



CHRISTIAN COUNSELING

"Offering Hope and Healing through Redemptive Relationship"

505 Park Avenue North, Suite 212 • Winter Park, FL 32789
Phone: 407-539-0047 • Fax: 407-539-0048 • Web: graceclinic.org

GENERAL INFORMATION

Date: _____ Referred by: _____

Full Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

Nick Names: _____ Name You Prefer: _____

Social Security Number: _____ Age: _____ Date of Birth: _____

Race: White Black Hispanic Asian Other: _____ Sex: Male Female

CONTACT INFORMATION

Street Address: _____ Suite or Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: Yes No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: Yes No

Home Phone: (_____) _____ May We Leave a Message Here: Yes No

Mobile Phone: (_____) _____ May We Leave a Message Here: Yes No

Work Phone: (_____) _____ Extension: _____ May We Leave a Message Here: Yes No

Email Address: _____ May We Send Email Here: Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary: \$0 to \$10,000 \$20,001 to \$40,000 \$50,001 to \$60,000 \$80,001 to \$100,000
 \$10,001 to \$20,000 \$40,001 to \$50,000 \$60,001 to \$80,000 More than \$100,000

EDUCATION INFORMATION

Last Year of School Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

Are You Currently in School: Yes No. If Yes, What Level: _____ Degree Pursuing: _____

RELATIONAL INFORMATION

Current Relational Status: Single Dating Engaged Married Separated Divorced Widowed

Are You Content with Your Current Status: Yes No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How long: _____

Partner's Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: White Black Hispanic Asian Other: _____ Partner's Sex: Male Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: Yes No Unsure Partner Doesn't Know

With Whom Do You Currently Live (Check All that Apply): Alone Spouse Children Parent(s) Sibling(s)
 Boyfriend Girlfriend Roommate Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Natural, Adopted, Step)</i>	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: Yes No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: Yes No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Mom, Dad, Sibling, Step)</i>	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are You Currently Receiving Medical Treatment: Yes No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (Use Back If Necessary):

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back If Necessary):

Medication: _____ Dosage: _____ Improves Prevents Controls: _____

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Are You Taking these Medication(s) According to Your Doctor's Recommendations: Yes No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

- Headaches Past Present Dizziness Past Present Stomach Trouble Past Present
- Visual Trouble Past Present Sleep Trouble Past Present Trouble Relaxing Past Present
- Weakness Past Present Tension Past Present Rapid Heart Rate ... Past Present
- Difficulty Breathing .. Past Present Intestinal Trouble Past Present Hearing Noises Past Present
- Change in Appetite .. Past Present Tiredness Past Present Pain Past Present
- Hearing Voices Past Present Seeing Things Past Present Other Past Present

Your Height: _____ Your Weight: _____ How has Your Weight Changed in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

- Stress You Family Nervousness You Family Anxiety You Family
- Panic You Family Unhappiness You Family Depression You Family
- Guilt You Family Apathy You Family Terminal Illness You Family
- Recent Death You Family Grief You Family Hopelessness You Family
- Inferiority Feelings You Family Defective Feelings You Family Loneliness You Family
- Shyness You Family Fears You Family Friends You Family
- Marriage You Family Communication You Family Physical Abuse You Family
- Emotional Abuse You Family Verbal Abuse You Family Sexual Abuse You Family
- Temper You Family Anger You Family Aggressiveness You Family
- Bad dreams You Family Concentration You Family Racing Thoughts You Family
- Unwanted Thoughts ... You Family Memory You Family Loss of Control You Family
- Impulsive Behavior You Family Self-Control You Family Compulsivity You Family
- Sexual problems You Family Pregnancy You Family Abortion You Family
- Legal Matters You Family Trauma You Family Eating Problems You Family
- Drug Use You Family Alcohol Use You Family Trouble with Job You Family
- Career Choices You Family Ambition You Family Making Decisions You Family
- Children You Family Being a Parent You Family Finances You Family
- Recent Loss You Family Disaster You Family Other You Family

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing 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 Experiencing Any Suicidal Thoughts: Yes No. Have You Experienced Them in the Past: Yes No

Have you Ever Attempted Suicide: Yes No. If Yes,When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: Yes No

If Yes,When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling (i.e., What Are Your Issues, Problems?): _____

Why Have You Decided to Come for Counseling Now: _____

What Do You Hope to Gain or Change by Coming for Counseling: _____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back If Necessary):

Therapist: _____ Location: _____ Dates: _____ Reason: _____

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RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself: _____

If God Were to Describe You,What Would He Say: _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: _____

Complete the Following Thought: God Is _____

Do You Regularly Attend a Place of Worship: Yes No. If Yes,Where: _____

What Is the Name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader: _____

Do You Have a Personal Support System: Yes No. If Yes,Who: _____

TERMS OF SERVICE

I Understand that it Is Customary to Pay for Professional Services when Rendered. I Accept Full Responsibility for Payment of Any Balance Incurred for Services. I Further Understand that Without 24-Hour Notice of Intention to Cancel, I Will be Charged the Full Fee for Professional Service.

