



7890 St. Andrews Cir
Orlando, FL 32835
(407) 342-3559
debbie@
daringsoulcare.com

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CLIENT INFORMATION

Contact and Household Information

I am here to see: _____ Date: _____

Client Name: _____

Age: _____ D.O.B: _____ Last 4 digits of SSN.: _____

Home Address: _____

Primary Phone: _____ Secondary Phone: _____

Preferred email address: _____

Permanent Address: Same as above Yes No If no, please provide:

May we leave a message for you at: _____ Primary Number: Yes No

Secondary Number: Yes No

May we contact you via text to discuss scheduling/other issues? Yes No

May we contact you via email to discuss scheduling/other issues? Yes No

How did you hear about our practice? _____

If applicable, may we thank your referral source? Yes No

Emergency Contact: _____

Phone Number: _____

Your Occupation: _____

Work Status: Full-time Part-time _____ avg. hours/week

Employer/School: _____

Average Annual Gross Household Income: _____

Marital status:

Married Remarried Single Widow(er)

Divorced Separated Other _____

If applicable, Spouse's Name: _____

Do you have children? Yes No If yes, names and ages:

Who lives in your home? _____



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CLIENT INFORMATION

History, Current Status & Counseling Goals

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? Yes No If yes, when? _____

Please briefly list the reasons: _____

Are you currently taking any medications? Yes No If yes, explain:

What brings you to counseling today? What goals would you like to accomplish?

What is your current level of distress? Please mark an "X" on the scale below;
(1 = very little distress; 10 = extreme distress):

1 2 3 4 5 6 7 8 9 10

Are you currently having suicidal thoughts? Yes No If yes, briefly describe:

Have you experienced them or attempted suicide in the past? Yes No
If yes, briefly describe:

Personal Beliefs and Support System

What words would you use to describe yourself?



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CLIENT INFORMATION

How important is spirituality/faith to your life? Please mark an "X" on the scale below:
 (1 = not important at all; 10 = extremely important):

1 2 3 4 5 6 7 8 9 10

If God were to describe you, what do you imagine that God would say?

Briefly describe the spiritual/religious environment of your home growing up:

Complete this thought: "God is: _____."

_____.

Do you regularly attend a place of worship? Yes No

If yes, where?

Do you have a personal support system? Yes No

If yes, please describe:

Have you completed any of the following inventories or assessments?

(Check all that apply; if you know the results, please list them.)

Myers Briggs Type Indicator Results: _____

Enneagram Results: _____

StrengthsFinder 2.0 Results (top 5): _____

Spiritual gifts inventories: Results: _____

Terms of Service

I have read, understood, and agree to comply with the Policies and Procedures of Daring Soul Care. I attest that the information provided here is accurate as of this date. I will promptly notify my Daring Soul Care therapist of any changes to this information.

Signature: _____ Date: _____

Print Name Clearly: _____



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INFORMED CONSENT AND RELEASE OF LIABILITY

Debbie Miller, LLC, doing business as Daring Soul Care, offers professional mental health counseling services by Christian practitioners who have earned a Master's Degree from an accredited graduate program, and who have been licensed as Licensed Mental Health Counselors or provisionally licensed as Registered Mental Health Counselor Interns by the State of Florida.

The completion of an intake questionnaire and an informed consent and release of liability form are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent at fees to be determined.

In order to initiate counseling, please read the following agreement; your signature attests that you both understand and agree to the terms contained herein.

- 1) I understand that my counselor is a Licensed Mental Health Counselor or a Registered Mental Health Counseling Intern working under the supervision of a Licensed Mental Health Counselor, as specified by Florida law.
- 2) I understand that my counseling records are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession.
- 3) In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Debbie Miller, LLC and the Daring Soul Care counseling practitioners from any and all claims, demands, damages, actions or causes of action whatsoever related to the counseling process.

I waive any right I may otherwise have to seek to use the record of my counseling with Daring Soul Care as evidence in any judicial proceeding or to compel the testimony of any licensed counselor, registered mental health counseling intern, or supervisor providing counseling to me through Daring Soul Care/Debbie Miller LLC.

