Lutheran Counseling Services

Personal Information Form

(Please print clearly.)

No information leaves this office without signed release. All information is privileged and confidential to the extent permitted by law.

Today's Date: _____ Would you like to receive our newsletter via email: ☐ Yes ☐ No

Client's Full Name: _____ Preferred name_____

Gender: _____ DOB:____/_____/____ Age: _____Email_____

Address_____ City: _____ State: _____ Zip: _____

County _____ Phone_____ Messages ok? ___Yes ___ No

Employer/School: _____Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

How were you referred to LCS? ☐ Friend ☐ Insurance ☐ Church/Pastor ☐ School ☐ Other:_____

Relationship Status: __ Single __ Engaged __Committed Relationship __Married (__yrs) __ Divorced in _____ (year) __Widow(er)

Race: _____ Choose not to disclose: _____

People living in home: _____ (list below)

Name	Age	Relationship

Primary Physician/Psychiatrist: _____ Phone: _____

Prescription Medications (if any): _____

Have you or a family member ever been hospitalized for emotional disorders? Yes ___ No ____

Name/ When/ Where: _____

Previous Therapy/Counseling (List below, most recent first)

Year	Therapist/Counselor	# of Sessions

Reason for making appointment: _____

Additional relevant medical or personal information: _____

_____

_____

Lutheran Counseling Services

Supplemental Information for Minors

(Please print clearly.)

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Parents are: ___ Married ___Divorced* ___Separated* ___Never Married* Other_____

Is there a Parenting Plan? ____ Yes ___ No (*Please provide a copy to LCS.)

Mother's Name: _____ Email_____

Address_____ City: _____ State: _____ Zip: _____

Mother's DOB___/___/___ Age: _____Phone_____ Messages ok? ___Yes ___ No

Employer: _____Occupation: _____

Father's Name: _____ Email_____

Address_____ City: _____ State: _____ Zip: _____

Father's DOB___/___/___ Age: _____ Phone_____ Messages ok? ___Yes ___ No

Employer: _____Occupation: _____

Other Parent(s) or Guardians (if applicable) _____

Address: _____Phone: _____

Siblings names & ages: _____

Consent for treatment of Minors:

I, _____, do hereby authorize that my child, _____,
(Parent/Legal Guardian Name) (Child's Name)

may receive mental health treatment provided under the establishment of Lutheran Counseling Services. I am aware that custodial parents and legal guardians must give consent before treatment begins. If parents are currently separated or divorced, both parents are required to give consent. If one parent has full legal right, LCS would need to be made aware with proper documentation (i.e. copy of divorce agreement) if the other parent does not have rights to access information regarding the child.

Print Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

LCS believes children/minors deserve an environment that provides a sense of reflection while feeling safe, secure and comfortable. We believe that an important component of this environment is to build a trusting relationship between the therapist and the client (child). Confidentiality between your child and the mental health professional is a part of the therapy process. We are legally obligated not to reveal information learned about your child to the parent(s) unless for the purpose to warn and protect the child or another person(s). We also believe that the parent(s)/legal guardian(s) are an integral part of the therapeutic process and we will certainly communicate the parents by providing general information about the therapeutic process.

Lutheran Counseling Services

Cancellation & Missed Appointment Policy

Lutheran Counseling Services (LCS) has a required *minimum 24-hour cancellation policy* which includes rescheduling appointments. If an appointment is missed, rescheduled, or cancelled within the 24- hour period, you will be assessed a fee.

Cancellation Fees:
$50 – Missed Appointments
$35 – Cancelled Appointments
$35 – Last minute rescheduled appointments

For reoccurring missed, rescheduled, or cancelled appointments, the client will be asked to leave a credit card and a deposit on file. Your Insurance does not pay for the missed or late cancellations; you will be responsible for this fee.

