POSITIVE START COUNSELING SERVICES, INC.
REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐Yes ☐No	If not, what is your legal name?	Primary Language Spoken:	Birth date: / /	Age:	Sex: ☐M ☐F

Street address:	Social Security no.:	Home phone no.: ( )

Other contact no.:	City:	State:	ZIP Code:

Occupation:	Employer Name and Address:	Employer phone no.: ( )

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

AUTHORIZATION INFORMATION

ASSIGNMENT OF BENEFITS:

I hereby assign to Positive Start Counseling Services, Inc., any insurance, or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under my "insurance," I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

FOR RELEASE OF INFORMATION:

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPPA Notice of Privacy Practices" information provided to me a under a separate cover. This information is on file as a permanent record and may be amended as necessary.

Patient/Guardian signature *Date*

POSITIVE START COUNSELING SERVICES, INC

CONSENT TO TREATMENT AND RECIPIENT'S RIGHTS

Client_____Chart#_____

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, with Positive Start Counseling Services, Inc, hereby referred as the therapist. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The office encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content.

Privacy of Information Policies: I acknowledge receiving a copy of the privacy of information policies and certify that I have read and understand its content. I understand that if I have any questions or concerns regarding my privacy rights, I will contact Positive Start Counseling Services, Inc.

Non-Voluntary Discharge from Treatment: A client may be terminated from the office non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the office, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner.

Attendance/Cancellations: I understand that regular attendance will produce the maximum benefits. I understand that cancellations without 24hours notice or missed appointments will result in a fee of $75.00.

Returned Checks: Clients are responsible for any bank fees incurred due to returned checks. A bank service fee of $35.00 per check will be charged to the client.

Acknowledgement of Financial Responsibility: I understand that I am financially responsible for any portion of fees not covered or reimbursed by my health insurance. I understand and consent to release of information that may need to be shared with my insurance provider in order for payment to be rendered for services.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the office is protected by Federal and/or State law and regulations. Generally, the office may not say to a person outside the office that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a 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.

Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the office, against any person who works for the program, 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 to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the therapist's duty to warn any potential victim, when a significant threat of harm has been made.

I consent to treatment and agree to abide by the above stated policies and agreements with Positive Start Counseling Services, Inc.

Patients Name (Printed)

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

Therapist Signature Date

POSITIVE START COUNSELING SERVICES, INC

CONSENT & AUTHORIZATION TO CORRESPOND ELECTRONICALLY

While Positive Start Counseling Services, Inc takes reasonable precautions to protect your confidential information, e-mail and texting are not completely secure methods of communication. Please read and sign the following consent regarding electronic correspondence.

I acknowledge that if I use electronic mail to initiate contact with the staff at Positive Start Counseling Services, Inc., regarding my therapeutic care, the staff at Positive Start Counseling Services, Inc. has my permission to correspond via that email address.

The content of e-mail and texting communications is limited to the following: scheduling appointments, appointment reminders, obtaining insurance information or other information regarding the clients' account, and clarification on homework assignments.

Email and texting may *not* be used for discussing any form of therapy issue, or for communicating about emergency treatment. You must call and address therapy issues with your therapist at Positive Start Counseling Services, Inc. either on the phone or during your next session.

☐ I give Positive Start Counseling Services, Inc. my permission to communicate with me via email or text messaging for the purpose of sending me notices related to my scheduling or account.

_____@_____

Phone number for receiving text messages: _____

_____ _____

Client/Guardian Signature Date

CREDIT CARD AUTHORIZATION FORM

I hereby authorize Positive Start Counseling Services, Inc. to charge my credit card on the day of my appointment for the appropriate fee assigned to the service received.

Assessment Interview: (60min) - **$125**
Individual or Family Psychotherapy: (20 - 30 min) - **$50**; (60 min) - **$75-$125**
Other Professional Services: (30 min) - **$35**; (60 min) - **$75**
Legal Involvement: **$150 per hour**
Drug Testing: **$50**
Copay: _____

I hereby authorize Positive Start Counseling Services, Inc. to charge my credit card a fee of $75.00 for any missed psychotherapy appointments or appointments cancelled with less than 24 hours advance notice (excluding true emergency situations).

Name: _____

Cardholder's Name:_____

Billing Address:_____

Street City State Zip:_____

Type of Card: Visa _____ Master Card _____ American Express _____ Discover _____

Credit Card Number: _____/_____/_____/_____

Card Expiration Date: _____/_____

Card Security Code: _____(3 digit code on the back of the card)

I have read, understand, and agree to the terms outlined in the above credit card policy for psychotherapy services provided by Positive Start Counseling Services, Inc..

_____ _____
Signature of Cardholder Date

*Positive Start Counseling Services, Inc. **securely maintains your credit card information and adheres to all HIPAA regulations.**

POSITIVE START COUNSELING SERVICES, INC

RECIPIENT'S RIGHTS NOTIFICATION

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

Your rights as a client

1. Complaints. We will investigate your complaints.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil Rights. Your civil rights are protected by federal and state laws.
4. 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.
5. Treatment. You have the right to take part in formulating your treatment plan.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
8. 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.
9. 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.

