OCALA CONSULTING AND PREVENTION

CONFIDENTIAL PATIENT INFORMATION

CLIENT INFORMATION

Name (First, Middle, Last): _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Appointment Reminder: ☐ Text ☐ Email

By providing this information you agree that we may use this information to contact you and remind you of an appointment via call or text messaging.

Social Security Number: _____-_____-_____ Birthdate: _____-_____-_____ Age: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered

REFERRAL INFORMATION

Referred By (Physician): _____ Physician Phone: _____

Other Referral Source: ☐ Website ☐ Social Media ☐ Yellow Pages ☐ Insurance Co.

EMERGENCY CONTACT

Emergency Name: _____

Relation: _____ Emergency Contact Phone: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Insurance Phone: _____

Policy Holder Name: _____ Birthdate: _____-_____-_____

Policy/ID Number: _____ Group Number: _____

Employer: _____ Relationship of Patient to Insured: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process all claims thru my insurance company. I authorize payment of medical benefits to: Ocala Consulting & Prevention, LLC.

☐ Client ☐ Parent/ Guardian

Signature: _____ Date: _____

Medications:

_____

_____

_____

What Brings You to Counseling?

_____

_____

_____

MINOR CHILDREN SEEKING COUNSELING

Mother's Name: _____

Father's Name: _____

Marital Status: ☐ Single ☐ Married ☐ Remarried ☐ Divorced ☐ Partnered ☐ Widowed Who Has Legal Custody: _____ Full or Joint: _____

If Applicable, Please Provide Copy of Custody Agreement Upon Initial Appointment.

FINANCIAL AGREEMENT

As a courtesy, this office will file claims with your insurance company for you and any benefit check given is not a guarantee of coverage. I understand that it is my responsibility to pay any deductibles, co-insurance or any other balance not paid by my insurance or third-party payer within a reasonable period of time, not to exceed 60 days. If you need to cancel or reschedule an appointment, please give us 24 business hours advance notice; otherwise, you will be billed a no-show fee of $50.00. Returned check fee is $25.00. Checks will no longer be accepted as a mode of payment after a "dishonored" or returned check is received on your account. Acceptable modes of payment will only be money orders, credit card, or cash. OCP requests that you provide your credit card to keep on file so that your services may be charged at time of service. By providing us a credit card to remain on file, you are consenting for OCP to charge your card at time of services for any copay or fees.

LEGAL MATTERS AND REQUESTS FOR LETTERS

Ocala Consulting & Prevention does not provide disability letters, companion pet letters, or letters regarding your ability to work, or any letters that would inform providers of your mental health history. You must discuss these needs with your medical or primary care provider. If a letter is required attesting the client's needs the therapist will provide it for a fee of $35. Letters are only provided to clients who have been seen for 8 sessions or longer.

COURT APPEARANCE

Clients are discouraged from having the therapist subpoenaed. Though the client's attorney, who initiates the subpoena request is responsible for the court appearance and testimony fees, it does not mean that the therapist's testimony will be solely in in the client's favor. The Therapist will only testify their professional opinion and to the facts of the case. The following fees apply for court appearances: Preparation Time (including submission of records): $120/hour Phone Calls: $120/hour Depositions: $150/hour Time Required in Giving Testimony: $150/hour

☐ Client ☐ Parent/ Guardian

Signature: _____ Date: _____

CONSENT FOR SERVICES

This form is to document that I, _____ give my permission and consent to the above, Ocala Consulting & Prevention, LLC., to provide psychotherapeutic treatment and/ or assessments to me and/or _____, who is/ are my child/ children or for whom I am legal guardian, custodian, or legal Power of Attorney. By signing below, I understand that Drug Testing (Urine or Swab Testing) may be part of my treatment at Ocala Consulting & Prevention, LLC. I also understand that a refusal to submit to Urine Analysis Testing or Swab Drug Testing could result in discharge from Ocala Consulting & Prevention, LLC. I understand the following: Although I expect benefits from this treatment and/or evaluation, such benefits or outcomes cannot be guaranteed. This therapist is not providing an emergency service. In case of an emergency, please call 911.Regular attendance will produce maximum benefits, but I am free to discontinue treatment at any time. Conversations with the therapist are confidential. However, by law, there are certain exceptions to the limits of confidentiality. These limits include actual or suspected child abuse, elder abuse, and threats of harm toward oneself or others. The therapist will make reasonable efforts to discuss these issues before breaking confidentiality, however disclosure may become necessary when ordered by a court of law. I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

To ensure OCP can fully focus on you during our sessions and provide the best care possible, we now use a virtual scribe that generates the necessary documents for the counselor, eliminating the need for note-taking throughout the sessions. The documents produced by the virtual scribe are derived from session recordings, which are not stored and are automatically deleted after processing. The scribe complies with HIPAA regulations, with all data encrypted both in transit and at rest. Additionally, notes are automatically deleted after 30 days or can be manually deleted at any time.

