

Twelve Stones

2461 West SR 426, Suite 1051
Oviedo, FL 32765

GENERAL INFORMATION

Date: _____ Referred by: _____

Full Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

Nick Name: _____ Name You Prefer: _____

Social Security: _____ Age: _____ Date of Birth: _____

Race: White Black Hispanic Asian Other: _____ Sex: Male Female

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: Yes No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: Yes No

Home Phone: (_____) _____ May We Leave a Message Here: Yes No

Mobile Phone: (_____) _____ May We Leave a Message Here: Yes No

Work Phone: (_____) _____ May We Leave a Message Here: Yes No

Email Address: _____ May We Send Email Here: Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

EDUCATION INFORMATION

Last Year of School Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

Are You Currently in School: Yes No. If Yes, What Level: _____ Degree Pursuing: _____

RELATIONAL INFORMATION

Current Relational Status: Single Dating Engaged Married Separated Divorced Widowed

Are You Content with Your Current Relational Status: Yes No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: White Black Hispanic Asian Other: _____ Partner's Sex: Male Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: Yes No Unsure Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): Alone Spouse Children Parent(s) Sibling(s)
 Boyfriend Girlfriend Roommate Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Natural, Adopted, Step)</i>	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: Yes No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: Yes No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Mom, Dad, Sibling, Step)</i>	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are You Currently Receiving Medical Treatment: Yes No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (Use Back if Necessary): _____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ Improves Prevents Controls: _____

Medication: _____ Dosage: _____ Improves Prevents Controls: _____

Are You Taking these Medication(s) According to Your Doctor's Recommendations: Yes No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

- | | | |
|---|---|---|
| Headaches..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Dizziness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Stomach Trouble.... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Visual Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Sleep Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Trouble Relaxing.... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Weakness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Tension..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Rapid Heart Rate... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Difficulty Breathing.. <input type="checkbox"/> Past <input type="checkbox"/> Present | Intestinal Trouble.... <input type="checkbox"/> Past <input type="checkbox"/> Present | Hearing Noises..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Change in Appetite. <input type="checkbox"/> Past <input type="checkbox"/> Present | Tiredness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Pain..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Hearing Voices..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Seeing Things..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Other..... <input type="checkbox"/> Past <input type="checkbox"/> Present |

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

- | | | |
|---|---|--|
| Stress..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Nervousness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Anxiety..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Panic..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Unhappiness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Depression..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Guilt..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Apathy..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Terminal Illness..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Recent Death..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Grief..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Hopelessness..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Inferiority Feelings.. <input type="checkbox"/> Past <input type="checkbox"/> Present | Defective Feelings.. <input type="checkbox"/> Past <input type="checkbox"/> Present | Loneliness..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Shyness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Fears..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Friends..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Marriage..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Communication..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Physical Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Emotional Abuse.... <input type="checkbox"/> Past <input type="checkbox"/> Present | Verbal Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Sexual Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Temper..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Anger..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Aggressiveness..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Bad Dreams..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Concentration..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Racing Thoughts.... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Unwanted Thoughts <input type="checkbox"/> Past <input type="checkbox"/> Present | Memory..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Loss of Control..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Impulsive Behavior. <input type="checkbox"/> Past <input type="checkbox"/> Present | Self-Control..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Compulsivity..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Sexual Problems.... <input type="checkbox"/> Past <input type="checkbox"/> Present | Pregnancy..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Abortion..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Legal Matters..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Trauma..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Eating Problems.... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Drug Use..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Alcohol Use..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Trouble with Job.... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Career Choices..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Ambition..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Making Decisions... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Children..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Being a Parent..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Finances..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Recent Loss..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Disaster..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Other..... <input type="checkbox"/> Past <input type="checkbox"/> Present |

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1 = Very Little Distress; 10 = Extreme Distress):

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: Yes No. Have You Experienced Them in the Past: Yes No

Have You Ever Attempted Suicide: Yes No. If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: Yes No

If Yes, When and Who: _____

CURRENT ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling (i.e. What Are Your Issues, Problems?): _____

Why Have You Decided to Come for Counseling Now: _____

What Do You Hope to Gain or Change by Coming for Counseling: _____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back If Necessary):

Therapist: _____ Location: _____ Dates: _____ Reason: _____

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RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself: _____

If God Were to Describe You, What Would He Say: _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: _____

Complete the Following Thought: God Is _____

Do You Regularly Attend a Place of Worship: Yes No. If Yes, Where: _____

What Is the Name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader: _____

Do You Have a Personal Support System: Yes No. If Yes, Who: _____

TERMS OF SERVICE

I understand that it is Customary to Pay for Services when Rendered. I accept Full responsibility for Payment of Any Balance Incurred for Services. I further understand that without 24-Hour Notice of Intention to Cancel, I will be charged the Full Administrative Fee for Service.

