LIFE CONNECTIONS
COUNSELING CENTER
4903 Van Dyke Rd, Lutz, FL 33558
813-265-3859 Voice 813-265-3966 FAX info@lc-online.org www.LifeConnectionsOnline.org

Welcome to Life Connections

Welcome to Life Connections. We are pleased that you have chosen us to help you achieve emotional and relational health. We are committed to doing all we can to make your work with us as effective and helpful as possible. Although you will see only one counselor, we use a team approach, so each counselor is supported by all the others.

What follows is our intake materials. The information we request will give your counselor background information on you. Completeing it is part of your preparation for counseling.

Our sessions with you usually last 50 minutes each. How many times you meet with your counselor depends on the issues you bring and your commitment to the process. We believe that time spent in counseling is a powerful investment in your self and in your future.

We have several policies about fees that you should be aware of: (Please initial each blank, indicating that you have read and understood each policy.)

_____ **We collect fees when services are provided.** If you have insurance coverage, you have the responsibility of submitting claims to collect from your insurance company.

_____ **We bill for any additional professional services we provide beyond the office visit.** Additional services include, but are not limited to, unscheduled phone sessions, written reports for third parties, consultation with other professionals, and any reports needed for legal reasons.

_____ **If you and your counselor decide that a psychological assessment may be needed, you will be responsible for the fees for the assessment.**

_____ **Please notify us of cancellations at least 36 hours in advance.** You may cancel by leaving a voice mail message. If you cancel less than 36 hours before your appointment, we will bill you for the appointment.

_____ **If you cancel twice in a row with less than 36 hours notice, or if you miss a total of two scheduled appointments without notifying us, we reserve the right to suspend services.**

_____ **If you have provided us with a debit or credit card for billing purposes, that card may be used for payment in the event of a missed appointment with less than 36 hours notice.**

_____ **If we are seeing you or your children for counseling or psychotherapy, we are prevented by Florida law from serving as expert witnesses in legal matters dealing with child custody, fitness of parenting, or divorce.**

_____ **Digital communication with us vie email or cell phone may not be secure. We are obligated ethically and legally to protect the confidentiality of all communication with you. We have procedures and technology in place to protect all records we keep, but we can not protect digital communication that leaves our office.**

We also want you to know that we cannot guarantee around-the-clock availability. If you should experience a behavioral or emotional crisis and you cannot reach us by phone, you should contact the Hillsborough Suicide & Crisis Hotline at **813-238-8822** or **813-234-1234**. For Children's Crisis Services call **813-238-5909**. For the Mobile Crisis Unit call **813-237-3101**.

General Information

Date ____

Child's Name ____

Parent/Guardian's Name(s) ____

Sex M F Age _____ Date of Birth ________________

Address ____

____

____ Zip ____

Phones Day ____________________________________ May we leave a message? Yes No

Evening ________________________________ May we leave a message? Yes No

Cell __________________________________ May we leave a message? Yes No

Email Address ____

How did you learn about Life Connections?

____

My Situation,
for Parent/Guardian

Please complete the following items as completely and honestly as you can about your child. Your answers will help us better understand your situation with your child.

If you are completing this form anywhere other than our office, you are responsible for keeping the form confidential.

General Consent

I understand that by completing this form I am requesting services from Life Connections Counseling Center for my child. I understand that Life Connections staff will use the information in this form to determine what services Life Connections staff may be able to offer. If Life Connections staff determine that they are not able to provide services, they will give me appropriate referrals to other professionals.

If Life Connections staff determine that they are able to provide services, I give my general consent to use the information in this form for treatment, payment, and health care operation purposes. This consent does not allow Life Connections to release any protected health care information to any person or organization outside Life Connections, except when mandated by law. I understand that this consent is governed by the practices described in the document titled *Notice of Privacy Practices for Protected Health Information*, which is at the end of this packet. I have received a copy of this document.

I also consent to digital communication via email and cell phone that may not be secure.

I hereby give permission to the staff of Life Connection to use my child's protected health information for purposes of treatment, payment, and health care operations.

____

Signature of parent/guardian   Date

Name of person completing this form and relationship to the child.

