CLIENT INFORMATION FORM

Date:_____

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____Cell phone:_____

DOB:_____ SS#_____ E-mail_____

Employer:_____

Can you receive phone calls at work? Yes, No Work Phone:_____

Spouse or significant other:_____

DOB:_____ SS#_____ E-mail_____

Employer:_____ Cell Phone_____

Contact at work? Yes, No Work Phone:_____

Children:

Name:_____DOB:_____ Name:_____DOB:_____

Name:_____DOB:_____ Name:_____DOB:_____

Are you taking any psychiatric medication? If yes, please provide names and dosages.

_____

Please explain why you are seeking counseling at this time.

_____

_____

_____

RIGHTS AND EXCEPTIONS TO THE RELEASE OF CONFIDENTIAL INFORMATION

Joel S. Brooks, LCSW, maintains a strict ethical and legal obligation to protect the privacy of clients by not disclosing names, diagnosis or any other personal information disclosed in the course of treatment to anyone outside of the treatment setting. Treatment information will only be released to appropriate persons or institutions, (such as physicians, mental health professionals, etc.) upon a signed consent to do so.

All inquiries about any client of Mr. Brooks, whether by mail, telephone or person will be responded to with a statement such as, "I cannot release that information unless I have the patients written consent."

It is very important to know and understand that there are rare occasions when Mr. Brooks will be required by law to breach confidentiality. The exceptions to confidentiality are as follows:

1) Cases that involve suspicion or knowledge of abuse or neglect of children, elderly persons or disabled adults. Florida law requires all Mental Health Professionals and a variety of other professionals to immediately report any suspected or known abuse, neglect or abandonment of a child, elderly person or disabled adult. These reports will be made to the Florida Abuse Registry.

2.) When there is a clear and immediate probability of physical harm to self or to other individuals or to society and the therapist communicates the information only to the potential victim, appropriate family members or law enforcement or other appropriate officials.

3) When the therapist is a defendant in a legal proceeding arising from a complaint filed by the client.

4) A court order is obtained for an evaluation or report and the therapist is appointed or retained to provide these services. However, only the records required to prove the case should be released.

I have read and understand the terms as stated above. I also understand that Mr. Brooks can not be held accountable for any breach of confidentiality as long as the release of information falls withing the exceptions as described.

Client Signature_____ Date_____

CANCELLATION POLICY

Mr. Brooks is committed to providing you the most effective and efficient treatment services possible. To do so, it is important for you to be aware of the fee policy and reasoning behind it as well as your cooperation.

Payment is due at the time services are rendered, unless other arrangements have been made with Mr. Brooks. If you have an HMO, or PPO plan, you will be responsible for your co-pay, if any, at the time you are seen. Any other out of pocket fee will be due at the time of service. By having you pay at each session this will eliminate the need to bill you. This helps to keep our costs as low as possible, prevents accumulation of large debts on your part and avoids possible risk of your privacy that occur when invoices for services are mailed to you.

Mr. Brooks encourages you to discuss any assistance you may need due to unexpected or temporary financial problems that you may experience. Mr. Brooks will always take into consideration any problems you may have that could limit your ability to pay.

Mr. Brooks requires 24 hour advance notification if you are not able to keep a scheduled appointment. This notice permits Mr. Brooks to offer that time to someone else. If you have given 24 hours' notice, you will not be charged for the appointment. However, if you break your appointment and do not call within 24 hours, you may be charged for the session.

Mr. Brooks understands that there may be occasional emergencies when you will not be able to keep your appointment and also will not be able to provide notification within 24 hours. These circumstances will be considered and taken into account.

Charges for broken appointments and appointments cancelled without 24 hours notice cannot be billed to your insurance. You will be personally responsible, therefore for the full amount of the session.

I have read the above policy and understand I wll be responsible for payment in full should it become necessary.

Client signature:_____ **Date:**_____

If you would like a copy of this, please let Mr. Brooks know and he will be glad to provide you with one.

WHAT TO EXPECT FROM THERAPY
A PERSONAL MESSAGE FROM JOEL BROOKS

Therapy is a process for change that will help you find new solutions to difficult problems you are experiencing. I will help you to find these solutions for yourself by respecting your right to self-determination with a non-judgmental, empathetic and compassionate approach that will build on your strengths rather than weaknesses.

All therapy sessions will be kept strictly confidential. If you wish to have your therapy shared with a family member, spouse, friend or your primary care physician, please let me know. Otherwise, no information will be released without your written consent.

As you work for successful resolution to your problems, you may experience many changes in your feelings that may cause you to feel uncomfortable. I will be available to help you work through these feelings, that at different times in therapy may be difficult. Please take advantage of your therapy appointments to discuss with me, at any time how you are feeling about your counseling experience.

Upon the conclusion of each therapy session, another appointment will be scheduled for you, unless it is agreed upon by you and me, or you have self-determined that therapy is no longer necessary. Appointments are scheduled Monday thru Thursday, 10:00 am to 7:00 pm. You will be provided with two telephone numbers to contact me directly at any time.

I received my Master's Degree in Social Work from the University of Nebraska at Omaha in 1981. I am licensed with the state of Florida as a Licensed Clinical Social Worker. I have been practicing Clinical Social Work in Tampa, Hillsborough and Pinellas Counties since moving to Tampa in 1981, specializing in and providing treatment services for individual adults, couples, children and adolescence as well as providing supervision and administrative programing in other private/non profit organizations. I have been in private practice since 2002.

If you have any questions or concerns about your treatment, please feel free to discuss them with me at any time. I look forward to working with you.

INSURANCE/FEE CONSENT

I understand I am personally responsible for the cost of services not covered by my insurance including but not limited to unmet deductibles, co-payments and any fee or portion of fees not paid by my insurance carrier, or for those fees that I chose to pay out of pocket, should I chose not to file with my insurance company. I understand these fees are due at the time of service.

I understand that I am personally responsible to provide Joel S. Brooks, LCSW of any changes in my insurance coverage. I will be responsible for any fees not paid by my insurance due to changes not being provided in a timely manner.

Costs of service that include but not limited to, unmet deductibles, co-payments, fees that cannot be billed to insurance, or those fees chosen not to be submitted to insurance, that are not paid within 30 days of written notice of the balance due may be submitted for billing/collections with IC System. A 10% service charge will be added to all outstanding debt beyond 30 days. Other additional fees may apply.

By choosing to have my insurance company billed for services, the benefits due to me under my policy are hereby assigned to Joel S. Brooks, LCSW. I understand that my insurance company will require specific diagnostic and treatment information. I consent to the release of all requested confidential information to Mr. Brooks' billing agent D. Black Practice Services and my insurance company for the purpose of processing my claim. I understand that Joel S. Brooks, LCSW cannot be responsible for confidential information once it is released to my insurance.

Client Printed Name:_____
(Parent or Guardian)

Client Signature:_____ Date:_____