Signed: _____

Date: _____

Twelve Stones

Statement of Counseling Policies and Procedures

COUNSELING SESSIONS

Counseling sessions with a Twelve Stones counselor are available weekly. Sessions are scheduled to begin on the hour and are 45-50 minutes in length. Therefore, it will be to your advantage to arrive on time so that you can benefit from a full-length session. Since your counselor has sessions scheduled after yours, the sessions must end 45-50 minutes after the appointment time regardless of your arrival time.

FEES

Payment is due at the beginning of each session, either by cash, credit card, or by a check made payable to “Twelve Stones.” A \$25.00 service charge will be levied on all checks returned by a bank for insufficient funds.

RESCHEDULING APPOINTMENTS

It is our policy to schedule you for a “standing appointment.” Your counselor will confirm at each session that you intend to come at the same time for your next appointment. If you occasionally need to come at a different time you can ask your counselor to arrange an alternative appointment time, if one is available. Please be aware that repeated cancellations or no-shows will result in the loss of your standing appointment.

CANCELLATIONS AND MISSED APPOINTMENTS

When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, the therapist is unable to make use of that time. If you must cancel your appointment, please **call the number below at least 24 hours in advance** of your scheduled time. This number is available 24 hours a day for confidential voice mail messages. **Failure to do so** will result in a session charge on your credit card on file.

YOUR COUNSELOR IS: _____

**YOU MAY LEAVE A CONFIDENTIAL VOICE MAIL MESSAGE FOR HIM/HER AT
407-353-3218, ext _____.**

Twelve Stones

Credit Card Authorization Form

Client Name: _____

Name on Card: _____

Counselor: _____

Type of Credit Card (MasterCard or Visa): _____

Credit Card Number: _____

Expiration Date: _____

3 digit verification code (# on back of card): _____

Date of Service: _____

Charge amount: _____

I, _____, authorize Twelve Stones to bill my credit card for the amount indicated above and/or for any ongoing balances on my account.

Twelve Stones

Clients,

Please take a minute to read the *Notice of Privacy Practices* attached to this letter. We are asking you to read this notice of procedures in compliance with the *Health Insurance Portability & Accountability Act of 1996 (HIPAA)*. This Federal law requires that all health care professionals notify all patients how their information is protected and how may be used.

Florida law regarding psychotherapy is much stricter than Federal guidelines. HIPAA allows these stricter laws to prevail where conflict between the two may exist.

Please review the enclosed document, complete and sign the *Acknowledgment of Receipt of Privacy Practices*, and return the acknowledgment form to your counselor.

If you have any questions regarding HIPAA or our privacy practices, please feel free to contact me at 407-353-3218

Thank you for your cooperation in this matter.

Sincerely,

Marcia Davis

Marcia Davis
HIPAA Officer

Twelve Stones

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH CARE INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how Twelve Stones, its staff members, employees, and volunteers may use and disclose your protected health information (PHI) for purposes of treatment, payment and health care operations, and for other purposes that are permitted or required by law.

I. OUR RESPONSIBILITIES:

Twelve Stones takes the privacy of your / your child's mental health information seriously. We are required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. We will abide by the terms of this Notice of Privacy Practices. We reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that we maintain. Any new Notice of Privacy Practices adopted will be posted in the Community room, posted on our website, and made available at your next appointment.

II. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)?

Protected health information ("PHI") is demographic and individually identifiable health information that will or may identify the client and relates to the client's past, present or future mental health or condition and related mental health care services.

III. WHAT DOES "MENTAL HEALTH CARE OPERATIONS" INCLUDE?

Mental Health Care operations include activities such as communications among health care providers, conducting quality assessment and improvement activities; and general administrative and business functions.

IV. HOW IS MENTAL HEALTH CARE INFORMATION USED?

Twelve Stones uses Mental Health Care records as a way of recording mental health information and planning care and treatment. Other health care providers must follow the same confidentiality laws and rules required of Twelve Stones.

V. EXAMPLES OF HOW INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR MENTAL HEALTH CARE OPERATIONS

We will use information to establish a treatment plan.