____

Presenting problem

Describe the problems yourchild is having and when they began.

____

____

____

Rate the severity of this concern, with 1 being not at all severe, and 10 being very severe. ___

When did this problem begin?____

____

What seems to make the problem worse?____

____

What seems to make the problem better?____

____

What have you done to try to solve this problem?_______________________________

____

Please check any symptoms your child is experiencing

___Aggression or Anger outbursts
___ Alcohol abuse
___ Anxiety
___ Avoidance of people
___ Computer addiction
___ Depression
___ Difficulty concentrating
___ Difficulty thinking
___ Distractibility

___ Dizziness
___ Drug abuse
___ Eating disorders
___ Elevated mood
___ Fatigue
___ Fears (list)
____
___ Hallucinations
___ Headaches
___ Helplessness
___ Hopelessness
___ Impulsivity
___ Indecisiveness

___ Irritability
___ Loneliness
___ Memory problems
___ Mood swings
___ Muscle tension
___ Panic attacks
___ Racing thoughts
___ Restlessness or on edge
___ Sexual addiction
___ Sleeping problems

___ Stressed out
___ Suicidal thoughts
___ Trembling
___ Weight gain/loss
___ Withdrawal
___ Worrying
___ Worthlessness
___ Other symptoms
____
____
____
____

List all the child’s previous mental health treatment, and the provider.

____

____

____

Please list any mental health problems in the child's extended biological family

____

____

Pregnancy and birth history

Was the pregnancy ____ planned or ____ unplanned? Was it full term? ____Yes ____No

How did the mother feel about this pregnancy? ________________________________

How did the father feel about this pregnancy? ________________________________

Were any alcohol, drugs, or medications used during pregnancy? ____ Yes ____ No

If yes, please describe. ____

Describe any problems with the pregnancy?

____

Describe any problems with the birth?

____

Developmental history

Was the baby ____ breast fed ____ bottle fed ____both?

Who was the primary caregiver for the child? ________________________________

Estimate when the child first:

Began menstruation ____	Said first words ____	Smiled ____
Crawled ____	Said phrases ____	Stood ____
Fed self ____	Said phrases ____	Toilet trained ____
Ran ____	Sat up on own ____	Walked ____

Were there any illnesses, behavioral difficulties, or discipline problems during early childhood?

____

____

If the child had temper tantrums, please describe when, how often, and about what?

____

____

What discipline techniques were used, and how consistent was parental discipline?

____

____

Medical history

Who is your child's primary care physician?

____

Date of last visit ________________ Date of last physical _________________

Are the child's immunizations up-to-date? ____ YES ____ NO

Check which of the following your child has experienced

___ Arthritis
___ Asthma
___ Cancer
___ Chronic pain
___ Diabetes
___ Head injury
___ Headaches
___ Heart disease
___ Hepatitis
___ HIV
___ Hypertension
___ Hypoglycemia
___ High fevers
___ Kidney disease
___ Liver disease
___ Loss of consciousness
___ Lung disease
___ Meningitis
___ Memory problems
___ Migraines
___ Seizures
___ Sexually transmitted disease
___ TB
___ Thyroid problems
___ Other
____
____
____

For each item checked above, please describe your child's age at onset and the treatment and outcome.

____
____
____

List any hospitalizations or surgeries your child has had.

____
____

Please list all current medications, prescribed and over the counter, including herbal supplements. Include those prescribed for emotional or behavioral problems:

Medication	Dosage	Date started	Prescribed by	Condition prescribed for

What allergies does your child have?

____

Social history

Place of birth ____

Where did your child grow up? ____

If your child is adopted, at what age? ____

If the child's family moved around, please describe.

____

____

Please list all members of the household, their ages, and relationship to the child.

____

____

____

Which family members is the child close to?

____

List any trauma your child may have suffered (physical, sexual, emotional).

____

____

____

Describe the child's relationship like with the FATHER.

____

____

Describe the child's relationship with the MOTHER.

____

____

Please describe any significant conflicts the child has with family members.____________________

____

Whom does the child rely on for emotional support? ___________________________________

____

What losses, changes, or transitions have occurred in the child's life? _____________________

____

What spiritual, cultural, or religious beliefs have influenced the child?