I have read and understood the preceding information and agree to the policies of Debbie Miller, LLC, as stated. I understand that these comments are prerequisite to my receiving and continuing counseling through the Daring Soul Care practice.

Signed: _____ Date: _____

Print Name Clearly: _____



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POLICIES AND PROCEDURES

APPOINTMENTS AND OFFICE HOURS

Counseling sessions are typically 50-60 minutes long. Please arrive on time so that you can benefit from a full-length session. Office hours are by appointment only. We prefer to schedule your counseling sessions at a set time on a weekly, bi-weekly or monthly basis as agreed upon with your therapist.

Initial Here _____

CANCELLATIONS

24 hour notice is expected when canceling an appointment. You will be charged your full fee for no-shows or cancellations made with less than 24 hours' notice.

Emergencies and extreme circumstances are taken into consideration. If you fail to show up for an appointment and have not notified your counselor at least 24 hours in advance, it is your responsibility to contact your counselor before your next session to confirm your next appointment.

Repeated no shows or cancellations may be grounds for terminating your counseling relationship with Daring Soul Care. By reading and signing this document, you agree to be liable for any balance due for therapeutic sessions conducted or missed without proper notification.

Initial Here _____

CONFIDENTIALITY

Maintaining a safe, ethical and professional counseling environment is important to us at Daring Soul Care. Your therapy sessions are held with the strictest ethical standards to honor your confidentiality. There are limitations that you should know about:

By law, your therapist is required to report:

- Suspected past or present abuse and/or neglect of children, dependent adults, and elders to the appropriate authorities based on information provided by a client or collateral sources (other individuals involved in a client's psychotherapy, such as parents, guardians, spouses); and
- Information that may help to avert danger to a client or to others, e.g., imminent risk of suicide or homicide.

Selected information may also be released in the following circumstances:

- When you or a legal guardian have submitted written authorization for information be released to designated parties;
- When financial information is released to a collections agency, attorney, or small claims court for delinquent client accounts; or



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- When significant clinical aspects of your case are presented for peer consultation or supervision as part of providing you with the best care. Your confidentiality is still honored strictly during supervision or consultation. If you have any questions or concerns regarding your confidentiality and clinical supervision, please make sure to address these concerns with your therapist.
- Where otherwise required or compelled by State, federal or local laws.

The following information is protected as confidential: the acknowledgment of your presence in therapy, documentation you give to your therapist, and your therapist's clinical notes (except as required by law).

Initial Here _____

COMMUNICATIONS

You may leave a voice mail on your therapist's voicemail at any time. At the discretion of your therapist, you may also communicate via text or email. Under normal circumstances, you will receive a response within 24 to 48 hours.

IMPORTANT: If you have a life-threatening or urgent situation, please call 911.

Any phone calls with your therapist longer than 10 minutes will be treated as a therapy session, and you will be expected to pay your normal session rate.

Email communication is also appropriate for brief questions or communications to your therapist and will be discussed at your next session. It is important to note that email is not 100% secure. Any emails relevant to your treatment will be kept in your file.

Initial Here _____

FEES AND PAYMENT ARRANGEMENTS

Payment is due at the time services are rendered either by Cash, Check, or Credit Card. Professional service fees are \$125 per individual/couples session (50-60 minutes) and/or \$50 per group session. Checks should be made payable to "Debbie Miller."

Consultations with other professionals and reports prepared on your behalf will be charged a pro-rated fee, calculated in 15 minute increments. Assessment testing is charged on a per-instrument basis. A \$25 charge is made for any check returned to us as non-payable for any reason. Accounts over 90 days past due may be sent to collections and additional fees may be applied.

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POLICIES AND PROCEDURES

INSURANCE

Daring Soul Care therapists are not on any insurance panels. If you have PPO insurance and you would like to receive reimbursement from your insurance plan, you will be provided a super bill that will have the necessary information for you to submit to your insurance company. Please review your plan with your insurance carrier to see if they offer partial reimbursement for out-of-network mental health care providers.