We may disclose protected health information to another provider for treatment (i.e. supervisor, referring physicians.)

We may contact you to discuss treatment alternatives or other health related benefits that may be of interest.

VI. WHY DO I HAVE TO SIGN A CONSENT FORM?

When you, as the client or the parent or guardian of a client, sign a consent form, you are giving Twelve Stones permission to use and disclose protected health information for the purposes of treatment, payment, and mental health care operations. This permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records and other privileged categories of information which require a separate authorization. You will need to sign a separate authorization to have protected health information released for any reason other than treatment, payment or healthcare operations.

VII. WHAT ARE PSYCHOTHERAPY NOTES?

Psychotherapy notes are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the client's Mental Health Care record.

IX. WHY DO I HAVE TO SIGN A SEPARATE AUTHORIZATION FORM?

In order to release client protected health information for any reason other than treatment, payment and health care operations, we must have an authorization signed by the client or the parent or guardian of the client that clearly explains how they wish the information to be used and disclosed.

X. CAN I CHANGE MY MIND AND REVOKE AN AUTHORIZATION?

You may change your mind and revoke an authorization, except (1) to the extent that we have relied on the authorization up to that point. All requests to revoke an authorization should be in writing.

XIII. WHEN IS MY AUTHORIZATION / CONSENT NOT REQUIRED?

The law requires that some information may be disclosed without your authorization in the following circumstances:

In case of an emergency

When required by law

To report suspected child or elder abuse or neglect

In the event of a serious threat to health or safety

XIV. YOUR PRIVACY RIGHTS

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. You have the right to request a restriction of your health information.

This means you may ask us to restrict or limit the information we use or disclose for the purposes of treatment, payment or health care operations. Twelve Stones is not required to agree to a restriction that you may request. We will notify you if we deny your request

2. You have the right to receive an accounting of disclosures of your health information.

You have the right to request an accounting of certain disclosures of your PHI made by Twelve Stones. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting.

3. You have the right to receive a paper copy of this Notice of Privacy Practices.

XV. WHAT IF I HAVE A QUESTION / COMPLAINT?

If you have questions regarding your privacy rights, please contact the Twelve Stones Privacy Officer at (407) 353-3218. If you believe your privacy rights have been violated, you may file a complaint by contacting the Twelve Stones Privacy Officer (407) 353-3218.

Twelve Stones

Acknowledgement of Receipt of Privacy Practices Notice

I, _____ have received a copy of Twelve Stones
(Full name)

Notice of Privacy Practices.

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Signed: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____

Twelve Stones

Informed Consent & Release of Liability

Twelve Stones is operated to provide counseling with a distinctively Christian framework to the local community, as a whole. Counseling services are provided by Christian practitioners who have earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and who have been licensed by the state of Florida as Mental Health Counselors, Registered Mental Health Counselor Interns (hereafter referred to as Counselors).

The completion of an intake questionnaire and an informed consent and release of liability are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent. In order to initiate counseling, please read the following agreement. Your signature attests that you both understand and agree to the terms and conditions contained herein.

1. I understand that my counselor is a registered intern, a mental health counselor, or a pastoral counselor, working under the laws and rules specified by the state of Florida and/or the Federal Government where applicable.
2. I understand that my counseling records (files) are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession (e.g. child, elder, disabled abuse/neglect reporting requirements, serious threat of harm to self or others, etc.) The clinical records are the property of the Twelve Stones counselors and as such, are deemed records of confidential sessions between counselors and clients. Other than as required by law these records will only be released subject to the following paragraph and with the advanced written consent of the client and Twelve Stones.
3. In consideration of the benefits to be derived from the counseling, the receipt of which is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable the ministry of Twelve Stones, the counselors, the registered interns, the staff, and the supervisors, from any and all claims, demands, damages, actions, or causes of action whatsoever related to the counseling process.
4. I waive any right I may have otherwise to seek to use my counseling records with Twelve Stones, except as may otherwise be agreed upon in writing, in any judicial proceeding or to compel the testimony of any Counselor or supervisor associated herewith. If testimony is required, I agree to pay twice the normal hourly rate for any, and all, of these individuals for their testimony, and preparation therefore.

I have read and understood the preceding information and agree to the terms and conditions of Twelve Stones as stated herein. I understand that these comments are prerequisite to my receiving and continuing counseling services through Twelve Stones.

Signed: _____ Date _____

Witness: _____ Date _____