Dr. Samuel F. Shuman, Ph.D. LMHC

"Counseling for Essential Change"

"a place for insights and options"

Intake Data Sheet and Agreement
(please print)

Name _____
Last *First* *Middle*

Address _____ **City** _____ **State** _____ **Zip Code** _____

Cell Phone _____ **Other** *phone / Home* _____

Email : _____

Marital Status Single Married Divorced Widowed **Partner's Name** _____

Employer's Name _____ **Occupation** _____

Address _____ **City** _____

State ____ **Zip code** _____ **Home phone** _____ **Cell phone** _____

Emergency Contact _____ **Phone** _____

Please visit our website at CounselingForEssentialChange.com for fee information.

Payment AGREEMENT: Payment is due 3 business days prior to you counseling session. Crisis or emergency calls will be billed based on the portion of time spent, prorated at the regular session fee. Any non-emergency call after business hours will be returned on the following business day._____(Initial)

Cancellation AGREEMENT: There is a 24-hour cancellation policy for scheduled appointments. Client is responsible for Full payment if session is cancelled less than 24 hours before the scheduled appointment time.

_____Initial

I **hereby agree to the terms of the Payment and Cancellation Agreement:**

_____
Client Signature Date

Whom do we thank for referring you (Name) _____ **Phone** _____

INTAKE INFORMATION

Print Name.....Social Security No. _____

Please select any of the following which presently apply to you or have applied to you in the last 30 days:

Depressed mood	Panic attacks
Appetite disturbance	Low energy
Obsessive thoughts	Impaired memory
Sleep disturbance	Aggressive behaviors
Low self-esteem	Health concerns
Substance abuse	Process abuse (gambling, sex., love, or any behavior to excess)
Resentments	
Regrets	Suicide ideation
Fears	Anxiety
Loneliness	self-criticism / negative self-talk

Note: If you were not comfortable checking an area that applied, you are encouraged to talk about it in the initial session or in the next session when you may feel more comfortable doing so.

Briefly describe your reason(s) for coming here today:

_____
_____
_____
_____
_____
_____
_____

How would you rate your physical health?

Poor Fair Good Excellent

When was your last physical check-up.

_____

Dr. Samuel F.Shuman, Ph.D.,LMHC

Office Contact Information

Email: DrShuman@Counselingforessentialchange.com

Phone: 813-501-8031

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records, including those related to behavioral health, and other identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient/client, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for the misuse of personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your behavioral and other health information and how we may use and disclose such information. We may use and disclose your medical and/or behavioral health records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating or managing health services by one or more health care providers. An example of this would include a diagnosis based on an initial as well as subsequent psychotherapy sessions or referral for a physical examination.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill for your therapy session to you or your healthcare insurance when applicable.
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 be an internal quality assessment review.

We may contact you to provide appointment reminders, information about alternative treatments or other behavioral health-related benefits that may be of interest to you. Our office is fully committed to compliance with the "HIPAA" guidelines by:

1. Providing appropriate security for our patient records.
2. Protecting the privacy of our patient's medical and behavioral health information.
3. Providing our patients with proper access to their behavioral health information and any known related medical information.
4. Appropriately maintaining our patient information and billing processes in compliance with national standards.
5. Additionally, if it is determined that an exchange of information with another individual with whom you are familiar would be a benefit to you, such inquiry will not be made without you signing a release/exchange of information permission form.

If you have a concern about or inquiry about your confidential information you may inquire in person during a therapy session or by telephone at 813-501-8031. If you believe the privacy and/or confidentiality of your behavioral health information has been violated, you may file a complaint with the Secretary of Health and Human Service toll free 1-877-696-6775.

Patient Signature_____Date: _____

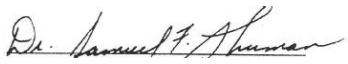
Effective date of privacy practices: the date of the initial psychotherapy session

Disclaimer

In the course of treatment, you may be advised of medications, nutrition, nutritional supplements and alternative approaches that have shown to be of benefit to individuals in similar circumstances, emotionally or physically, to yourself. Additionally, books and/or research material related to such may be recommended for your reading.

Such an approach is intended only for your awareness and to expand your considerations and possible options. With any approach involving medications, nutritional plans, nutritional supplements and other alternatives, a physician is to be consulted and involved in the both the initiation and the monitoring of the process. Other certified and/or licensed individuals should also be considered as well.

Sincerely,



Your signature acknowledges your understanding that provided information is not intended to be interpreted as "prescribing" and that you are responsible for consulting the necessary medical care persons before embarking on any of the above-mentioned approaches.

Client Signature:_____ Date: _____