ATTAIN YOUR DREAMS

Coaching and Counseling Services, PL

INITIAL CONSULTATION FORM

For Coaching and Counseling

INTRODUCTION

Sandra Shern, LMHC

I welcome you and respect your decision to enter into counseling or life coaching. My approach to is both educational and therapeutic in order to assist you in working through problems and gaining more from life. I am eclectic in style, utilizing the most appropriate technique for each client as needed.

MY BACKGROUND

I hold two Master's of Science Degrees, one in Human Resources and a second Master's in Mental Health Counseling. I am a Licensed Mental Health Counselor as deemed by the State of Florida, and my training in Hypnotherapy meets the state regulations for certification. Additionally, I am Myers-Briggs Qualified and a Certified Employee Assistance Professional. I work with individuals and couples. I specialize in stress, relationships, depression, EAP, and life coaching.

I do not perform psychological evaluations, testify in court or become involved in legal procedures.

GETTING THE MOST FROM OUR SESSIONS

Coaching and counseling is most effective if you attend once a week until your goals are achieved. At that point, we will discuss the amount of sessions needed in order to terminate counseling. At each session we will review your progress and discuss how many sessions will be needed to complete a course of treatment.

APPOINTMENTS

Sessions are 45 minutes in length.
If you must reschedule an appointment, at least 48 hours notice is required to avoid being charged.

FEES

$150.00 per session unless otherwise arranged. We can also create a program/ package for you. If more time is needed and available then the typical 45 minute session, this will be charged per half hour.

CONFIDENTIALITY

All therapy sessions are confidential except when the laws regarding confidentiality take precedent or overrules the right to privacy, as when (1) issued a court ordered or subpoena, (2) there is intent to hurt or kill yourself or someone else, (3) report or

suspicion of child abuse, and (4) when you have agreed, in writing for therapeutic information to be shared with me, another therapist, physician, lawyer, insurance company or anyone with whom you have signed a “release of information” and (4) in accord with all new HIPAA regulations.

LEGAL MATTERS

If you are involved in or are contemplating litigation or legal proceedings or custody disputes, it is very important to inform me.

CELL PHONES / PAGERS

Please turn off cell phones and pagers during our sessions.

EMERGENCIES

It is important to know that I am not available 24 hours a day. I will typically return a phone call within 48 hours. If you should have an emergency, listed below are some resources. (You may have to dial “1” plus the area code -- 305, 954, 561, etc., depending upon where you live.) A psychiatrist, physician or pharmacist should be consulted to answer medical questions. If you are suicidal or are experiencing a true emergency, call 911, a local hospital, your psychiatrist and/or crisis line.

CRISIS, INFORMATION, ELDER HELP, TEEN HOT LINE - PALM BEACH COUNTY (From land line dial: 211 / From a cell phone dial: 383-1112)

MENTAL HEALTH ASSOCIATION: (Palm Beach County) 561-832-3755.

SOUTH COUNTY MENTAL HEALTH CENTER: (561) 637-2101

FAIR OAKS HOSPITAL: (Boca/Delray) 561-498-4440

The RENFEW CENTER [Eating Disorders]: www.renfewcenter.com

DIVORCED AND SEPARATED HELP: Groups at Spanish River Church 561-994-5000 or Center for Group Counseling 561-483-5300.

NATIONAL DOMESTIC VIOLENCE HOTLINE: (Crisis intervention and referral 24/7) 1-800-799-7233 or 1-800-787-3224; Website: www.ndvh.org/ Fax: 512-453-8541.

FL DOMESTIC VIOLENCE HOTLINE: (800) 621-4202

“WOMEN IN DISTRESS” (Abuse) -- 954-761-1133 (24hr.)

ELDER HELPLINE: 1-800-963-5337 / ABUSE HOTLINE: 1-800-962-2873 (1-800-96-ABUSE)

REFERRAL FOR MEDICATION (IF SUGGESTED): Veronica Motiram, MD (561) 364-0945

AGREEMENT

By signing below, I acknowledge having read and understood the above information. Further, I agree to any and all stipulations in this document as to partaking in counseling/psychotherapy with Sandra Shern. I also attest that I have received a copy of my privacy rights.

[Photocopy this for your records.]

Name: _____
Please Print

Signature: _____

Date: _____

PERSONAL DETAILS

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Date:

Name:

Address:

Phone Numbers: OK to leave message? ☐

Email Address: Accept Text? ☐

Emergency Contact (Name and Phone):

Date of Birth: Place of Birth:

Insurance Company:

Primary Cardholder:

Group Number: ID Number:

State in your own words the nature of the problem or what you are here to accomplish: What are your goals?