Your rights to receive information

1. Costs of services. We will inform you of how much you will pay.
2. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our clinic.
3. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.
4. Policy changes.

Our ethical obligations

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will appropriately end services or refer clients to other programs when appropriate.
6. 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.
7. We hold respect for various institutional and managerial policies but will help improve such policies if the best interest of the client is served.

Client's responsibilities

1. You are responsible for your financial obligations to the office as outlined.
2. You are responsible for following the policies of the office.
3. You are responsible to treat staff and fellow clients in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.

What to do if you believe your rights have been violated

If you believe that your client rights have been violated please discuss with Michelle Fyfe, LMHC, CAP (Director).

POSITIVE START COUNSELING SERVICES, INC

PRIVACY OF INFORMATION POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this office for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this office such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this office not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest, safety for public health activities, judicial/administrative proceedings, law enforcement, serious threats to public safety, essential government functions, military, and worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, we may share your medical information with the medical examiner.

POSITIVE START COUNSELING SERVICES, INC

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the timeframe, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the office or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the office or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the office or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the office. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify the office (to protect confidentiality). If we reach an answering machine or voice mail, we will follow the same guidelines.

Your Rights
You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1.00 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

POSITIVE START COUNSELING SERVICES, INC

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the therapist at this location.

Complaints
If you have any complaints or questions regarding these procedures, please contact the office. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Florida Department of Health. If you file a complaint we will not retaliate in any way.

Direct all correspondence to Michelle Fyfe, LMHC, CAP

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name/Legal Guardian (please print): _____

Signature: _____ Date: _____

Signed by: ☐ client ☐ guardian ☐ personal representative

Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

☐	Abuse-physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
☐	Aggression, violence
☐	Alcohol use
☐	Anger, hostility, arguing, irritability
☐	Anxiety, nervousness
☐	Attention, concentration, distractibility
☐	Career concerns, goals, and choices
☐	Childhood issues (your own childhood)
☐	Children, child management, child care, parenting
☐	Codependence
☐	Confusion
☐	Compulsions
☐	Custody of children
☐	Decision making, indecision, mixed feelings, putting off decisions
☐	Delusions (false ideas)
☐	Dependence
☐	Depression, low mood, sadness, crying
☐	Divorce, separation
☐	Drug use-prescription medications, over-the-counter medications, street drugs
☐	Eating problems-overeating, under eating, appetite, vomiting (see also "Weight and diet issues")
☐	Emptiness
☐	Failure
☐	Fatigue, tiredness, low energy
☐	Fears, phobias
☐	Financial or money troubles, debt, impulsive spending, low income
☐	Friendships
☐	Gambling
☐	Grieving, mourning, deaths, losses, divorce
☐	Guilt
☐	Headaches, other kinds of pains
☐	Health, illness, medical concerns, physical problems
☐	Inferiority feelings
☐	Interpersonal conflicts
☐	Impulsiveness, loss of control, outbursts
☐	Irresponsibility
☐	Judgment problems, risk taking
☐	Legal matters, charges, suits
☐	Loneliness
☐	Marital conflict, distance/coldness, infidelity/affairs, remarriage
☐	Memory problems

☐	Menstrual problems, PMS, menopause
☐	Mood swings
☐	Motivation, laziness
☐	Nervousness, tension
☐	Obsessions, compulsions (thoughts or actions that repeat themselves)
☐	Oversensitivity to rejection
☐	Panic or anxiety attack
☐	Perfectionism
☐	Pessimism
☐	Procrastination, work, inhibitions, laziness
☐	Relationship Problems
☐	School problems (see also "Career concerns . . .")
☐	Self-centeredness
☐	Self-esteem
☐	Self-neglect, poor self-care
☐	Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
☐	Shyness, oversensitivity to criticism
☐	Sleep problems-too much, too little, insomnia, nightmares
☐	Smoking and tobacco use
☐	Stress, relaxation, stress management, stress disorders, tension
☐	Suspiciousness
☐	Suicidal thoughts
☐	Temper problems, self-control, low frustration tolerance
☐	Thought disorganization and confusion
☐	Threats, violence
☐	Weight and diet issues
☐	Withdrawal, isolating
☐	Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

Tell what your like will look like after you complete therapy.

How many sessions do you think it will take to get there?

***This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

POSITIVE START COUNSELING SERVICES, INC.

HOW I WANT MY COUNSELING TO GO

Since there are many ways to go about working together in counseling, I would like to know how you want things to unfold for you. Your decisions will inform me of how best to support you and assist you in this endeavor.

