FLORA
AND ASSOCIATES

SOCIAL HISTORY INTAKE

Your cooperation in completing this questionnaire will be helpful in planning my services for your child.

Child's Name:
DOB:
Grade:
Home Address
Parent #1 Name and Cell:
Parent #1 email:
Parent #2 Name and Cell:
Parent #2 email:
Child phone number:

Who suggested that you contact me?_____

Briefly describe your reason for seeking help for your child:

_____
_____
_____
_____
_____
_____
_____
_____
_____

CHILD'S EDUCATION:

Name of School	
Grade	
Does your child have any learning issues?	
How would you describe your child's performance in school?	
Has your child ever been evaluated by the Child Study Team?	
Does your child receive special education services?	
School Attendance	

FAMILY INFORMATION:

Parent #1's name:_____Age:_____Occupation:_____

Education of Parent #1:_____

Parent #2's name:_____Age:_____Occupation:_____

Education of Parent #2:_____

Marital
Status:_____

(If divorced include date of separation and final divorce)

FAMILY INFORMATION (CONTINUED)

List of brothers and sisters of the child:

Name	Sex	Age	Indicate where the child lives (include 2 households if necessary)

Religion:_____

MEDICAL HISTORY:

When was your child's last physical exam:_____

Your child's pediatrician:_____

List any major health problems for which your child currently receives treatment:

_____

_____

_____

List any medications your child is currently taking:

Medication	Dosage	Effectiveness

List any other important information that you think may be helpful:

_____

_____

List any hospitalizations your child has had (include dates of hospitalization):

_____
_____
_____
_____
_____

Please circle any of the following problems which pertain to your child:

Nervousness	Temper	Poor Appetite
Shyness	Bowel Troubles	Nightmares
Separation	Depression	Suicidal Thoughts
Drug Use	Alcohol Use	Anxiety
Anger	Self Control	Unhappiness
Fighting	Stress	Completing Tasks
Sleep	Headaches	Tiredness
Relaxation	Memory	Making Decisions
Isolation	Peer Relationships	Concentration
Trauma	Inferiority Feelings	Health Problems
Loneliness	Fear of Death	Stomach Trouble
Education	Other Fears	Expressing Feelings

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

Patient Name _____

Date of Birth _____

Address _____

Phone _____

I authorize Flora & Associates LLC to use or disclose information from my mental health record, which may include information about psychiatric diagnosis, treatment & substance abuse to the following agency/provider for coordination of care.

Name: _____

Phone _____

Address:_____

1. I understand that, unless withdrawn, this authorization will not expire unless requested otherwise. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Flora and Associates LLC, in writing, and this authorization will cease to be effective on the date notified.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

By signing below, I acknowledge that I have read and understand this authorization.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian Date

FLORA
AND ASSOCIATES

48-HOUR CANCELATION POLICY

You will never be charged for a cancellation if it is made more than 48 hours in advance of your scheduled appointment time.

Reason for this Policy: Notifying your therapist of your intention to cancel or reschedule 48 hours in advance gives our office an opportunity to schedule someone else for that time slot. This is important because others may be on a waiting list or may also be looking for an opportunity to reschedule for a different time. As much advance notice as possible is always appreciated.

IF YOU CANCEL YOUR APPOINTMENT WITH LESS THAN 48 HOURS NOTICE, YOU WILL BE CHARGED FOR THE MISSED APPOINTMENT.

If you simply do not show up for a scheduled appointment you will be charged for the missed appointment. Because it is illegal to bill your insurance company for a missed appointment, you will pay the full fee for the missed session out-of-pocket.

This cancellation policy is standard in the medical and mental health fields and will be strictly enforced. On occasion, there will be understandable reasons for missing appointments.

Please sign below to indicate you have read, understand, and agree to abide by my cancellation policy.

Thank you.

_____

Signature & Date

AUTHORIZATION FOR RELEASE OF ARTWORK

Patient Name _____
Date of Birth _____
Address _____
Phone _____

Throughout my treatment I have participated in therapy I used art as a means for self-expression. I authorize Flora and Associates LLC to use images of my artwork on their website, social media and for educational material related to therapy. I _____ understand that my artwork will not have my name attached to it due to confidentiality.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent Legal Guardian Date

Email Consent

I, _____, give consent for Flora & Associates LLC, to share healthcare- related communications with our family and our treatment team via email.

In accordance with the HIPAA Privacy Rule, Flora & Associates LLC uses appropriate safeguards to protect the privacy and security of electronic Protected Health Information (ePHI). ePHI is stored in an encrypted, HIPAA compliant environment. Additionally, Flora & Associates' email messages are sent using an encrypted connection -- Transport Layer Security (TLS). However, if a client's email provider does not support TLS, Flora & Associates' email system will fall back to an unencrypted connection.

By consenting, the above named client acknowledges that email messages may contain electronic Protected Health Information (ePHI), and also recognizes that email messaging is not a completely secure means of communication.

