerton Road
Suite 11C
Clearwater, FL 33762

Tel: 727-744-2559
Gayle@Lotuscwc.com
www.Lotuscwc.com

If we revise our policies and procedures, we will provide a notice to you in writing indicating a change has been made and provide you a copy of the updated notice.

IV. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact, Gayle M. Elazar at 727-744-2559, who will serve as the Privacy Officer for Lotus CWC.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to Gayle M. Elazar, 2325 Ulmerton Road, Suite 11C, Clearwater, FL 33762.

If you are not satisfied, you may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We can provide you with the complete address upon request. Lotus CWC understands and agrees that you have specific rights under the Privacy Rule and we will not retaliate against you for exercising your right to file a complaint.

By signing below, you agree that you have read, understood, and accept the above information.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Guardian Name *(if client is a minor)*	Guardian Signature	Date

**If signing for a minor client, I hereby state that my parental rights and/or guardianship has not been revoked by a Court of law.*

Lotus Counseling & Wellness Center

Feather Sound Square
2325 Ulmerton Road
Suite 11C
Clearwater, FL 33762

Tel: 727-744-2559
www.Lotuscwc.com

Informed Consent for Services

Client Name:_____ DOB: _____

I, _____, am voluntarily consenting (or am giving my consent, if the client is a minor who is under my legal guardianship), to treatment and/or services provided by Lotus Counseling & Wellness Center and/or its employees.

Additionally:

- The rights, risks, and benefits associated with these services have been explained to me.
- I have been informed of, understand, and agree with the nature and purpose of evaluation, coaching, and/or treatment or other services, the approximate length of treatment/services, and alternative treatment/service modalities that may be used throughout the course and scope of my treatment/ services with Lotus Counseling & Wellness Center.
- I have read, understand and agree with the HIPAA Privacy Practices contained in the New Client Packet.
- I understand that I have the right to discontinue or withdraw from this treatment / coaching services at any time.
- Disclosure of PHI for Emergency Purposes: I authorize Lotus Counseling & Wellness Center to disclose my PHI in case of an emergency and (b) to release or obtain any PHI to and from hospitals, the police, or other health care and/or related providers, which is necessary to aid in the emergency situation, but only to the extent that is necessary for the emergency, and as allowed by HIPAA Privacy Policy.

I understand the Limitation of Confidentiality as listed below:

- *Abuse of Children and Vulnerable Adults:* If a client states or suggests that he or she is abusing a child or vulnerable adult or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, a mental health professional is required to report this information to the appropriate social service and/or law enforcement.

- *Duty to Warn and Protect:* When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim when possible and report this information to law enforcement. When a client discloses or implies a plan for suicide or fatal risk of self-harm, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family and/or legal guardian of the client.

By signing below, you agree that you have read, understood, and accept the above information.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Legal Guardian Name *(if client is a minor)*	Guardian Signature	Date

**If signing for a minor client, I hereby state that my parental rights and/or guardianship has not been revoked by a Court of law.*