

435 Main Street Islip, Suite 5 Islip, NY 11730

*(631) 664-1582 • nylifeworks@gmail.com*

www.nylifeworks.com

**Client Information Form**

Today’s Date:      First Name:                     Last Name:                

Date of Birth:           Age:     Gender:       SSN:                    

Address:                                                                  

Referred By (How did you hear about us? ):                     Reason for Referral:      

Primary Phone Number:                     May we leave a detailed voicemail? Secondary Phone Number:                     May we leave a detailed voicemail?

**Emergency Contact**

Name:                     Number:                    Relationship:            Primary Care Physician(Name/Number):                                         

Psychiatrist (if applicable) (Name/Number):                                         

**Medical Information**

Current Medication:                                                             Allergies:                                                                       Significant Medical/Psychological History:                                                                                                                                                                                                                                                 



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**CONSENT TO TREATMENT**

Name:                                                             Date:                         

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, at LifeWorks Mental Health Counseling Services, PLLC, hereby referred to as LWC. Further, I consent to have treatment provided by a psychiatrist, nurse practitioner, mental health counselor, social worker, marriage and family therapist or intern in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the treatment may be discontinued at any time by either party. LWC encourages that this decision be discussed with the treating clinician. This will help facilitate a more appropriate plan for the future.

Recipient’s Rights: I certify that I have received the Recipient’s Rights notice and certify that I have read and understand its’ content. I understand that as a recipient of services, I may get more information from the Recipient Rights Advisor, the owner of the practice.

Non-Voluntary Discharge from Treatment: A client may be terminated from LWC non-voluntarily, if A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the facility, and/or B) the client refuses to comply with the stipulated program rules, refuses to comply with the treatment recommendations or does not make payment or payment arrangements in a timely matter. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the owner of the practice or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by LWC is protected by Federal and/or State laws and regulations. Generally, LWC may not disclose to a person outside of LWC that a client is a recipient of services unless 1) the client consents in writing, 2) the disclosure is allowed by 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.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to the appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a client either at the facility, against any person who works at the facility, 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 or regulation to the appropriate state and/or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the duty of LWC to warn any potential victim, when a significant threat of harm has been made. In the event of a client’s death, the spouse or parents of a deceased client have the right to access their spouse’s or child’s records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client’s records. When fees are not pain in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

Financial Policy: As a service to you, LWC may bill insurance companies and other third party payers, if the therapist is an in network provider, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. Clients are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates. Insurance companies may deny payment for treatments that they deem unnecessary, and in this instance, the client is responsible for payment. Insurance deductibles and co-payments are due at the time of service. Your signature below indicates authorization for LWC to bill your insurance company for reimbursement unless fees are paid in full at the time of services.

Clients are responsible for payments at the time of services. The adult accompanying a minor is responsible for payments for the child at the time of services.

Missed appointments or cancellations less than 24 hours prior to the appointment time are charge at a rate equal to your session fee. You will be held responsible for this fee. Please provide us with adequate notice.

Payment methods include cash, check or credit card. Payments not received after 120 days are subject to collections. A 10% per month interest rate is charged for accounts over 60 days late. There will be a $30 fee for checks returned for insufficient funds.

Clients will be charged a fee for all non-clinical services and reports that are requested of the clinician. The fee for providing documentation, reports, files and/or client records to any third party by way of a release of information are charged at a rate of $100/hour of work and may be prorated when applicable. This fee must be paid before records are released.

Court Testimony: Clients will be charged a rate of $300 per hour to be paid in advance in the event that expert testimony or judicial interviewing/witness or other in person legal services are required.

I consent to treatment and agree to abide by the above stated policies and agreements with LWC.

