People Expressing and Caring for their Emotions, LLC

CLIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Work: _____

Social Security: _____ ☐ I *wish not disclose my SS#*

Gender: ☐ Male ☐ Female Primary Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Cohabitating

Race/Ethnicity:☐ American Indian or Alaska Native ☐Asian ☐ Black/African-American ☐ Caribbean ☐Latino/a/Hispanic ☐African ☐ White American/Caucasian ☐Native Hawaiian or Other Pacific Islander----- OTHER:_____ I identify as_____

☐

LEGAL GUARDIAN/RESPONSIBLE PARTY INFORMATION

Person Responsible for Client & Payment (if other than client):

Name: _____

Relationship to Client: ☐ Self ☐ Legal Guardian ☐ Custodial Parent ☐ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ e-mail: _____

MAY WE LEAVE A VOICE MESSAGE AND/OR TEXT MESSAGE? ☐ YES ☐ NO

Adult/Guardian Email address: _____

If client is under the age of 18 and there are legal sole/joint/foster care custody/time-sharing/parenting plan agreement(s) in effect, please provide a copy of all relevant documents. Custodial parents/guardians must sign all forms.

EMERGENCY CONTACT

Name: _____

Relationship to Client: _____ Primary Phone: _____

Email: _____

Client Name: _____ **DOB:** _____

Please inform us immediately on any changes to your insurance, email, your name, address, and/or phone number.

INSURANCE INFORMATION

1. Primary Insurance Provider

Insurance Company Name: _____ Contact #: _____

Member ID: _____ Group#: _____

Relationship of client to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Please provide the following information for the Insurance Policy Holder:

Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

2. Secondary Insurance Policy

Insurance Company Name:_____ Phone#:_____

Member ID: _____ Group#: _____

Relationship of client to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

By completing this form, you accept to be treated and give P.E.A.C.E. consent to provide the necessary information to your insurance company that will allow us to bill for our services. You also understand that if there is a report of abuse towards a child or vulnerable adult that has not already been reported, your therapist is mandated to make a report. You also agree that if you are a harm to yourself or others or are under the influence of illicit drugs or alcohol, we are obligated to initiate a Baker Act or Marchman Act.

Other services provided: Letters or Forms: $120 - $200(depending on detail paperwork required)

Court Testimony Fee: $250 per hour with a 3-hour minimum. The $750 minimum needs to be paid in advance and in local practice area.

Consent for Treatment – Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of attending therapy. Inconsistencies in keeping appointments and cancelations will cause termination of services and affects progress of your treatment.

Limits of Confidentiality:

What you discuss during your bi-weekly/weekly therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect:

If you disclose a plan or implies a plan of suicide, the therapist is required to notify legal authorities and make reasonable attempts to notify the client of the family. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults:

If you disclose, suggest, and/or implies it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e., the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances:

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers will be provided information upon request regarding services to the clients. The type of information that may be requested includes types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

Cancellation/Late Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, P.E.A.C.E. reserves the right to charge a fee If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice for cancellation or rescheduling policy. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment.

If there are recurring no shows, late, and/or cancellations you might be discharge or you must re-establish any two consistent missed appointments is a discharge and you will have to wait to establish again; therefore, wait list or next new client availability. All of this is at the discretion of the provider.

In the case that the insurance provider does not cover the cost of the session, the client will be responsible for the insurance rate amount of the session.

For cancellations made with less than 24-hour of appointment time notice there will be a charge of the full session fee for either self-pay and contracted insurance rate or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule and helping others keep their appointments. All sessions are based by appointment only. If you are more than 15 minutes late to your appointment it may be rescheduled. Let the provider know if you are going be or log in late.

CANCELATION FEE: Cancellations made less than 24-hour notice or a scheduled appointment that is completely missed, you will be billed a $100.00 cancelation fee. A $40.00 fee will be charged for any returned checks.

By completing this form, you accept to be treated and give P.E.A.C.E. consent to provide the necessary information to your insurance company that will allow us to bill for our services. You also understand that if

there is a report of abuse towards a child, minor, or vulnerable adult that has not already been reported, your therapist is mandated to make a report. You also agree that if you are to do harm to yourself or others or are under the influence of illicit drugs or alcohol, we are obligated to initiate a Baker Act or Marchman Act.

Other services provided: Letters or Forms: $120 - $195 (depending on detail paperwork required)

Court Testimony Fee: $250 per hour with a 3-hour minimum. The $750 minimum needs to be paid in advance and in local practice area.

AFTER HOURS, HOLIDAYS, during provider in other session, WEEKEND, AND CLINICIAN UNAVAILABLE. **EMERGENCY NUMBERS FOR YOU TO WRITE DOWN 407-425-2624 AND 800-273-8525**

By signing below, I agree to the above assumption of risk, limits of confidentiality, and terms and conditions. I further understand their meanings and ramifications.

PRINTED NAME: _____ DOB: _____

Client Signature: _____ Date: _____

Primary Contact Phone #: _____ Email Address: _____

_____
Parent/Guardian Printed Name

_____ _____
(Client's Parent/Guardian if under the age of 18) Date

USE OF INSURANCE

Use of Insurance is a complex issue. We ask our clients to call their insurance company to discover/inquire what mental health/chemical dependency coverage is available. Mental health coverage is usually different than physical health coverage. Please ask your insurance company if you need pre-certification, what your co-pay is given our hourly rate, and how many sessions you are allowed in what period of time. We reserve the right to call your insurance company and verify coverage and benefits. We provide the courtesy of billing your primary insurance company and ask for you to make your co-payment at the time of service. We also ask that you assume the responsibility of tracking the usage of allotted sessions. In this regard you should take the initiative

to discuss with your therapist (1) the number of sessions remaining before further approval is needed, and (2) when no further sessions are available under your policy.

