Adventure Therapies
SLB, LLC

Date: _____ Client Name: _____ Date of Birth: _____

Age: _____ Gender: Male / Female

Client Address: _____ City: _____ Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Okay to contact at work? Yes / No

Email address: _____ Okay to email? Yes / No

Okay to leave message: (circle approved location) home cell work

Okay to text: yes no

Emergency Contact (Name & Phone Number):_____

Referred by: _____

Reason for referral: _____

Insurance

Company Name and Phone Number _____
Billing Address _____
Name of Insured and Relation to Patient _____
Insured's ID/Member Number _____ Group Number _____
Date of Birth of Insured: _____ SSN of Insured _____
Address of Insured if different from patient: _____

Counselor Use:

Date of first appointment: _____ Time of first appointment: _____

Financial Obligations and Policies discussed: yes / no comments: _____

_____

Copy of Insurance Card on File (if applicable): yes / no

Comments: _____

_____

Adventure Therapies
SLB, LLC

Policies, General Information, and Informed Consent
Agreement to Provide Psychotherapy Services

CONSENT: I, _____ give my consent and approval for Susan Brenner, LISW, LCSW (therapist), to work with me in therapy. I understand that the therapy sessions are confidential. By signing below I am stating approval of services. I understand that I am consenting to treatment and I have read this policy, general information, and informed consent agreement.

CONFIDENTIALITY: Adventure Therapies, SLB, LLC is required to keep timely records of therapy and maintain confidentiality of all records. All information disclosed within sessions and the written records pertaining to those sessions and communication between client and therapist are confidential and may not be revealed to anyone without your (client's) written permission, except where required by law. In the event that a counselor is incapable of continuing therapy services due to illness or death, files will be accessed by a designated therapist who will keep the confidentiality of those files as expected and continue services if jointly agreed upon. Therapy files are kept for seven years.

WHEN LAW REQUIRES DISCLOSURE: The State of Florida requires that Adventure Therapies, SLB, LLC inform you that under the following circumstances, confidentiality will be breached:

1. When there is cause to suspect a child, adolescent, or elder has been or may be abused or neglected.
2. When there is reasonable cause to believe that someone poses risk of imminent harm to themself.
3. When there is reasonable cause to believe that someone poses risk of imminent harm to another individual.
4. When there is a valid court order compelling records or witness testimony.

SUPERVISION AND CONSULTATION: If any representatives of Adventure Therapies, SLB, LLC are serving a Registered Marriage and Family Therapy, Social Work, or Mental Health Counseling Intern, working towards licensure, it has been disclosed during your intake session and you are fully aware of this status. During this time, those Registered Intern representatives will be supervised by Susan Brenner, LISW, LCSW, and any other needed licensure supervisor, which will be disclosed, to ensure that you are receiving the highest quality of services. In addition, all representatives of Adventure Therapies, SLB, LLC consult regularly with other professionals regarding clients; however, client's names or other identifying information are never mentioned. The client's identity remains completely anonymous and confidentiality is fully maintained.

YOUR RIGHTS: As a client, you have the right to terminate treatment at any time and request appropriate referrals from Adventure Therapies, SLB LLC. If at any time you want another professional's opinion or wish to consult with another therapist, your assigned Adventure Therapies, SLB LLC counselor will assist you in finding someone qualified. If your written consent has been obtained, the counselor will provide the new therapist with the essential information needed. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Adventure Therapies, SLB LLC assesses that releasing such information might be harmful in any way. In such a case, Adventure Therapies, SLB LLC will provide the records to an appropriate and legitimate mental health professional of your choice.

PAYMENTS: Clients are expected to pay by cash, check, or credit card (Visa, MasterCard, Discover, or American Express) at the rate of $200 per 55-minute initial evaluation session and $150 per 55-minute session thereafter at the time of service unless other arrangements have been made. Telephone conversations, emails, site visits, school observations, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. may be charged at the same rate as indicated and agreed upon. If you are receiving Victim's Compensation or any other insurance benefit to help pay for your sessions, please be aware that you are fully responsible for any charges not covered by those benefits, which include but are not limited to, services provided after the exhaustion of benefits, or missed appointments. Please notify Adventure Therapies, SLB LLC if any problem arises during the course of therapy regarding your ability to make timely payments.

APPOINTMENTS & CANCELLATIONS: Appointments are reserved specifically for you, therefore a 24-hour cancellation notice is required if you are unable to attend a scheduled appointment. You will be charged $60 for missing an appointment or not giving 24 hours' prior notice to cancelling an appointment.

INSURANCE: I hereby authorize payment of medical benefits to Adventure Therapies, SLB LLC, I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by insurance, if Adventure Therapies, SLB LLC is not a participating provider in my insurance network. I agree to pay all copayments, coinsurance, and deductibles at the time service is rendered.

