POSITIVE START COUNSELING SERVICES, INC.
REGISTRATION FORM

(Please Print)

Today's date: | PCP:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F

Street address: | Social Security no.: | Home phone no.: ( )

Other contact no.: | City: | State: | ZIP Code:

Occupation: | Employer Name and Address: | Employer phone no.: ( )

INSURANCE INFORMATION

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

AUTHORIZATION INFORMATION

ASSIGNMENT OF BENEFITS:

I hereby assign to Positive Start Counseling Services, Inc., any insurance, or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under my "insurance," I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

FOR RELEASE OF INFORMATION:

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPPA Notice of Privacy Practices" information provided to me a under a separate cover. This information is on file as a permanent record and may be amended as necessary.

Patient/Guardian signature | *Date*

POSITIVE START COUNSELING SERVICES, INC

CONSENT TO TREATMENT AND RECIPIENT'S RIGHTS

Client_____Chart#_____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, with Positive Start Counseling Services, Inc, hereby referred as the therapist. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The office encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content.

Privacy of Information Policies: I acknowledge receiving a copy of the privacy of information policies and certify that I have read and understand its content. I understand that if I have any questions or concerns regarding my privacy rights, I will contact Positive Start Counseling Services, Inc.

Non-Voluntary Discharge from Treatment: A client may be terminated from the office non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the office, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner.

Attendance/Cancellations: I understand that regular attendance will produce the maximum benefits. I understand that cancellations without 24hours notice or missed appointments will result in a fee of $50.00.

Returned Checks: Clients are responsible for any bank fees incurred due to returned checks. A bank service fee of $35.00 per check will be charged to the client.

Acknowledgement of Financial Responsibility: I understand that I am financially responsible for any portion of fees not covered or reimbursed by my health insurance. I understand and consent to release of information that may need to be shared with my insurance provider in order for payment to be rendered for services.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the office is protected by Federal and/or State law and regulations. Generally, the office may not say to a person outside the office that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the office, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the therapist's duty to warn any potential victim, when a significant threat of harm has been made.

I consent to treatment and agree to abide by the above stated policies and agreements with Positive Start Counseling Services, Inc.

_____
Patients Name (Printed)

_____ _____
Signature of Client/Legal Guardian Date
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Therapist Signature Date

POSITIVE START COUNSELING SERVICES, INC

CONSENT & AUTHORIZATION TO CORRESPOND ELECTRONICALLY

While Positive Start Counseling Services, Inc takes reasonable precautions to protect your confidential information, e-mail and texting are not completely secure methods of communication. Please read and sign the following consent regarding electronic correspondence.

I acknowledge that if I use electronic mail to initiate contact with the staff at Positive Start Counseling Services, Inc., regarding my therapeutic care, the staff at Positive Start Counseling Services, Inc. has my permission to correspond via that email address.

The content of e-mail and texting communications is limited to the following: scheduling appointments, appointment reminders, obtaining insurance information or other information regarding the clients' account, and clarification on homework assignments.

Email and texting may *not* be used for discussing any form of therapy issue, or for communicating about emergency treatment. You must call and address therapy issues with your therapist at Positive Start Counseling Services, Inc. either on the phone or during your next session.

☐ I give Positive Start Counseling Services, Inc. my permission to communicate with me via email or text messaging for the purpose of sending me notices related to my scheduling or account.

_____@_____

Phone number for receiving text messages: _____

_____ _____

Client/Guardian Signature Date

POSITIVE START COUNSELING SERVICES, INC

CREDIT CARD AUTHORIZATION FORM

I hereby authorize Positive Start Counseling Services, Inc.to charge my credit card on the day of my appointment for the appropriate fee assigned to the service received.

Assessment Interview: (60min) - **$125**
Individual or Family Psychotherapy: (50 min) – **$125**
Other Professional Services: (30 min) - **$50**
Legal Involvement: **$150 per hour**
Copay/Co-insurance:_____(as determined by insurance company)

I hereby authorize Positive Start Counseling Services, Inc. to charge my credit card a fee of $50.00 for any missed psychotherapy appointments or appointments cancelled with less than 24 hours advance notice (excluding true emergency situations).