____

Relationship history

How does your child make friends?

____

____

How does your child get along with others?

____

____

Educational history

What grade does your child attend? ___________________

What kind of student is your chid? ____

____

List any special educational services your child receives. _________________________________

____

How does your child get along with teachers and peers? __________________________________

____

What discipline problems does your child have in school? ________________________________

____

What are the child's strengths?____

____

What are the child's weaknesses?____

____

Legal history

Have you been court ordered to bring your child in for counseling? ___Yes ___No

List any current involvement you or your child has with the criminal or civil legal system

____

____

What additional information would be helpful for your therapist to know?

____

____

Please mark the times you are available

Time/Day	Mon	Tue	Wed	Thr	Fri	Sat
8 am						
9 am						
10 am						
11 am						
12 noon						
1 pm						
2 pm						
3 pm						
4 pm						
5 pm						
6 pm						
7 pm						

What phone number can we call to schedule an appointment? ___________________________

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Protected health information (PHI) is the information we record when we provide counseling services to you. Such information may include your reason for seeking counseling, assessment results, diagnosis, treatment plan, notes from your counseling sessions, and both billing and payment records.

With your consent, Life Connections is permitted by federal privacy laws to use and disclose your health information for purposes of treatment, payment, and health care operations. Here are examples of how we might use your PHI for each of these purposes.

- We use your PHI for treatment purposes when a counselor reviews notes about your last counseling session prior to your next session.
- We use and disclose your PHI for payment purposes when we submit a request for payment to your health insurance company or to any other organization, such as a church, that may be paying for a portion of your treatment costs.
- We use your PHI for health care operations when the Director reviews your records in order to evaluate how well clinical staff members are documenting their counseling services.

Your health information rights:

The health and billing records we maintain are the physical property of this office. The information in it, however, belongs to you. You have a right to:

- Request that we restrict our use and disclosure of your protected health information by delivering the request in writing to our office. We are not required to grant the request, but we will work to comply with any request granted or negotiate with you an acceptable alternative.
- Request that you be allowed to inspect and receive a copy of your health and billing records. You may exercise this right by delivering the request in writing to our office.
- Appeal a denial of access to your PHI except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your PHI.
- Obtain an accounting of all disclosures of your health information to third parties outside this office not associated with treatment, payment, or health care operations, or disclosures made to you.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office.
- Revoke any authorizations that you made previously to use or disclose information by delivering a written revocation to our office. This revocation does not apply to any disclosures your authorized and that have already taken place.

- Review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

If you want to exercise any of the above rights, please contact James Reed, PhD, Director of Life Connections, in person or in writing, during normal business hours. He will help you take the right steps to exercise your rights.

Our responsibilities

Life Connections is required to:

- Maintain the privacy of your health information as required by law
- Provide you with this notice that explains how we protect information that we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we cannot accommodate a requested restriction or request
- Accommodate your reasonable requests regarding methods to communicate health information to you.

Within our rights and responsibilities by law, we reserve the right to amend, change, or eliminate provisions in our privacy and access practices and to enact new provisions regarding the PHI we maintain. Any time our practices change, we will amend our Notice to reflect these changes.

To request information or file a complaint

If you want to file a complaint or report a violation of the privacy of your PHI, please contact James Reed, PhD, Director of Life Connections, in person, or in writing, during normal business hours. You may also file a complaint by mailing or emailing your complaint to the Secretary of Health and Human Services. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

When will we disclose your PHI

Life Connections will only release, or disclose, your PHI to any person or organization not a part of Life Connections if you give us written authorization to do so. By law, however, we *must* report to legal authorities if we suspect abuse of children, elderly persons, or disabled persons. Such a report would only disclose that you are receiving services at Life Connections. By law, also, we *may* disclose appropriate portions of your PHI if you are receiving services under workers compensation, if you are a danger to yourself or others, or if we are legally compelled by a court order or similar judicial action. In these cases, our practice will be to secure written authorization from you unless doing so is dangerous or will lead to harm to you. You may revoke any written authorization you have given to us at any time.