772-208-7834

Information Face Sheet

Admission/Intake Date:
Name (Preferred and/or Given):
Date of Birth:
Social Security Number:
Phone Number:
Address:
Name of Emergency Contact:
Phone Number for Emergency Contact:
Previous Client? Yes or No
Are you currently having thoughts about wanting to harm yourself or others? Yes or No
Name of person responsible for payment:
Payments will be expected at the time of service unless payment arrangements are arranged with the agency/ therapist prior to the appointment. Individual and Couple sessions are as follows 50 min $120, 75 min $150, 90 min $180, 120 min $220 (reserved for couples only). All sessions can be purchased as a package option to receive the greatest benefit financially. Please speak to your therapist/coach regarding that. HRT letter consideration sessions no session minimum per WPATH SOC and based on professional opinion of therapist as to appropriateness/readiness. Additional evaluation is needed for HRT letter per WPATH SOC and must be within the last 6-12 months. Referrals to MD or Psych are available upon request.

Please indicate the reason for seeking services with Center for Sexual Health & Wellness, LLC

By signing below, Client is agreeing to provide fees for service at time that the service is provided and accepting responsibility for payments for all services regardless of EAP or Insurance coverage.

_____ _____ _____ _____

Client's Signature Date Parent/Guardian Date

_____ _____

Therapist's Signature Date

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In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Personal Health Information (PHI). The individual also has the right to request confidential communication, or that communication of PHI can be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. TeleTherapy through Breakthrough in addition to following HIPPA, falls under The Health Information Technology for Economic and Health Information Act (HITECH).

I wish to be contacted in the following ways (check all that apply):

- Home Phone Number: _____
- Cell Phone Number: _____
- Text Message: Yes or No (Please note that we cannot guarantee confidentiality in case of text messages)
- Voicemail: Yes or No
- Written Communication (home address/email):

_____

_____

- TeleTherapy (Breakthrough or Google Hangouts):
  _____

_____ _____ _____
_____

Client's Signature Date Parent/Guardian
Date

_____ _____

Therapist's Signature Date

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Consent for Release of Confidential Information

Client Name: _____ SS#:_____
DOB:_____ Today's Date:_____

I, _____, authorize Center for Sexual Health & Wellness, LLC to communicate with _____ in order to obtain information from or disclose information for the purpose of coordinating services and development of the treatment plan

I authorize Center for Sexual Health & Wellness, LLC to release and obtain the following information:

- Release of psychiatric and psychological information related to condition and treatment
- Release of medical records
- Permission to speak to the following: _____
- Release of the following information:_____
- Release of gender identity
- Release of sexual orientation or preference

I understand that I can revoke this authorization in writing at any time, refusal to authorize release of information will not jeopardize my status in treatment, a copy of this release is valid as the original, and release of information is valid for 12 months from date of signature unless otherwise indicated or unless release is revoked.

Prohibition on Redisclosure: This information has been disclosed from records whose confidentiality is protected. Federal and state rules prohibit anyone from making any further disclosure of this information unless the patient provides specific written authorization for the subsequent disclosure of this information or as otherwise permitted by 42 C.F.R. Part 2 or F.S.A. 394.4615. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (42 C.F.R.2.32). Florida law requires that any person, agency or entity receiving this information shall maintain such information as confidential and exempt from provisions of the public records law. (F.S.A.394.4615(6)). Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to F.S.A. 394.4615 or other Florida statute is not subject to civil or criminal liability for such release. If this authorization releases protected information to a third party payor, it is understood that payment may result.

I understand by approving the release of information in the form of a facsimile (FAX), confidentiality cannot be assured. My initials indicate that I accept the risks that confidentiality may be breached when FAXING information. Client or guardian initials (_____)

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
Witness: _____ Date: _____
I hereby revoke this Release of Information on (date): _____ Initials: _____

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Authorization for Treatment

Client Name:_____ Date: _____

I hereby authorize Center for Sexual Health & Wellness, LLC to provide Mental Health Counseling, Coaching and/or Sex Therapy services. I certify that no guarantee or assurance has been made as to the results.

I hereby authorize the release of information from my file for statistical purposes. Identifying information will be deleted and my anonymity is guaranteed for this purpose. I authorize the staff of Center for Sexual Health & Wellness, LLC to contact me after treatment is completed for the purposes of evaluating the effectiveness of treatment.

I understand that Center for Sexual Health & Wellness, LLC is committed to providing services free of discrimination and harassment based on race, color, religion, age, gender, gender identity or expression, national origin, disability, citizenship, sexual orientation, or any other protected status.

I understand that I need to give 24-hour notice of appointment cancellation. I understand that I may be billed for the session if I do not give 24-hour notice and I authorize the release of pertinent information for collection purposes, should it become necessary. I understand that any client who has missed two scheduled appointments may be terminated from services. Clients who arrive more than fifteen minutes late for an appointment may be considered to have missed that appointment. I understand that I will be financially responsible for services rendered at full self-pay rate within 14 days of an insurance claim being denied.