Name: _____

Cardholder's Name:_____

Billing Address:_____

Street City State Zip:_____

Type of Card: Visa _____ Master Card _____ American Express _____ Discover _____

Credit Card Number: _____/_____/_____/_____

Card Expiration Date: _____/_____

Card Security Code: _____(3 digit code on the back of the card)

I have read, understand, and agree to the terms outlined in the above credit card policy for psychotherapy services provided by Positive Start Counseling Services, Inc.

_____ _____
Signature of Cardholder Date

***Positive Start Counseling Services, Inc. securely maintains your credit card information and adheres to all HIPAA regulations.**

Behavioral/Emotional

Please check any of the following that are typical for your child:

__ Affectionate
__ Aggressive
__ Alcohol problems
__ Angry
__ Anxiety
__ Attachment to dolls out
__ Avoids adults
__ Bedwetting
__ Blinking, jerking
__ Bizarre behavior
__ Bullies, threatens
__ Careless, reckless
__ Chest pains
__ Clumsy
__ Confident
__ Cooperative
__ Cyber addiction
__ Defiant
__ Depression
__ Destructive
__ Difficulty speaking
__ Dizziness
__ Drugs dependence
__ Eating disorder
__ Enthusiastic
__ Excessive masturbation
__ Expects failure
__ Fatigue
__ Fearful
__ Frequent injuries

___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels

___ Sad
___ Selfish
___ Separation
___ Sets fires
___ Sexual addiction
___ Sexual acting
___ Shares
___ Sick often
___ Short attention
___ Shy, timid
___ Sleeping
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries
___ Other:
_____
_____

Behavioral/Emotional

Please check any of the following that are typical for your child:

__ Affectionate
__ Aggressive
__ Alcohol problems
anxiety
__ Angry
__ Anxiety
__ Attachment to dolls
out
__ Avoids adults
__ Bedwetting
__ Blinking, jerking
span
__ Bizarre behavior
__ Bullies, threatens
problems
__ Careless, reckless
__ Chest pains
__ Clumsy
__ Confident
__ Cooperative
__ Cyber addiction
__ Defiant
attempts
__ Depression
__ Destructive
__ Difficulty speaking
__ Dizziness
twitching
__ Drugs dependence
__ Eating disorder
__ Enthusiastic
__ Excessive masturbation
__ Expects failure
excessively
__ Fatigue
__ Fearful
__ Frequent injuries

__ Frustrated easily
__ Gambling
__ Generous
__ Hallucinations
__ Head banging
__ Heart problems
__ Hopelessness
__ Hurts animals
__ Imaginary friends
__ Impulsive
__ Irritable
__ Lazy
__ Learning problems
__ Lies frequently
__ Listens to reason
__ Loner
__ Low self-esteem
__ Messy
__ Moody
__ Nightmares
__ Obedient
__ Often sick
__ Oppositional
__ Over active
__ Overweight
__ Panic attacks
__ Phobias
__ Poor appetite
__ Psychiatric problems
__ Quarrels

__ Sad
__ Selfish
__ Separation
__ Sets fires
__ Sexual addiction
__ Sexual acting
__ Shares
__ Sick often
__ Short attention
__ Shy, timid
__ Sleeping
__ Slow moving
__ Soiling
__ Speech problems
__ Steals
__ Stomach aches
__ Suicidal threats
__ Suicidal
__ Talks back
__ Teeth grinding
__ Thumb sucking
__ Tics or
__ Unsafe behaviors
__ Unusual thinking
__ Weight loss
__ Withdrawn
__ Worries
__ Other:
_____
_____

POSITIVE START COUNSELING SERVICES, INC.

HOW I WANT MY COUNSELING TO GO

Since there are many ways to go about working together in counseling, I would like to know how you want things to unfold for you. Your decisions will inform me of how best to support you and assist you in this endeavor.