You are responsible for full payment of fees that your insurance company does not agree to cover. Therefore, it is important to you to fully understand your coverage benefits regarding mental health and/or chemical dependency. You will be responsible for discussing with your health insurance company any disputes regarding coverage. If you are disputing a claim for lack of payment with your insurance company People Expressing and Caring for their Emotions, LLC (P.E.A.C.E.), may request that you pay your balance with us and agree to be reimbursed by the insurance company at a later date if/when the matter is eventually resolved. *Accepted payment forms cash, checks, Zelle or Cashapp.*

Employee Assistance Program (EAP) is a program that is temporarily used during the year. For on-going clients eventually EAP will ask that you use your insurance. EAP sessions are 30-45min max. If you wish to extent time, is self-pay service. P.E.A.C.E. will also determine after year that is time to use insurance or payment that will go towards your insurance. For people in need of further therapy and support, the EAP will not provide a long-term solution. The EAP is designed to provide short-term counseling, to simply listen, assist in problem solving, or identify new ways to cope with common, but sometimes painful problems. Established clients will need to use their insurance. Continuous use of EAP for long term and insurance/self-pay will have to be used. Please discuss with provider to clarify any questions each situation is different as EAP differ from one another.

Psychiatrist services, if needed, please use your insurance to find a provider in network. **Please inform us immediately on any changes to your insurance, your name, email, address, and/or phone number.**

_____ _____

Client Signature Date

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

People Expressing And Caring for their Emotions, LLC

Telehealth Consent

Telemedicine/Telehealth-Telehealth means the delivery of health care services with the use of interactive audio and video technology, permitting real-time communication between the patient/client at the originating site and the provider, for the purpose of diagnosis, intervention, consultation, and/or treatment. If you or your family decides to use our Teletherapy Services, this document has been provided to you to outline our procedures for those services. It contains instructions on how to connect with your therapist for your teletherapy sessions, along with important policies about P.E.A.C.E. and Teletherapy Polices.

I _____ (Client(s)/guardian name/s) hereby consent to participating in Telehealth Services with People Expressing And Caring for their Emotions, LLC (P.E.A.C.E.). Telehealth services are defined as communication between yourself and our practice via telephone, email, text message, video conferencing, or any other remote means that utilize electronic transmitting technology. This includes what is defined as "teletherapy" (psychotherapeutic intervention done remotely via videoconferencing or telephone), as well as use of technology for administrative purposes (e.g., emails and phone calls regarding scheduling appointments). I understand that Telehealth allows my therapist to diagnose, consult, treat, transfer medical data, and educate using interactive audio, video, or data communication regarding my treatment. This Consent Form covers all forms of electronic communication (teletherapy and administrative). I have read and understand the following important information regarding Telehealth Services:

I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in Florida State. There are always risks with Telehealth mental health services, including, but not limited to, the possibility that: the transmission of your confidential information could be disrupted or distorted by technical failures or interrupted by unauthorized persons, and/or the electronic storage. P.E.A.C.E. takes reasonable efforts to operate in a secure and confidential space, minimizing interruptions and distractions.

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with Telehealth mental health services, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be ***no*** recording of any of the online/person/audio sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. Only the identified patient and/or client(s) by therapist will be part of the session; those who are not part of therapy will not be in the room during telehealth sessions. Sessions standard time are 53 minutes and EAP session minutes 30-45 minutes with client participation.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Telehealth mental health services unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding). In writing release of information to: P.E.A.C.E. PO BOX 781153 Orlando, Florida 32878

5) By completing this form, you accept to be treated and give P.E.A.C.E. consent to provide the necessary information to your insurance company that will allow us to bill for our services. You also understand that if there is a report of abuse towards a child or vulnerable adult that has not already been reported, your therapist is mandated to make a report. You also agree that if you are a harm to yourself or others or are under the influence of illicit drugs or alcohol, we are obligated to initiate a Baker Act or Marchman Act.

You also understand that if there is a report of abuse towards a child or vulnerable adult that has not already been reported, your therapist is mandated to make a report. You also agree that if you are a harm to yourself or others or are under the influence of illicit drugs or alcohol, we are obligated to initiate a Baker Act or Marchman Act.

6) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telehealth mental health services are not appropriate, and a higher level of care is required.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. I agree to update my address, phone number, emergency contact if it changes.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____and my

emergency contact is _____, located at _____,

primary contact number is _____.

I understand that scheduling is conducted through P.E.A.C.E. and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. **Crisis or mental health emergencies should be directed to the local county crisis line 407-425-2624 or by dialing 911. OUTSIDE ORANGE COUNTY 800-273-8525Please record the crisis line number for your records.**

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form was e-mailed/mail and all my questions have been answered to my satisfaction. Electronic signature and/or return email deems read and understood. I understand breach of any agreement and policies of P.E.A.C.E. will be a termination of teletherapy with P.E.A.C.E.

Other services provided: Letters or Forms: $100 - $200 (depending on detail required)

Court Testimony Fee: $250 per hour with a 3-hour minimum. The $750 minimum needs to be paid in advance and in local practice area.

_____ _____

Client Printed Name Date

_____ _____

Client Signature Adult/Guardian Signature DOB

MINORS Adult/guardian email:_____

Client address related to telehealth: _____

Primary Phone number: _____

Child name agree to participate: _____

Clinician Electronic Signature: Gisella Ubillus, LCSW