☐ Client ☐ Parent/ Guardian

Signature: _____ Date: _____

RELEASE & WAIVER OF LIABILITY

I, _____ am willingly entering Ocala Consulting & Prevention, LLC and give my consent to participate in therapeutic, psycho-educational and/or wellness counseling sessions and/or groups. I, the undersigned, agree to the following: I am participating in the programs and activities offered at Ocala Consulting & Prevention, LLC on my own accord. I understand and agree to comply with all facility and program rules. In case of emergency illness or accident, I authorize Ocala Consulting & Prevention, LLC to take me to the hospital of my choice, or, if I have no personal choice, to Ocala Regional Medical Center. I agree to follow the universal precautions: Program participants will allow staff to clean any toxic spills, blood, or other bodily fluids. I am entering Ocala Consulting & Prevention, LLC at my own request. I agree not to hold Ocala Consulting & Prevention, LLC or any of its Board of Directors and/or staff liable for any loss and/or injury to my person or property suffered by me while I am in or about the premises of Ocala Consulting & Prevention, LLC. I assume all risk involved in participation in the programs and activities. This assumption is made freely and voluntarily and with full and complete understanding of the consequences of such risk assumption.

THIS AGREEMENT SIGNED BY:

☐ Client ☐ Parent/ Guardian

Signature: _____ Date: _____

GENERAL INFECTION CONTROL POLICY

All clients are instructed to read their handbook given to them at time of admission. This outlines preventative health care. All participants at Ocala Consulting & Prevention, LLC are to be treated with universal precautions.

☐ Client ☐ Parent/ Guardian

Signature: _____ Date: _____

CLIENT LEGAL RIGHTS / GRIEVANCE

All individuals who apply for services, regardless of sex, race, age, color, creed, financial status, military status, religion, sexual preference, or national origin are assured that their lawful rights as patients shall be guaranteed and protected. While being served, the Patient is assured and guaranteed the following rights:

✓ To be treated with respect and dignity. To receive timely treatment by qualified professionals. Every effort will be made to use the least restrictive, most appropriate treatment available, based on patient need. Each Patient shall be afforded the opportunity to participate in activities designed to enhance self-image. To receive quality treatment that is best suited to his/her needs and shall include appropriate services medical, vocational, social, educational, and/or rehabilitative services. To express by signature an informed consent of the right to release information for communication purposes, with other agencies. To receive communication and correspondence from individuals. To privacy for interview/counseling sessions.

✓ To report abuse by the following toll-free number: 1-800-962-2873

✓ To confidentiality, except where noted in the Federal Law of Confidentiality. To receive full information regarding the treatment process. To refuse treatment. To all other constitutional and legal rights, including the right to personal clothing and effects. To be informed of the Patient grievance procedure upon request.

✓ Grievance Procedure It is the policy of Ocala Consulting & Prevention, LLC to treat our patients with dignity and respect and in a humanitarian manner, utilizing standard treatment practices applicable to each patient's needs. If, despite these efforts of Ocala Consulting & Prevention, LLC staff, a patient feels that his/her rights have been violated in any way, he/she will have a right to seek a remedy by filing a grievance. I hereby acknowledge receipt of and understand the "Patient Rights" statement as indicated by my signature:

☐ Client ☐ Parent/ Guardian

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of privacy Practices that we have in effect at the time. We must provide you with the following important information. How we may use and disclose your PHI, your privacy rights to your PHI and Our obligations concerning the use and disclosure of your PHI. The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to change or amend this Notice of Privacy practices. Any change or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current Notice in our office in a prominent location.

WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI. Treatment. Our practice may use your PHI to treat you. We may also disclose PHI about you for the treatment activities of another healthcare provider. Payment. Our practice may use and disclose your PHI to bill and collect payment for the services you may receive from us. Healthcare Operations. Our practice may use and disclose your PHI to operate our business.as examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment or to provide information about treatment alternatives or other health benefits and services that may be of interest to you. Release of Information to Family/Friends. In certain situations, our practice may release your PHI to a family member or close friend that is involved in your care or payment for your care.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES WITHOUT YOUR AUTHORIZATION

The following categories describe special situations in which we may use or disclose your PHI without your authorization, or opportunity to agree or object:

Public Health Risks - Our practice may disclose your PHI to public health authorities that are authorized by law to collect information, including: maintaining vital records, such as births and deaths, reporting child abuse, neglect or domestic violence, preventing or controlling disease, injury or disability , notifying a person regarding potential exposure to a communicable disease ,notifying a person regarding a potential risk for spreading or contracting a disease or, condition, reporting reactions to drugs or problems with products or devices regulated by the Federal Food and Drug Administration (FDA), notifying individuals if a product or device they may be using has been recalled.

Notifying your employer under limited circumstances to workplace injury/illness or medical surveillance information.

Law Enforcement - We may release PHI if asked to do so by a law enforcement official: Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement Concerning a death we believe has resulted from criminal conduct Regarding criminal conduct at our offices In response to a warrant, summons, court order, subpoena or similar legal process To identify/locate a suspect, material witness, fugitive or missing person In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

Serious Threats to Health or Safety - Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military - Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

Right to a Paper Copy of This Notice - To obtain a paper copy of this notice, contact the Privacy Official.

Complaints - If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health Services. To file a complaint with our practice, contact the Privacy Official. All complaints must be submitted in writing within 180 days of the alleged violation. You will not be penalized for filing a complaint. Again, if you have any questions regarding this notice or our health information privacy policies, please contact: Ocala Consulting & Prevention, LLC Jackie Gibson, CEO 2100 SE 17TH Street, Suite 701 Ocala, FL 34471-4171 (352) 622- 4488.

☐ Client ☐ Parent/ Guardian

Signature: _____ Date: _____