Electronic Communication & Social Media Policy

Contacting your Therapist between appointments: You may contact your therapist via voicemail with any issues regarding scheduling appointments, policy, billing and other non-emergency or non-clinical concerns. In case of a life-threatening emergency, call 911 or go to your nearest emergency room. We strive to respond to communications within 48 business hours whenever possible.

Email – LCS may use email in order to arrange appointments or address billing questions. Any clinical matters or issues related to treatment will be addressed in the clinical session only. Please avoid emailing content related to your therapy sessions, as email exchanged outside of our office is neither completely secure nor confidential. Email, text messaging, and other forms of electronic communication are not effective means of communicating with your therapist in a clinical emergency.

Social Media - We are committed to maintaining professional and ethical boundaries that include, but are not limited to, protecting the privacy of our therapeutic relationship. Therefore, your therapist will not accept "friend" or contact requests from current clients on any social networking site.
Please do not attempt to contact your therapist by using networks such as Twitter, Facebook, Linked-In, Instagram, or any other networking site. It is our practice not to respond to such contacts from current clients. However, please feel free to subscribe to posts, blogs and business pages on any of Lutheran Counseling Services' social network accounts.

Legal - Any emails your therapist receives from you and any responses sent back to you become a part of your Legal Clinical Record.

I understand LCS policies as stated above. I am fully aware I will be charged for any of the above stated fees, and I will be responsible for payment of these fees. Additionally, I am aware future appointments will not be allowed until the balance on my account is paid in full.

By signing below, you express your understanding and agreement of these policies.

Client Name/Legal Guardian (if necessary) Printed: _____

Client/Legal Guardian Signature: _____ Date: _____

Lutheran Counseling Services

HIPAA and Privacy Policies

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Client health records contain personal information about the client and their health. This information, which may identify the client and relates to their past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information or PHI. This Notice of Privacy Practices describes how Lutheran Counseling Services may use and disclose the client PHI in accordance with applicable law. It also describes client rights regarding how they may gain access to and control PHI.

LCS is required by law to maintain the privacy of PHI and to provide clients with notice of our legal duties and privacy practices with respect to PHI. LCS is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide clients with a copy of the revised Notice of Privacy Practices by mail or in person at the time of appointment.

How LCS may use and disclose health information about clients:

For Treatment: The client's PHI may be used and disclosed for the purpose of providing, coordinating, or managing the client's health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with client's authorization.
For Payment: LCS may use or disclose PHI so that we can receive payment for the treatment of services provided to the client. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, 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, we will only disclose the minimum amount of PHI necessary for purposes of collection.
Required by Law: Under the law, LCS must make disclosures of the client's PHI to the client (or legal guardian) upon request. In addition, LCS must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining LCS' compliance with Privacy Laws.
The following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization:

Abuse and Neglect	**Emergencies**
National Security	**Judicial Proceedings**
Law Enforcement	**Public Safety (duty to warn)**

Without Authorization: Applicable law and ethical standards permit us to disclose information about the client without the client's authorization only in a limited number of other situations. The types of uses and disclosures that may be made without client's authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the marriage and family licensing board or the Health Department)
- 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.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with client's written authorization, which may be revoked by the client at any time.

Client Rights regarding PHI:

- **Right of access to inspect and copy**. Client's have the right, which may be restricted only in exceptional circumstances to inspect and copy PHI that may be used to make decisions about client care. Client's rights to inspect and copy will be restricted only in those situations where there is compelling evidence that access would cause serious harm to the client. LCS may charge a reasonable, cost-based fee for copies.
- **Right to amend.** If a client feels that the PHI that LCS has about the client is incorrect or incomplete, you may ask LCS to amend the information although LCS is not required to agree to the amendment.
- **Right to an Accounting of Disclosures**: Clients have the right to request an accounting of the disclosures that LCS makes to PHI. LCS may charge a reasonable fee if disclosures are requested more than once during a 12-month period.
- **Right to Request Restrictions**: Clients have the right to request a restriction or limitation on the use or disclosure of the PHI for treatment, payment, or health care operations. LCS is not required to agree to client's request.
- **Right to request confidential communication**: Clients have the right to request that LCS communicates with clients in a certain way or at a certain location.
- **Right to copy this notice**. Clients have a right to a copy of this notice.
- **Electronic Transaction Standards**