1. **I want to use my appointment times to: (choose up to 3)**

___ Get things off my chest and vent
___ Figure things out
___ Receive emotional support
___ Explore possibilities for my future
___ Determine what changes I want
___ Set goals and steadily work on achieving them
___ Other

2. **I want to mainly focus on: (choose up to 5)**

___ Gaining understanding about myself ____The past
___ Understanding my situation better ____The present
___ Developing skills ____The future
___ Building on my strengths and abilities ____Changing my behavior or habits
___ Processing past traumatic experiences ____Changing the way I think
___ Recovering and healing ____What is missing from my life
___ What my needs are ____My relationships
___ My job/career ____My performance (ex: work, school,
___ The past various roles or responsibilities)
___ The present
___ The future ____Having sense of fulfillment
____Other

3. **In general, I would like you, as my counselor, to: (choose up to 3)**

___ Support me
___ Challenge me
___ Listen to me
___ Teach me
___ Help me be motivated
___ Advise me
___ Other

4. **Is there anything that you don't want to focus and spend time on?**

*Naturally, sometimes things change over time. If you change your mind on any of the above, please let me know so that we can adjust for that together.

TECHNOLOGY ASSISTED COUNSELING (TAC)
CONSENT, POLICIES, & AGREEMENT

This form is in **addition** to the regular Therapy, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in Technology Assisted Counseling (TAC) sessions. TAC incorporates email, phone and video counseling. Prior to engage in TAC an assessment/consultation will be done to assure that TAC is an appropriate form of counseling. This is to inform you about what you can expect regarding your participation in TAC counseling.

Benefits:
The benefits to TAC counseling are:

1. The ability to expand your choice of service provider.
2. More convenient counseling options including location, time, no driving, etc.
3. Reduces the overall cost and time of therapy due to not having to drive to and from and office.
4. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.
5. Increased availability of services to homebound clients. clients with limited mobility, and clients without convenient transportation options.

Limitations:
It is important to note that there are limitations to TAC counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. Due to technology limitations I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the TAC counseling session.
4. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
5. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

Logistics:
When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. I expect that you are available at our scheduled time and are prepared, focused and engaged in the session. I

am calling you from a private location where I am the only person in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others can hear you, I cannot be responsible for protecting your confidentiality. Every effort MUST be made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. Please know that I cannot guarantee the privacy or confidentiality of conversations held via phone, as phone conversations can be intercepted either accidentally or intentionally. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment.

Please know that per best practices and ethical guidelines I can only practice in the state(s) I am licensed in. That means wherever you reside I must be licensed. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

Connection Loss During Phone Sessions:
If we lose our phone connection during our session, I will call you back immediately. Please also attempt to call me if I cannot reach you. If we are unable to reach each other due to technological issues, I will attempt to call you 2 times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, I will call you from an alternate number. The number may show up as restricted or blocked please be sure to pick it up.

Connection Loss During Video Sessions:
If we lose our connection during a video session, I will call you to troubleshoot the reason we lost connection. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, we can either complete our session via. phone or plan an alternate time to complete the remaining minutes of our session.

Please list your main number and an alternate number below.

_____

Number(s)

11440 Okeechobee Blvd #205B
Royal Palm Beach, Florida 33411
954-817-5825
561-693-5514 (Fax)
positivestartcounseling@msn.com
www.positivestartcounseling.webs.com

Recording of Sessions:
Please note that recording, screenshots, etc. of any kind of any session is not permitted and are grounds for termination of the client-therapist relationship.

Payment for Services:
Payments for services must be made **prior** to each session. I will charge your card on file. Payment is to be completed prior to our session.

Cancellation Policy:
If you must cancel or reschedule an appointment, 24-hour advance notice is required, otherwise you will be held financially responsible. Should you cancel or miss an appointment with notification less than 24 hours this will result in being charged the $50 fee for your missed appointment. Cancellations must be communicated by phone, NOT email or text. If clients have more than 2 cancellations during the course of treatment/therapy the therapist and client will address the need for ongoing therapy. Should a client express and wish and/or desire to continue a client may be asked to pre-pay for sessions when they are scheduled. If the client cancels or misses the session with less than 24 hours notice and the session is pre-paid, this follows the cancelation guidelines and the payment will not be reimbursed for the missed or canceled session less than 24 hours. Phone/video sessions should be treated as regular in office sessions. If you are late getting on the phone, are unable to talk at our scheduled time, your battery has died and you are unable to access another confidential place to talk, or any other variable that would have you not be able to attend our session please know that you will be charged for the session. Please make the necessary arrangements you need to be available and present for your session.

Emergencies and Confidentiality:
I request an emergency contact for you. Please list the person's first and last name, relationship and phone number(s) of your emergency contact:

_____

Full Name Relationship Number(s)

I also request the address from which you are calling and the number to your local police department including area code in the area in which you are located during the time of our call.

_____

Street Address

_____

City State Zip Code

11440 Okeechobee Blvd #205B
Royal Palm Beach, Florida 33411
954-817-5825
561-693-5514 (Fax)
positivestartcounseling@msn.com
www.positivestartcounseling.webs.com

PSCS
Positive Start Counseling Services, Inc

City and State of Local Police Department Phone Number

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433.

If I have concerns about your safety at ***any*** time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Consent to Participate in TAC Sessions:
By signing below you agree that you have read and understand all of the above sections of TAC informed consent. You agree that you also understand the limitations associated with participating in TAC counseling sessions and consent to attend sessions under the terms described in this document.

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

Clinician's Signature/Credentials: _____ Date: _____

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