I understand that all contacts with Center for Sexual Health & Wellness, LLC are usually considered confidential or privileged communication within the agency. My case may be discussed with colleagues or supervisors for the purposes of supervision or consultation, only providing minimal information necessary. Information about my case will not be shared with others unless I give my written permission. The limits of confidentiality would include situations where I intend to harm myself or others or if there is identification or if there is strong suspicion that a child, elderly adult, or disabled person is the victim or potential victim of physical or sexual abuse or neglect.

I represent and warrant that all information submitted is true and correct. In the case of a minor child, who is identified as the client, I warrant that I have complete and proper authority to involve that child in treatment. I understand that Center for Sexual Health & Wellness, LLC is relying on the parent/legal guardian's representation to accept the minor child as a client and I shall hold harmless and indemnify Center for Sexual Health & Wellness, LLC as the result of any representations that are not true and correct.

I agree to participate in the therapeutic process for myself or my child by following the therapist's recommendations. I will provide phone-contact and participate in family therapy sessions when appropriate as indicated by the therapist. I understand that if I do not follow these terms, therapy sessions may be reviewed for closure and services may be terminated.

_____ _____

Signature of the client Date Signature of Legal Guardian Date

_____

Signature of Witness/Provider Date

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Informed Consent for Group Counseling

Welcome to your group therapy experience!

Group counseling can be a powerful and valuable place to experience growth and healing. It is our hope that you are able to experience all of the benefits that group counseling has to offer. To help this occur, groups are structured to include the following:

- A safe environment where you can feel respected and valued
- An understanding of group goals and group norms
- Investment by the facilitator and members to produce a consistent group experience

A Safe Environment

A safe environment is created and maintained by the facilitator and the group members. This is done by offering mutual respect and an opportunity to create trust. Another aspect of safety in this environment has to do with confidentiality. The facilitator is bound by law to maintain confidentiality, just as the group members are bound by honor to keep information divulged in the group as a part of the group and not take information learned in group outside of this experience. We realize that you may want to share what you are learning about yourself in group with others but just remember not to talk about other clients or any events that can compromise confidentiality of other group members.

A release can be signed to allow the group facilitator to communicate with your individual therapist if the need arises. This is completely up to the discretion of the client and/or guardian.

Limits of Confidentiality

- If you are a threat to yourself or others (suicidal or homicidal), then the facilitator may need to report your statements or behaviors to family or other mental health or law enforcement personnel in order to keep you and others safe
- There are a broad range of events that can be reported per DCF including physical or sexual abuse or neglect of a child or a vulnerable adult
- If a court orders the release of records
- Facilitators may consult with other professionals regarding group interactions or to gain insight of how to better help the group or an individual. No identifying information would be shared in these situations unless prior consent has been obtained.

Records may also be released with your written permission and will only include your personal progress in group

Other Safety Factors

- Members of group may not use drugs or alcohol before or during group
- Members of group should not engage in discussion of group issues outside of group
- Members of group should remember that keeping confidentiality allows for an environment where trust can be built and all members may benefit from the group experience
- Your group facilitator will monitor discussions and maintain a respectful environment to keep safety and trust a priority

Attendance

Your presence in group is very important in order to create a dynamic that is beneficial for group members to experience growth and change. If you are absent from group, this dynamic suffers and affects the experience of everyone in the group. Your facilitator asks that you make a commitment to participate in and attend group whenever possible. It is understood that there may be times that an emergency or event occurs that makes attendance an issue but we request that you contact the facilitator and inform them of this.

It may take several group sessions for clients to "settle in" and receive the full benefits that a therapy group provides. We ask that you make a commitment to attend groups regularly and give two weeks of notice if you intend to stop attending groups. This allows other group members to process a member of the group leaving.

What to Expect

Group time consists of both teaching and processing time. Processing may revolve around an issue of one member of the group or multiple members of the group. It can include time for structured feedback and reactions by other members in the group. Sometimes the topic may apply to all members of the group. The group dynamic offers a place where you can experience support, give support, understand more clearly how to relate and differ to other group members, and share your concerns, experiences, thoughts and feelings. It is also a place to understand that every client has a different experience and while the experiences may differ, the thoughts and feelings are often the same.

Remember, the more you give of yourself during the sessions, the more you will receive. The more honest and open you are, the more you allow for insight and growth.

Fees

The fee for this group is $20 per 60 minute session. You are responsible to pay for each session at the beginning of the session unless you have made a prior arrangement. When a client is a minor, counseling fees are the responsibility of the parent or legal guardian. Payments can be made via cash or debit/credit card. Chasity Chandler does not accept checks.

Consent

Group Consent Form – Name of Group: **Sexual Health & Wellness, LBGTQ+ Support Group 17 and up or Children's LGBT Group, Seeking Safety, Let's Talk About It, Parents Partners, Allies & Friends Group, Health Relationships Matter, Women's Issues Group.**

I have read the above information, understand the above information, and agree to the terms of group participation.

_____ _____

Client date Guardian date

_____

Signature of Facilitator date