Should your insurance company, disability provider, or healthcare agency require reporting, copies of treatment plans, or other paperwork, you will need to authorize release of that information. Administrative fees to respond to the requests will be calculated based on your normal counseling fee, pro-rated in 15-minute increments. Administrative fees will be collected at the next client session following the request or billed to your credit card.

Initial Here _____

PARTIAL SCHOLARSHIPS

Upon completing a scholarship application, clients with demonstrated financial need may qualify for a partial scholarship of up to \$25 per session. Scholarships are awarded for up to a six-month period and a client's eligibility must be re-evaluated at that time.

By accepting a scholarship, you commit to the following:

- Promptly notifying your therapist if your financial situation improves;
- Completing all homework assigned between sessions; and
- Showing up for counseling ready to engage in the therapeutic process.

Initial Here _____

PROFESSIONAL CONDUCT

As with any professional relationship, the psychotherapeutic relationship requires high standards of moral, ethical, and appropriate conduct on the part of the therapist. Specifically, any form of sexual intimacy between a therapist and a client is never appropriate.

Initial Here _____

TERMINATING COUNSELING

If you feel that you would like to terminate counseling before your counselor suggests, we ask that you do so in person with one full session available to process your reasons for discontinuing, progress you have made, and suggested next steps.

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POLICIES AND PROCEDURES

CREDIT CARD ON FILE AGREEMENT

I acknowledge my credit card information will be kept on file to be used for session fees in which I do not provide payment (unless other arrangements have been made with my therapist). Charges for missed appointments not cancelled with 24 hours advanced notice, returned check fees plus the amount of the check that did not clear, unpaid administrative fees for consultation or reporting, and overdue balances of more than 30 days will be billed to my account.

My credit card will only be used under these circumstances or when I have not provided payment in another form (i.e. cash or check).

By signing below and providing my credit card information, I authorize Debbie Miller, LLC or my individual Daring Soul Care therapist to charge my credit card.

Signature: _____ Date: _____

Printed Name: _____

Name on Credit Card: _____

Billing Address on Card: _____

Credit Card Number: _____

Expiration Date: _____ CVV (3 digit code on back): _____

Phone Number on record with Card: _____

Credit Card Type: Visa MasterCard

CLIENT ACCEPTANCE

I have read and understand (or have asked for clarification about) the information presented in this form, and consent to treatment within these guidelines.

Client Signature: _____ Date: _____

Printed Name: _____



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66 OF PRIVACY POLICIES

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc. In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services.

We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION 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. Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law. You may contact our Privacy Officer in writing to invoke your following rights: (a) You may request in writing that we restrict using and disclosing your PROTECTED HEALTH INFORMATION to family members and relatives, friends, or others you identify. We reserve the right to deny this request; (b) You may request an amendment to your PROTECTED HEALTH INFORMATION; (c) You may request alternative means or locations in which you receive confidential communications; and (d) You may request an accounting of disclosures of PROTECTED HEALTH INFORMATION beyond treatment, payment, and health care operations. We are required by law to protect the privacy of your PROTECTED HEALTH INFORMATION and to abide by the terms of the Notice of Privacy Practices. We will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request. You may file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated. For more information regarding our Privacy Practices, please contact: Debbie Miller, LMHC 9860, Daring Soul Care, 4950 S. Apopka-Vineland Road, Orlando, FL 32819, (407) 342-3559. For more information about HIPAA or to file a complaint, please contact: The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, (877) 696-6775 (TOLL FREE). PLEASE PRINT AND RETAIN FOR YOUR RECORDS.



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RECEIPT OF PRIVACY POLICIES

I acknowledge that I have received a copy of Daring Soul Care's Notice of Privacy Policies.

Name: _____

Street Address: _____

City: _____ State: _____

Zip Code: _____

Signed: _____ Date: _____

Printed Name: _____

Parent/Guardian: _____ Date: _____

Printed Name: _____