2nd Chance 4 Counseling

Derenda Edmondson, Ed. D., L.M.H.C.

(904) 724-9960

ADULT REGISTRATION

Client Demographic Information

Client's Name: _____ Date: _____
(Last, First, MI)

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female Soc. Sec. # _____

☐ Single ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Living Cooperatively ☐ Partnered

Address: _____

City, State, ZIP: _____ Referred by: _____

Employer: _____ Occupation: _____

Home Phone: _____ May we identify ourselves and/or leave a message? ☐ Yes ☐ No

Work Phone: _____ May we identify ourselves and/or leave a message? ☐ Yes ☐ No

Cell Phone: _____ May we identify ourselves and/or leave a message? ☐ Yes ☐ No

Email: _____ May we email you regarding scheduling Issues? ☐ Yes ☐ No

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____

Home # _____ Work # _____ Cell# _____

Who is Financially Responsible for this Account? Who is the Insured?

Name: _____ Relationship: _____

Date of Birth: _____ Social Security # _____

Address: _____

City, State, ZIP: _____

Insurance Co. Name: _____ Insured's ID # _____

Group # _____ Insurance Co. Phone # for Mental Health _____

Employer: _____ Occupation: _____

Home # _____ Work # _____ Cell # _____

Email: _____

Authorization and Release

- ☐ I authorize/request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me.
- ☐ I authorize the release of necessary information to third party payers/insurance companies and/or other health practitioners.
- ☐ I have been informed of HIPAA guidelines and regulations related to confidentiality of medical records.
- ☐ I agree to be responsible for payment of all services (to include self pay) rendered on my behalf or for my dependents.
- ☐ I agree to notify your office at least 24 business hours in advance if I need to reschedule or cancel an appointment.

X _____ _____
Signature of Client or Responsible Party Date

*****PLEASE PROVIDE INSURANCE CARD & DRIVER'S LICENSE OR PICTURE ID FOR VERIFICATION OF BENEFITS AND IDENTITY*****

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CLIENT INFORMATION FORM

Name: _____ Date of 1st Appointment: _____

Gender: ☐ M ☐ F Date of Birth: _____

About your Education:

Where did you attend public school? _____

Did you attend college/professional School? When, where, degree earned?

Any plans to further your education: ☐ Yes ☐ No If so, when and what?

About your Relationships:

Please list your marriage(s) or other important "significant other" relationships:

Spouse's Name	Year Begun	Year Ended	Married to this person?	Children from this relationship and their ages
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

List all people who currently live with you _____

About your Family:

Father: Name; Living? Current age or age at death; Occupation; Describe the relationship:

Mother: Name; Living? Current age or age at death; Occupation; Describe the relationship:

Brothers: Name; Living? Current age or age at death; Occupation; Describe the relationship:

Sisters: Name; Living? Current age or age at death; Occupation; Describe the relationship:

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About Your Concerns:

Please check **all** of the items below that you currently experience or are having difficulty with. Feel free to add any others at the bottom under "Other concerns or issues." You may add details as needed to clarify.

