JAMES M. REINACH, LMHC, MCAP, NCC

Welcome!

Congratulations on your decision to begin counseling. Please take a few minutes and read and fill out the paperwork attached. The therapy session will be 45-50 minutes in length. Please be aware that I will make every effort to be available at your appointment time. Thank you.

JAMES M. REINACH, LMHC, MCAP, NCC

Client Information

Name:_____

Address:_____City/Zip:_____

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

E-Mail: _____

Age:_____ Date of Birth:_____ Sex: Male_____ Female_____

Social Security Number: XXX-XX- _ _ _ _ Education_____
(Last grade completed)

Marital Status: Single____ Married_____ Separated____ Divorced_____ Other_____

Occupation:_____ Company: _____

Person to contact in emergency:_____ Relationship_____

Telephone Number(s): Home_____ Work_____ Cell_____

Billing Information:

Insurance Company:_____

Address:_____

Phone Number:_____

Member ID or Policy Number:_____

This insurance policy lists you as: ___ Primary Subscriber ___ Dependent

Dependent relationship: Spouse_____ Child_____ Other_____

Primary Subscriber's name (if different from Client): _____

Date of Birth:_____ Employer:_____

You were referred by: _____

JAMES M. REINACH, LMHC, MCAP, NCC

Procedure for Telephone Contact

Please note that it is sometimes necessary to notify you of a change in appointment time. Please be assured that your confidentiality is very important at these times and if you cannot be reached a message will be left with only a first and last name and phone number. Please initial here as to the procedure you wish to be followed:

_____ Do not contact me under any circumstances

_____ Yes, you may contact me as described above

_____ Yes, you may contact me, but only under these conditions:

_____

JAMES M. REINACH, LMHC, MCAP, NCC

Notice of Therapist Availability

Please be advised that I am not available at all times. I will attempt to return phone calls in a timely manner for brief conversations between sessions when needed.

In the event that you cannot reach me at any given time (day, evening, weekend, holiday) and you feel it is an emergency, go to any emergency room for a psychological consultation, or call 911. Keeping yourself safe is your responsibility and if you are unable to do this you must contact me, your Primary Care Physician, or 911.

Signature_____ Date_____
(Client)

Signature_____ Date_____
(Witness)

JAMES M. REINACH, LMHC, MCAP, NCC

Agreement for Service/Informed Consent

1. I have chosen to receive psychotherapy services. My choice is voluntary and I understand that I may terminate at any time.

2. I understand that there are no assurances that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with the therapist in a cooperative manner to resolve my difficulties.

3. I understand that during psychotherapy, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

4. I have read and had explained to me the basic rights of an individual receiving mental health treatment. These rights include:

   a. The right to be informed of the various steps and activities involved in receiving services.
   b. The right to confidentiality under federal and state laws relating to the receipt of services.
   c. The right to make an informed decision whether to accept or refuse treatment

5. I understand that each individual appointment is scheduled for approximately 45-50 minutes . If I am unable to keep the appointment, I will call James M. Reinach at (813) 629-6890 to cancel 24 hours before the appointment.

Client_____ Date_____
(Signature)

Witness_____ Date_____
(Signature)

JAMES M. REINACH, LMHC, MCAP, NCC

Financial Responsibility

I, _____, understand that I am responsible for any service rendered, regardless of whether this service is covered by insurance. I further understand that it is my responsibility to give James M. Reinach 24 hours notice if I am going to cancel my appointment. Failure to notify may result in a charge commensurate with the total session fee, up to $50.00.

_____ _____

(Client's Signature) (Date)

JAMES M. REINACH, LMHC, MCAP, NCC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: CLIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____

Date of Birth:_____

SECTION B: TO THE CLIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

JAMES M. REINACH, LMHC
1111 Oakfield Drive Suite 115E
Brandon, FL 33511

Phone: (813) 629-6890
Fax: (813) 651-9778

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to JAMES M. REINACH, LMHC, MCAP, NCC at the address above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____Date_____

If this consent is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name:_____

Relationship to Client:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in the client's file

JAMES M. REINACH, LMHC, MCAP, NCC

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

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 April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the 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 may use and disclose health information about you for treatment, payment, and healthcare operation For example:

Treatment: We may use or disclose your health information to your Primary Care physician, psychiatrist, or other healthcare provider.

Payment: We may use and disclose your health information to your insurance company or Employee Assistance, in order to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. These activities are limited to billing, treatment planning, audits by insurance companies or state agencies, requests for authorizations from insurance companies or other payers and regulatory boards or agencies involved in audits for licensing and credentialing purposes.

Your Authorization: In addition to our 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 disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason, with the following exceptions:

a. If I sign a waiver requesting release of information.
b. If a court orders the release of my records.
c. If I raise the matter of my mental status or competency in legal proceedings.
d. If there is reason to believe that there is a clear and immediate probability that I will harm myself or others.

To Your Family and Friends: We must disclose your health information to you, as described in the Client Rights section of this Notice. We may disclose your health information to a family member, friend or other person only with a release signed by you authorizing release of confidential information specifically to that person.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to that person's involvement in your healthcare.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Harm to Self or Others/Abuse or Neglect: We may disclose your health information directly to the Florida Department of Children & Families in the case of abuse or neglect.

The Florida Legislature has enacted laws to protect a client's confidentiality while under the care of a Licensed Mental Health Counselor. Confidentiality refers to the broad expectation that what is revealed by individuals in therapy will not be shared with third parties. The concept of confidentiality is designed to allow for the free and open discussion of material. As with most laws within our country and Florida, there are limitations. You will find below the limitations of this confidentiality as determined by the Florida Psychological Services Act (491.0) and Florida Statutes 415.504 and 415.103.

Florida Statute 491
In essence this statute requires Licensed Mental Health Counselors to breach confidentiality if it is determined that a client presents a danger of harm to him/herself or others. If a client presents an imminent danger to someone else, then that person must be notified according to Florida Statutes "Duty to Warn". If a client presents a danger to himself or herself, then appropriate therapeutic intervention is mandated, which may include hospitalization.

Florida Statute 415.504
This Florida statute requires the mandatory reporting of any knowledge of child abuse or neglect. This information must be reported to the Department of Children and Families verbally and in writing. It is the policy of this office to notify the client prior to reporting such information to the Department of Children and Families. This prior notification is a courtesy provided to the client and in no way will inhibit or delay the report of suspected abuse or neglect.

Florida Statute 415.103
This statute requires the mandatory reporting of any knowledge of abuse, neglect, or the exploitation of the aged or disabled adults. This information must be reported to the Department of Children and Families both verbally and in writing. Again, it is the policy of this office to notify the client prior to the reporting of such information. This prior notification is a courtesy provided to the client and will in no way inhibit or delay the report of suspected abuse or neglect.

CLIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We will prepare a summary or an explanation of your health information upon your written request.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information, other than treatment, payment, and healthcare operations and certain other activities for the last six years, but not before April 14, 2003.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or location.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

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 us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, or to the U.S. Department of Health and Human Services. The addresses for the above entities are available 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, with the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, or with the U.S. Department of Health and Human Services.

Contact Information: JAMES M. REINACH, LMHC
Phone: (813) 629-6890
Fax: (813) 651-9778

JAMES M. REINACH, LMHC, MCAP, NCC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgment

I, _____
Please Print Name

have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgment

___ Other (Please Specify)

_____

_____

_____