Signature of Client or Legal Guardian Date



CANCELLATION POLICY ACKNOWLEDGMENT

Dear Valued Client,

Your time and commitment to therapy is extremely important to us. Likewise, our time is also important. Unlike a traditional medical practice, we reserve a room and a licensed specialist specifically for you and/or your family on a regular basis. We do not over book ourselves with clients and we strive to meet with you as close to your appointment time as possible. As a result of these factors, we require more than 24 hours notice should you need to cancel or reschedule your appointment. We do not make exceptions to this policy, except in extreme and dire circumstances. Any client who cancels an appointment less than 24 hours in advance will be responsible to pay the full session fee of $\_\_\_\_\_\_\_\_\_\_. Clients using their medical insurance for services will be charged a fee of $80, which is not covered by insurance. By signing this form, you are providing consent for your therapist to maintain a copy of your credit/debit card on file and to charge this card in the event of a late cancellation. You also agree to update your credit card information should you get a new card or billing address. Thank you in advance for your understanding.

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Address City State Zip Code

                                                                                                                         Phone Number Email



**RECIPIENT’S RIGHTS NOTIFICATION**

As a recipient of services at our facility, we would like to inform you of your rights as a patient. The information contained in this form explains your rights and the process of complaining if you believe your rights have been violated.

**Your Rights as a Patient**

Complaints – We will investigate your complaints.

Suggestions – You are invited to suggest changes in any aspect of the services we provide.

Civil Rights – Your civil rights are protected by federal and state laws.

Cultural/Spiritual/Gender Issues – You may request services from someone with training or experiences from a specific

cultural, spiritual or gender orientation. If these services are not available, we will help you in the referral process.

Treatment - You have the right to take part in formulating your treatment plan.

Denial of Services – You may refuse services offered to you and be informed of any potential consequences.

Record Restrictions – You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.

Availability of Records – You have the right to obtain a copy and/or inspect your protected health information; however, we may deny access to certain records in which we will discuss this decision with you.

Amendment of Records – You have the right to request an amendment in your records; however, this request could be

denied. If denied, your request will be kept in the records.

Medical/Legal Advice – You may discuss your treatment with your doctor or attorney.

Disclosures – You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

**Your Rights to Receive Information**

Costs of Services – We will inform you of how much you will pay.

Termination of Services – You will be informed as to what behaviors or violations could lead to termination of services at LifeWorks Mental Health Counseling.

Confidentiality – you will be informed of the limits of confidentiality and how your protected health information will be

used.

Policy Changes – You will be informed of any policy changes in a timely manner.

**Our Ethical Obligation**

We dedicate ourselves to serving the best interest of each client.

We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences or other personal concerns.

We maintain an objective and professional relationship with each client.

We respect the rights and views of other mental health professionals.

We will appropriately end services or refer clients to other programs when appropriate.

We will evaluate our personal limitations, strengths, biases and effectiveness on an ongoing basis for the purpose of self- improvement. We will continually attain further education and training.

**Patient’s Responsibilities**

You are responsible for your financial obligations to LifeWorks Mental Health Counseling as outlined in the

Payment Contract for Services.

You are responsible for following the policies of the facility.

You are responsible to respect the rights of others.

You are responsible to provide accurate information about yourself.

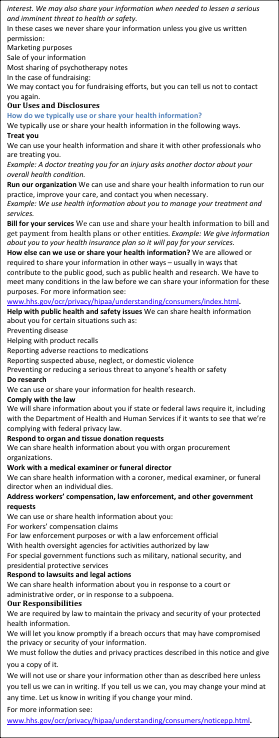
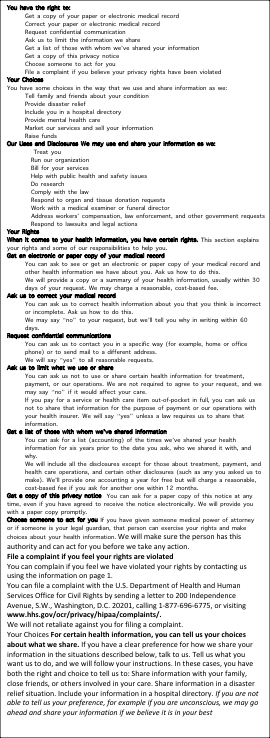
If you believe that your patient/client rights have been violated please contact the Director, Jill Rothar, LMHC