Complaints: If you believe that the client's privacy rights have been violated and wish to file a complaint with our office, you have the right to file a complaint in writing to us at: Lutheran Counseling Services, 1505 Orchid Avenue, Winter Park, FL 32789. You may also send a written complaint to the Secretary of Health and Human Services at: 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202)619-0257. You have specific rights under the privacy rule. LCS will not retaliate against a client for exercising their right to file a complaint.

I acknowledge that I have read and understand the above information.

Print Name: _____

Signature of client or legal guardian: _____

Date: _____

Lutheran Counseling Services

PAYMENT POLICY: Self-Pay Clients

Lutheran Counseling Services (LCS) requires payment in full when services rendered. As a client, you are either a self-paying client or your fees are being paid by your health insurance.

Our fee is $135 per session.

For those clients who are un-insured or are unable to pay the $135/session fee, LCS offers a sliding fee scale based on household income.

Gross Household Income: _____ Yearly or Monthly Income: _____

Sliding Scale Fee: _____

LCS's sliding scale fee is based on household income. Depending on the level of household income, a request for a subsidy application may be considered. LCS front-office staff will discuss self-pay and subsidy requests on an individual basis.

Subsidy Application: Yes ☐ No ☐

TERMS OF SERVICE/FINANCIAL RESPONSIBILITY

I understand LCS' payment policy as stated above. I am fully aware payment is due when services are rendered, and I accept full responsibility for payment of any balance incurred for services. Additionally, I am aware future appointments will not be allowed until the balance on my account is paid in full; this includes any missed appointment, rescheduled appointment, and/or cancellation fees.

By signing below, you express your understanding and agreement of these policies.

Client Name/Legal Guardian (if necessary) Printed: _____

Client/Legal Guardian Signature: _____ Date: _____

Lutheran Counseling Services, Inc.
Child/Adolescent Wellness Assessment

Client Name:_____ Todays Date:_____ Date of Birth:_____

Completed by: _____Relationship to child:_____

Directions: Emotional and physical health go together. Because parents are often the first to notice a problem with their child's behavior , emotions or learning, you may help your child get the best care possible by answering these questions.

Please mark under the heading that best describes you (or your child if completed by parent)	Never	Sometimes	Always
1. Complain of aches and pains			
2. Spend more time alone			
3. Tire easily			
4. Fidgety, unable to sit still			
5. Have trouble with teacher			
6. Less interested in school			
7. Act as if driven by a motor			
8. Daydream too much			
9. Are easily distracted			
10. Are afraid of new situations			
11. Feel sad, unhappy			
12. Are irritable, angry			
13. Feel hopeless			
14. Have trouble concentrating			
15. Less interest in friends			
16. Fight with other children			
17. Absent from school			
18. School grades dropping			
19. Down on yourself			
20. Visit the doctor with doctor finding nothing wrong			
21. Have trouble sleeping			
22. Worry a lot			
23. Want to be with parent more than before			
24. Feel that you are bad			
25. Take unnecessary risks			
26. Get hurt frequently			
27. Seem to be having less fun			
28. Act younger than children your age			

PLEASE COMPLETE OTHER SIDE BY FOLDING UP PAGE

Please mark under the heading that best describes you (or your child)	Never	Sometimes	Always
29. Do not listen to rules			
30. Do not show feelings			
31. Do not understand other people's feelings			
32. Tease others			
33. Blame other for your troubles			
34. Take things that do not belong to you			
35. Refuse to share			

Do you have any emotional or behavioral problems for which you would like help? ( ) No ( ) Yes

Do you want the therapist to know any other information?