Clients are not required to give consent, and consent may be withdrawn at any time

Parent or Legal Guardian Signature: _____ Date: _____

Client Signature: _____ Date: _____

PATIENTS RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ***("HIPAA")***

1. Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition or obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider).
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research- related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves the office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. ***Special Instructions for the completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis an progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

Notice of HIPAA Privacy Practices

Acknowledgement Form

This form must be signed upon receipt of the attached Notice of Privacy Practices and returned with the application. A Parent or the Legal Guardian must sign.

I, _____ (print name), hereby acknowledge that I have received the Notice of Privacy Practices on _____ (date).

Name of Client (Please Print):

_____

Name of Parent/ Legal Guardian (Please Print):

_____

Client Signature: _____ Date: _____

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, _____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If

we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____ and my emergency contact person's name, address, phone: _____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian: _____

Date: _____

Signature of therapist: _____

Date: _____

Consent to Services & Standard Notice Form

Part I: Your Rights as a Client

1. You have the right to ask questions about any procedures used during therapy; if you wish, I will explain my usual approach and methods to you.
2. You have the right to decide *not* to receive therapeutic assistance from me; if you wish, I will provide the names of other qualified professionals whose services you might prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued.
4. You have the right to review records in the files at any time.
5. One of your most important rights involves confidentiality: Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission.
6. If you request it, any part of your record in the files can be released to any person or agency you designate. I will tell you, at the time, whether or not I think releasing the information in question to that person or agency might be harmful in any way to you.
7. You should also know that there are certain situations in which I am required *by law* to reveal information obtained during therapy to other persons or agencies *without your permission.* Also, I am not required to inform you of my actions in this regard. These situations are as follows: a) if you threaten grave bodily harm or death to another person, I am required by law to inform the intended victim and the appropriate law enforcement agencies. b) If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in the subpoena. c) If you reveal information relative to child abuse and neglect, I am required by law to report this to the appropriate authority; and d) if you are in therapy or being tested by order of a court of law, the results of the treatment or tests ordered must be revealed to the court.

Part II. The Therapeutic Process

One major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a greater understanding of personal goals and values; this may lead to greater maturity and happiness as an individual. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy.

In working to achieve these potential benefits, however, therapy will require that firm efforts be made to change and may involve the experiencing of significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings of fear, anger, depression, and frustration. Seeking to resolve issues between family members, marital partners, and others persons can similarly lead to discomfort, as well as relationship changes that may not be originally intended.

Part IV: Good Faith Estimate

Effective January 1, 2022, a ruling went into effect called the “No Surprises Act,” which requires mental health practitioners to provide a “Good Faith Estimate” (GFE) about out-of-network care to any patient who is uninsured or who insured but does not plan to use their insurance benefits to pay for health care items and/ or services.

The Good Faith Estimate works to show the cost of items and services that are reasonably expected for your mental health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment.

You are entitled to receive this “Good Faith Estimate” of what the charges could be for psychotherapy services provided to you or your child. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person upon the initiation of psychotherapy, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

Good Faith Estimate:

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

Depending on environmental factors, family dynamics and ability to implement therapeutic tools, you may need between 20 to 40 sessions this year. I agree to pay $300.00 for the initial session. Following the initial assessment session, I agree to pay $175.00 for each completed (fifty three minute session). I understand that payment is expected at time of session.

Flora & Associates recognizes every client’s therapy journey is unique. How long you need to engage in therapy and how often you attend sessions will be influenced by many factors including:

- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances
- Ability to implement therapeutic tools and strategies

You and your therapist will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge and/ or a new “Good Faith Estimate” will be issued should the frequency of session(s) or needs change. As related, you may request a new GFE at any time in writing during your treatment.

Good Faith Estimate Disclaimer:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. Your provider may recommend additional services that are not reflected in this Good Faith Estimate.

The Good Faith Estimate is only an estimate—actual items/ service charges may differ. The Good Faith Estimate does not include any unknown or unanticipated costs that may arise and are not reasonably expected during treatment due to unforeseen events. You could be charged more if complications or special circumstances occur. Other potential items and/ or services associated with therapy charges may include but is not limited to no show/ late cancellation fee(s), record request(s), letter writing(s), legal fee(s)/ court attendance(s), professional collaboration(s), and in-between session supports). These potential items / services and associated fee(s) are discussed further within the Informed Consent documentation and should these items / services be initiated a new Good Faith Estimate will be provided. The Good Faith Estimate does not obligate the client to obtain listed items or services.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

With my signature, I am saying that I agree to get the items or services from Flora & Associates LLC. With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, and have to pay out-of-network under my health plan.
- I was given a written notice that my provider is not in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying Flora & Associates in writing.
- You can choose to get care from a provider or facility in your health plan's network.

Client Name :_____

Client Signature:_____

Parent/ Legal Guardian Name:_____

Parent/ Legal Guardian Signature: _____

Date:_____

Credit Card Documentation

Client Name: _____

Name on Card: _____

Card Number: _____

Expiration Date: _____

Security Code: _____

Zip Code: _____

I _____ give permission for Flora & Associates LLC to keep my credit card information on file for payment of therapeutic services provided.

Signature: _____