☐ Abuse - emotional	☐ Abuse - neglect	☐ Abuse - physical	☐ Abuse - sexual
☐ Aggression	☐ Anger	☐ Anxiety	☐ Arguing
☐ Attention Problems	☐ Career Concerns	☐ Childhood Issues	☐ Children - care of
☐ Children – Custody	☐ Children management	☐ Choices I have made	☐ Codependence
☐ Compulsive spending	☐ Concentration problems	☐ Confusion	☐ Crying
☐ Deaths	☐ Debt	☐ Decision making	☐ Delusions - false ideas
☐ Dependence	☐ Depression	☐ Distractibility	☐ Divorce
☐ Drug abuse - over the counter	☐ Drug abuse - prescription	☐ Drug abuse - street drugs	☐ Drug abuse - alcohol
☐ Eating - poor appetite	☐ Eating - making myself vomit	☐ Eating - overeating	☐ Eating - under-eating
☐ Emptiness	☐ Failure	☐ Fatigue	☐ Fears
☐ Financial troubles	☐ Friendship problems	☐ Gambling	☐ Goals not being met
☐ Grieving	☐ Guilt	☐ Headaches, pains	☐ Health
☐ Hostility	☐ Impulsive spending	☐ Impulsiveness	☐ Indecision
☐ Inferiority feelings	☐ Inhibitions	☐ Interpersonal conflicts	☐ Irresponsibility
☐ Irritability	☐ Judgment problems	☐ Laziness	☐ Legal Matters
☐ Loneliness	☐ Loss of control	☐ Losses	☐ Low energy
☐ Low frustration tolerance	☐ Low income	☐ Low mood	☐ Marital Coldness
☐ Marital conflict	☐ Marital distance	☐ Marital infidelity/affairs	☐ Medical concerns
☐ Memory problems	☐ Menopause	☐ Menstrual problems	☐ Mixed feelings
☐ Mood swings	☐ Motivation	☐ Mourning	☐ Obsessions
☐ Outbursts	☐ Oversensitive to criticism	☐ Oversensitive to rejection	☐ Panic or anxiety attacks
☐ Parenting	☐ Perfection	☐ Pessimism	☐ Perfectionism
☐ Phobias	☐ Physical Problems	☐ PMS	☐ Poor self-care
☐ Procrastination	☐ Relationship problems	☐ Relaxation	☐ Re-marriage
☐ Risk taking	☐ Sadness	☐ School problems	☐ Self-abuse - burning
☐ Self-abuse - cutting	☐ Self-abuse - other	☐ Self-abuse - scratching	☐ Self-centeredness
☐ Self-control	☐ Self-esteem	☐ Self-neglect	☐ Separation
☐ Sexual conflicts	☐ Sexual desire differences	☐ Sexual dysfunctions	☐ Sexual - other issues
☐ Shyness	☐ Sleep - insomnia	☐ Sleep - nightmares	☐ Sleep - too little
☐ Sleep - too much	☐ Step-parenting	☐ Stress	☐ Stress-management

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☐ Suicidal Thoughts	☐ Suspiciousness	☐ Temper problems	☐ Tension / stress
☐ Thought disorganization	☐ Threats of violence	☐ Tiredness	☐ Tobacco use
☐ Violence	☐ Violence - victim of crime	☐ Work problems	☐ Weight and diet issues
☐ Withdrawal - isolating	☐ Employment problems	☐ Employment - lack of	☐ Employment - overdoing
☐ Employment - termination	☐ Other Concerns or issues:		
	☐ Other Concerns or issues:		
	☐ Other Concerns or issues:		
	☐ Other Concerns or issues:		

The following information is very helpful in case we need to contact your physician or psychiatrist. Please provide accurate contact information. Thank you very much for providing this so we may be of help to you.

About Your Health:

Many managed care companies require that we have interaction with the client's physician to coordinate care.

Do you give us consent to discuss your care with the doctor(s) named below? ☐ Yes ☐ No (If the answer is Yes, please ask for release form.)

Please sign here for either answer. X _____

Who is your medical doctor? _____ Last Visit: _____

Address: _____ Phone: _____

Medical Concerns?

Prescribed Medications:

Who is your psychiatrist? _____ Last Visit: _____

For What reasons/issues?

Prescribed Medications:

Have you previously seen a counselor/therapist? ☐ Yes ☐ No Name: _____

Address: _____ Phone: _____

Reason(s) for visits:

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Do you have any chronic medical or mental-health conditions or concerns? ☐ Yes ☐ No If so, please list:

List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

List all other medications or drugs (prescribed or street) you have taken in the last year:

What are your goals for therapy?

Thank you for your time in completing these confidential forms.

Treatment Agreement

This document is intended to clarify in writing some of the issues we may have already discussed verbally that need to be brought to your attention regarding our professional relationship. In my work, I have found that it is best to specify as well as possible the form and content of our relationship by making a mutual agreement that you may receive the service you desire. It is my assurance that I am well aware and respectful of your basic rights as a consumer and that I will respond to your needs in the most highly ethical manner, according to the standards of care for my profession, mental health and marriage/family counseling. By clarifying the services I have to offer, as the person to be treated, you may best judge whether you desire or are satisfied with them. I remain personally and professionally committed to providing you with the highest quality of service.