Have you had previous counseling? If so, when and where:

Check any of the following symptoms that apply to you:

Headaches	☐	Fainting Spells	☐
No Appetite	☐	Palpitations	☐
Stomach Trouble	☐	Sleep Problems	☐
Bowel Disturbances	☐	Fatigue	☐
Alcoholism	☐	Nightmares	☐
Feel panicky	☐	Tremors	☐
Feel Tense	☐	Suicidal Ideas	☐
Take Drugs	☐	Depressed	☐
Sexual Difficuties	☐	Shy with people	☐
Unable to relax	☐	Inferiority Feelings	☐
Can't make decisions	☐	Don't like weekends	☐
Memory problems	☐	Can't make friends	☐
Can't keep a job	☐	Poor home conditions	☐
Financial problems	☐	Weight loss/gain	☐
Concentration difficulties	☐	Job change	☐
Dizziness	☐	Easily distracted	☐
Unable to have a good time	☐	Relationship problems	☐
Difficulty completing tasks	☐		

List others:_____

_____

_____

FAMILY MEMBERS

List family members (Parents, Siblings, Children):
NAME, AGE, GRADE/OCCUPATION, RELATIONSHIP AT HOME: (Yes/No)

Has anyone in your family ever suffered from alcohol/drug abuse, depression, anxiety or mental illness?

If so, whom and what symptoms?

EMPLOYMENT

Occupation:

Employer:

What kind of work would you prefer to do?

DRUG AND ALCOHOL USE

How much of the following alcoholic beverages do you drink on the average:

	Daily	Weekly
Glasses of wine	☐	☐
Cans or bottles of beer	☐	☐
Shots of hard liquor	☐	☐

	NO	YES
Has anyone ever suggested that you might have a drinking problem?	☐	☐
Have you ever considered cutting down your drinking?	☐	☐
Has your drinking or drug use ever been called to your attention at work?	☐	☐
Have you ever been charged with DUI or DWI?	☐	☐

Have you ever taken the following drugs:	NO	YES
Prescription: Tranquilizers, amphetamines, steroids, etc.?	☐	☐
Non-prescription: Marijuana, cocaine, etc.?	☐	☐
Do you smoke?	☐	☐
Do you want to stop?	☐	☐

MEDICAL HISTORY

Please list any diseases or medical symptoms that have you have currently or any major problems that you have had in the past:

Are you currently taking any medications? YES ☐ NO ☐

If yes, name:

Prescribed by: Dosage:

Have you ever thought you were having a nervous breakdown?

If yes, describe and give approximate date(s)

Hospitalizations? If so, when?

Why?

Have you ever attempted suicide? If so, when?

Have you ever overdosed from a drug? If so, when?

CONSENT FOR TREATMENT

To the best of my knowledge the above information is true and factual.

Client signature: _____ Date: _____

Therapist signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable federal and state laws as well as our professional codes of ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. When your information is shared for these purposes it is always the “minimum necessary “ required for providing your treatment. We may disclose PHI to any other consultant or treatment provider but only with your prior authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your consent for treatment. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities or operations including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required By Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures of individually identifiable health information permitted by law without an authorization from you.

Without Authorization. Applicable law and ethical standards permit us to disclose information

about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

• Required by Law, such as the mandatory reporting of child/elder abuse or neglect, or mandatory government agency audits or investigations (such as a government licensing board and regulatory organizations)
• Required by a Court Order
• Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
• To report a crime committed against the program's staff or while on the premises.
• In case of an emergency, and then only the minimum information needed to respond to that emergency
• When the person or agency is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the information would be limited to that action.

VERBAL PERMISSION

We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI
You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at the Sandra Shern, LMHC, 7301 W. Palmetto Park Road, Suite 205A, Boca Raton, FL 33433

• Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and receive a copy of your PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
• Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
• Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
• Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
• Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
• Right to a Copy of this Notice. You have the right to a copy of this privacy notice.

COMPLAINTS
If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at the Sandra Shern, LMHC, 5301 N. Federal Highway, Suite 370, Boca Raton, FL 33487; OR with the Secretary of Health and Human Services at 200 Independence Avenue, SW Washington, D.C. 20201 or by calling (202) 619-0257. Sandra Shern will not retaliate against you for filing a complaint.

The effective date of this Notice is April 14, 2003.