Client Name Signature Date

|  |
| --- |
| Authorization to Disclose Protected Health Information`  (If you would like for LifeWorks To Collaborate With A Trusted Medical Provider, Educator or Family Member-please complete this form)  Patient Name:                                                                                   Address:                           Date of Request:                  As required by HIPAA Privacy Regulations, protected health information may not be used or disclosed to a third party without patient authorization.  I hereby authorize LifeWorks Mental Health Counseling, PLLC and its associates to disclose my Protected Health Information to the following person(s), health care provider(s), or business associate indicated below:  Medical Doctor:                                                                         Psychiatrist:                                                                              Other:                                                                                  Patient Health Information authorized to be disclosed: Any and all information that may enhance my course of treatment with LifeWorks Mental Health Counseling, PLLC.  For the specific use or purpose of: Serving as an adjunct or enhancement to my course of treatment at LifeWorks Mental Health Counseling, PLLC.  Effective dates for this authorization:      /     /      through      /     /     . This authorization will expire at the end of the above period.  I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.  I understand I have the right to:  1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office’s previous reliance on the uses or disclosure pursuant to this authorization.  2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.  3. Inspect a copy of the Patient Health Information being used or disclosed under federal law.  4. Refuse to sign this authorization.  5. Receive a copy of this authorization.  6. Restrict what is disclosed with this authorization.  I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.                                                                                                            Patient Signature Date |





I have read the privacy notice and understand my rights contained in the notice. By way of my signature, I provide LifeWorks Mental Health Counseling, PLLC and any associate with my authorization and consent to use and disclose my Protected Health Information for the purposes of treatment, payment and health care operations as described in the privacy notice.

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**Agreement Regarding Minors**

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. We will assess whether a minor can benefit from meeting alone or with a parent/caregiver and make recommendations to you. The support of all the child’s caregivers is essential, as well as their understanding of the basic procedures involved in counseling children. In the case of divorce or separation, consent to provide mental health treatment to a child or adolescent must be given in writing by both *custodial* parents.

**CONFIDENTIALITY** The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy. We will identify which topics will be disclosed and which will remain private early in the therapeutic process. The following circumstances override the general policy that children are entitled to privacy while parents or guardians have a legal right to information. • Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible. • Minors may independently enter into therapy and claim the privilege of confidentiality in cases involving abuse or severe neglect, molestation, pregnancy, or communicable diseases, and when they are on active military duty, married, or officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder, but parents must be involved unless doing so would harm the child. (These circumstances may vary from state to state, and the specific laws of each state must be followed.) • Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school is not entirely confidential and will be shared with that agency with your specific written permission. Please also note that we do not have control over information once it is released to a third party.

I                         agree that my child                         should have privacy in his/her/their therapy sessions, and I agree to allow this privacy except in extreme situations, which I will discuss with the therapist. At the same time, except under unusual circumstances, I understand that I have a legal right to obtain this information. To increase the effectiveness of the therapy, I agree to the following: The goals of the therapy are as follows: (by parent)                               (by child)                                I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/children have been abused or is/are a clear danger to self or others, the therapist will normally tell me only the following: • whether sessions are attended • whether or not my child is/children are generally participating • whether or not progress is generally being made. The normal procedure for discussing issues that are in my child’s/children’s therapy will be joint sessions including my child/children, the therapist, and me and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present. Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child’s/children’s well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively. Please make any additions or modifications as desired.                                                                                            Print CHILD Name Signature Date                                                                                            Print PARENT Name Signature Date