In case of emergency with therapist, you authorize a representative of Adventure Therapies, SLB LLC to notify you of any appointment changes that may occur. This may include another counselor or administrative person within Adventure Therapies, SLB LLC. If you need to contact Susan Brenner, LISW, LCSW, telephone calls are returned within 24 hours, with the exception of Sundays and holidays. A message can always be left on confidential, office voicemail and your call will be returned. Email is only an appropriate mode of communication for non-therapeutic issues (i.e. appointment re-scheduling, etc.), however should NEVER be used for emergencies or time-sensitive issues. Email responses will be returned as soon as possible, generally within 48 hours of receipt.

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

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist Date

NOTICE OF PRIVACY PRACTICES
for
Adventure Therapies, SLB, LLC

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 7/26/16 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you. Co-payments are due at the time of service. If your portion of the bill is not paid within 90 days from the last date it was incurred, a letter will be sent to pay your account or to arrange for a payment plan.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to the use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in affect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Communication with Family: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so in writing.

Marketing Health-Related Services: We will NOT use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law, such as a subpoena or in regards to “Duty to Warn”.

Duty to Warn: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, or letters) with your authorization.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health and Human Services.

Contact: Susan Brenner, LISW, LCSW
Telephone: 239-682-3251
Address: 5020 Tamiami Trail N., #202, Naples, FL 34103

Receipt and Acknowledgment
of Privacy Practices Notice

Client Name: _____ Date of Birth: _____

I hereby acknowledge that I have received a copy of Adventure Therapies, SLB LLC. Notice of Privacy Practices and had the opportunity to ask questions and discuss the privacy rights described therein. I understand that if I have further questions regarding the Notice or my privacy rights, I can contact my therapist at her telephone number.

_____ _____
Signature of Patient/Client Date

☐ Client refused to acknowledge receipt.

Adventure Therapies
SLB, LLC

Client Rights and Informed Consent – Guideline

- I have chosen to receive treatment services and understand I may terminate therapy at any time, unless ordered by the court.
- I understand there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.
- I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my problems.
- I understand that records and information collected about me will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.
- I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.
- I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.
- I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
- I understand that I may be contacted by my health plan to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.
- I have read and had explained to me the Basic Rights of Individuals including:
    - The right to be informed of the various steps and activities involved in receiving services.
    - The right to share in the formation of the plan of care/treatment plan.
    - The right to confidentiality under federal and state laws relating to the receipt of services.
    - The right to humane care and protection from harm, abuse, or neglect without regard to race, color, religion, gender, sexual orientation, age, disability, or cultural background.
    - The right to make an informed decision whether to accept or refuse treatment.
    - The right to contact and consult with counsel at my expense.
    - The right to select practitioners of my choice at my expense.

I understand that my therapist, health plan representatives, and my primary care physician may exchange any and all information pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

_____ _____

Signature of Patient/Client Date

Adventure Therapies
SLB, LLC

Treatment Agreement

PLEASE INITIAL:

Co-payments are due at the time of service. _____

I hereby assign payment of insurance benefits directly to SLB, L.L.C. While SLB, L.L.C. will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay. _____

I accept responsibility for fees that exceed the payment made by insurance, if Adventure Therapies, SLB LLC is not a participating provider in my insurance network. _____

If your portion of the bill is not paid within 90 days from the last date it was incurred, a letter will be sent to pay your account or to arrange for a payment plan. _____

All individual therapy sessions are 55 minutes, in length. _____

Fees are $200 for the initial session and $150 for sessions thereafter. _____

You will be charged $60 for missing an appointment or not giving 24 hours' prior notice to cancelling an appointment. _____

I understand and agree to abide by my financial responsibilities. I understand that information will be released to my insurance company, if necessary, and any charges denied by my insurance company will be my responsibility.

_____ _____

Signature of Patient/Client Date

Adventure Therapies
SLB, LLC

Pre-Authorized Mental Health Care Payment Form

I, _____, authorize Susan Brenner, LISW, LCSW, of Adventure Therapy, SLB, LLC to keep my signature on file and charge my credit card account for:

*Charges for appointments attended (fees for services rendered)
*Charges for missed appointments (no show fees)
*Balances for charges not paid within 90 days

I understand that I may revoke this agreement at any time by a written request.

Client name: _____

Cardholder name: _____

Cardholder billing address: _____

Account number: _____ Billing Zip Code _____

Expiration date: _____ CVV: _____

Signature: _____

Susan Brenner, LISW, LCSW, agrees to charge only for reasons stated above at the agreed upon rates as committed to in policy letter.