Client Rights

As a client of Derenda Edmondson Ed. D., LMHC you have certain rights which are:

1. To participate voluntarily in treatment with your therapist and to terminate at any time without penalty.
2. To understand that "treatment" could include individual or conjoint therapy for up to 50 minutes (a therapy hour) or group therapy for 90 to 120 minutes conducted by your licensed therapist with no absolute guarantee of your desired results by your therapist.
3. To participate with your therapist in exploring your goals as a client and developing a Treatment Plan, which will include the benefits and risks associated with the particular approach to therapy.
4. To have reasonable access to your therapist by telephone in case of emergency
5. To have information available to you regarding your therapist's professional license and credentials as well as access to the ethical guidelines of "Standards of Practice" in Mental Health Counseling of the Agency for Health Care Administration in Tallahassee, Florida.
6. To understand that, under certain conditions, your therapist my choose to seek supervision from other qualified clinicians. If yours is one of the cases, you will be notified as to whom and given a release form to sign prior to the supervision.
7. To understand that, in keeping with generally accepted standards of practice, your therapist may confidentially consult with other mental health professions regarding cas management. The purpose of the consultation is to assure quality care, and every effort is made to protect the identity of clients.
8. To have all records and other information concerning your involvement with this office held in strict confidence and all communication with your therapist privileged, which means that no information is ever to be released to a third party without your written permission. Certain exceptions are: if you are in clear and imminent danger to yourself and others, in child abuse and neglect cases, therapist's subpoena or court order, if you carry an infectious or communicable disease (e.g. AIDS), or if there is a medical emergency.

I hereby commit to offering you these rights and providing these services.

Therapist's Signature: _____

Date: _____

Client Responsibilities

As a client / consumer, I have carefully read over and signed all of the policies regarding financial responsibilities, making, keeping and cancelling appointments with this therapist and this agreement.

Concent and Authorization for Treatment

I consent to and authorize the assessment and/or treatment I will receive as a client of Derenda Edmondson, Ed. D., LMHC. I have read the policies of this office and received a copy of them. I understand these rules and policies and agree to follow them.

_____ _____

Signature of Client Date

Derenda Edmondson Ed.D
Licensed Mental Health Counselor
(Florida License # LMHC 7910)
Licensed Mental Health Counselor

2ndChance4Counseling
Regency North 1

Phone: (904)724-9660

edmo7778@bellsouth.net
www.2ndchance4counseling.com

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Your health record contains personal information about you and your health. This information about you 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 I may use and disclose your PHI in accordance with applicable law and NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

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

PLEASE READ AND REVIEW THIS NOTICE CAREFULLY.

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

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

1. FOR TREATMENT

2. FOR PAYMENT
I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. 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, I will only disclose the minimum amount of PHI necessary for the purposes of collection.

3. FOR HEALTH CARE OPERATIONS
I may use or disclose as needed, your PHI in order to support my business activities, including but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (i.e., answering service, billing and accounting service) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI.

4. REQUIRED BY LAW
Under law, I must make disclosure of your PHI to you upon request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of litigating or determining my compliance with the requirements of the Privacy Rule.

5. WITHOUT AUTHORIZATION
Applicable law and ethical standards permit me to disclose information about you and your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are:
-Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as mental health licensing board or health dept.)

-Required by 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.

6. VERBAL PROTECTION

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

7. 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

RIGHT TO AMEND: If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restriction or limitation on the use of disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

RIGHT TO REQUEST CONFIDENTIAL INFORMATION: You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

RIGHT TO A COPY OF THIS NOTICE: You have a right to a copy of this notice.

COMPLAINTS

If you believe that I have violated your privacy rights, you have the right to file a complaint in writing with me or with the Secretary of Health and Human Services at:

200 Independence Ave, SW
Washington, DC 20201

or by calling (202)619-0257

Derenda Edmondson, Ed.D

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:

Date of Birth:

I hereby acknowledge that I have received and been given an opportunity to read a copy of the "Notice of Privacy Practices" of Derenda Edmondson, Ed.D, LMHC. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Derenda Edmondson, Ed.D, LMHC.

_____ _____

Signature of Patient/Client Date

☐ Patient/Client Refuses to Acknowledge Receipt

_____ _____

Derenda Edmondson Date