FLORA
AND ASSOCIATES

SOCIAL HISTORY INTAKE

Name:
DOB:
Occupation:
Home Address
Cell:
Home Phone:
Email:
Emergency Contact/Relationship:
Emergency contact phone number:

Who suggested that you contact me?_____

Briefly describe your reason for seeking help:

_____
_____
_____
_____
_____
_____
_____
_____

FAMILY INFORMATION:

Spouse/ Significant Other name:_____ Age:_____

Occupation:_____

Child #1 Name_____

Age:_____

Child #2 Name_____

Age:_____

Child #3 Name_____

Age:_____

Marital
Status:_____
(If divorced include date of separation and final divorce)

Religion:_____

MEDICAL HISTORY:
Last physical exam:_____

Your Primary Care Physician:_____

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 (include dates of hospitalization):
_____
_____
_____

Please circle any of the following problems which pertain to you:

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 I understand that, unless withdrawn, this authorization will not expire unless requested otherwise.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

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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

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

Client Signature: _____ Date: _____

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):

_____

N

Client Signature: _____ Date: _____

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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.

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: _____