1. **I want to use my appointment times to: (choose up to 3)**

___ Get things off my chest and vent
___ Figure things out
___ Receive emotional support
___ Explore possibilities for my future
___ Determine what changes I want
___ Set goals and steadily work on achieving them
___ Other

2. **I want to mainly focus on: (choose up to 5)**

___ Gaining understanding about myself ____The past
___ Understanding my situation better ____The present
___ Developing skills ____The future
___ Building on my strengths and abilities ____Changing my behavior or habits
___ Processing past traumatic experiences ____Changing the way I think
___ Recovering and healing ____What is missing from my life
___ What my needs are ____My relationships
___ My job/career ____My performance (ex: work, school,
___ The past various roles or responsibilities)
___ The present
___ The future ____Having sense of fulfillment
____Other

3. **In general, I would like you, as my counselor, to: (choose up to 3)**

___ Support me
___ Challenge me
___ Listen to me
___ Teach me
___ Help me be motivated
___ Advise me
___ Other

4. **Is there anything that you don't want to focus and spend time on?**

*Naturally, sometimes things change over time. If you change your mind on any of the above, please let me know so that we can adjust for that together.

POSITIVE START COUNSELING SERVICES, INC

PRIVACY OF INFORMATION POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this office for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this office such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this office not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest, safety for public health activities, judicial/administrative proceedings, law enforcement, serious threats to public safety, essential government functions, military, and worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, we may share your medical information with the medical examiner.

POSITIVE START COUNSELING SERVICES, INC

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the office or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the office or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the office or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the office. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the office (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights
You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1.00 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

POSITIVE START COUNSELING SERVICES, INC

Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the therapist at this location.

Complaints

If you have any complaints or questions regarding these procedures, please contact the office. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Florida Department of Health. If you file a complaint we will not retaliate in any way.

Direct all correspondence to: Michelle Fyfe, LMHC, CAP

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name/Legal Guardian (please print):_____

Signature:_____Date:____/____/____

Signed by: __client __guardian __personal representative

PSCS
Positive Start Counseling Services, Inc

Date:_____

Name:_____

Address_____

_____

Dear_____

A Psychotherapist as POSITIVE START COUNSELING SERVICES, INC has recently been contacted to provide services for _____ _____, and it is the understanding that you have shared parental responsibility. This is to inform you that according to Florida Statutes you have the right to be involved in the decision to have your child receive therapy.

Please find enclosed the Consent for Treatment form. Your signature on this form will authorize POSITIVE START COUNSELING SERVICES, INC to provide treatment for your child. Return this signed form as soon as possible. Failure to respond within then ten (10) working days of receipt of this letter will be documented and recognized as consent for treatment.

Sincerely,

POSITIVE START COUNSELING SERVICES, INC

Other Parent's
signature:_____

Date:_____

11440 Okeechobee Blvd #205B
Royal Palm Beach, Florida 33411
954-817-5825
561-693-5514 (Fax)
positivestartcounseling@msn.com
www.positivestartcounseling.webs.com

PSCS
Positive Start Counseling Services, Inc

STATEMENT OF PARENTAL RIGHTS TO CONSENT FOR TREAMENT OF MINOR

THIS IS TO CERTIFY FOR: (Child's Name)_____

Please check one:
____ I have Sole Custody or the other parent has no legal rights to the child
____ I have Shared Parental Responsibility**

The other parent is (name) _____
Contact Information (address/contact numbers)_____
_____

I understand that it is ultimately my responsibility to inform him/her that I am bringing said minor child for treatment with Positive Start Counseling Services, Inc., in Palm Beach County, Florida. I understand that the therapist will also inform him/her of the request for payment by mail, notifying him/her of his /her rights and requesting written consent. I understand if the other parent refuses consent, the therapist cannot provide services.

I have Shared Parental Responsibility but
____ do not know the whereabouts of the other parent.
____ she/he has never been involved in the life of my child.

I understand that according to Florida Statutes, the other parent has the right to be involved in the decision to have minor child receive therapy. I understand that it is ultimately my responsibility to inform him/her of me bringing said minor child for treatment with Positive Start Counseling Services, Inc., in Palm Beach County, Florida.

____ Other (Please Specify)_____
** Documentation must be provided

My signature below signifies my understanding and agreement of the above

_____ _____
Parent/Guardian Date

_____ _____
Therapist/Witness

11440 Okeechobee Blvd #205B
Royal Palm Beach, Florida 33411
954-817-5825
561-693-5514 (Fax)
positivestartcounseling@msn.com
www.positivestartcounseling.com