Signed: _____ Date: _____



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INFORMED CONSENT AND RELEASE OF LIABILITY

Grace Clinic Christian Counseling, Inc. is operated to provide counseling with a distinctively Christian framework to the local community. Counseling services are provided by independent Christian practitioners who have earned a Master's Degree from an accredited graduate program, and who have been licensed by the State of Florida or provisionally licensed by the State of Florida as registered interns.

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

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

- I _____ understand that my counselor is either a Licensed Mental Health Counselor, a Licensed Marriage and Family Therapist, a Licensed Clinical Social Worker, a Registered Mental Health Counselor Intern, a Registered Clinical Social Worker Intern or a Marriage and Family Therapist Intern. Registered Interns work under the supervision of a Licensed Mental Health Counselor or a Licensed Marriage and Family Therapist, as specified by Florida law.

I will allow my counselor to audio or video tape my counseling sessions for his/her supervision and continuing education. I understand that these tapes will be erased after these purposes are met. I further understand that these tapes, and all other information pertaining to these counseling sessions, will be secured in locked files and available to no one other than the staff of Grace Clinic, my counselor and his/her supervisor(s). This material will not be communicated to any other person(s) (with the exception of those named in this paragraph), in any form, without my written request and expressed written consent.

- 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 (e.g., child abuse/elder abuse reporting requirements, serious threat of harm to self or others, HIV/Aids reporting requirements, Patriot Act reporting requirements).

I consent to the use of my records for research purposes, including the publication and dissemination of research results, understanding that this will involve no participation on my part, and that my identity and any other identifying information will be protected and kept confidential.

- In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby indemnify and hold harmless, release, remise and forever discharge and covenant not to sue or hold legally liable Grace Clinic Christian Counseling, Inc; the licensed counselors; the licensed therapists; the registered interns; the supervisors; the graduate student counselors; or the staff 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 Grace Clinic as evidence in any judicial proceeding or to compel the testimony of any licensed counselor, licensed therapist, registered intern, graduate student counselor, or supervisor providing counseling to me through Grace Clinic.

I have read and understood the preceding information and agree to the policies of Grace Clinic Christian Counseling, Inc. as stated. I understand that these comments are prerequisite to my receiving and continuing counseling through Grace Clinic.

Signed: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____



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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____ have received a copy of Grace Clinic's Notice of Privacy Practices.
(Full Name)

Name: _____

Street Address: _____ Suite or Apartment Number: _____

City: _____ State: _____ Zip Code: _____

Signed: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____



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STATEMENT OF POLICIES AND PROCEDURES

COUNSELING SESSIONS

Counseling sessions with your Grace Clinic therapist are available weekly. Sessions are scheduled to begin on the hour and are 50 minutes in length. Sessions will end at 50 minutes past the hour. Therefore, it will be to your advantage to arrive on time so that you can benefit from a full-length session.

SERVICE FEES

Professional service fees range from \$85 to \$150 depending on your therapist's credentials and experience. Payment is due at the time of service. You may pay by cash, credit card, or check made payable to "Grace Clinic." Returned checks will be charged a \$20 service fee. Should you be unable to pay for all or part of a session, please speak with your counselor.

OFFICE HOURS

Grace Clinic's office hours are by appointment. Should you need to contact your therapist outside of your regularly scheduled appointment time please call (407) 539-0047.

RESCHEDULING APPOINTMENTS

It is our policy to schedule you for a "standing appointment." If you occasionally need to come at a different time, ask your counselor, who will see if an alternative appointment time is available. Please be aware that repeated cancellations or "no-shows" will result in the loss of your standing appointment.

CANCELLATIONS

If you must cancel your appointment, please contact your counselor at least 24 hours in advance of your scheduled time. You may call any time of day or night and leave a confidential voice mail message. Failure to do so will result in you being charged the full professional service fee, payable on your next visit. Your counselor has reserved a room for your session and has made himself/herself available for you at this time. Advance cancellations allow us to make the most efficient use of counselor time and office space.

NO SHOWS

If you fail to show up for an appointment and have not notified your counselor at least 24 hours in advance, you will be considered to have been a "no-show." It is your responsibility to contact your counselor before your next session to confirm your next appointment by leaving a message on his/her voice mail. After hearing from you, your counselor will then confirm your next appointment.

CONTACTING YOUR COUNSELOR

You may leave a confidential voice mail message for your counselor by calling (407) 539-0047, and asking for your counselor's voice mailbox. However, you may leave a message at any time by dialing (888) 861-5043 and then pressing your counselor's voice mail box number listed below.

Table listing counselors and their contact information: Sharonda Engram, M.S.; Dawna L. Probstak, M.A., N.C.C.; D.J. Snell, M.A., M.A.; Nicole Lively, M.S.W.; Kristi Alday; Monica Taffinder, M.A., M.A.; J.J. West, M.Ed./Ed.S.; Julia Sterne, M.A.; Laura Bravo, M.A., NCC.; Julie Wolf, M.S.; Katelyn Warner.



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

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:

- 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.

- You may request an amendment to your PROTECTED HEALTH INFORMATION.
- You may request alternative means or locations in which you receive confidential communications.
- 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:

- The Privacy Officer
Dawna Prostack, L.M.H.C.
Grace Clinic Christian Counseling
505 Park Avenue North, Suite 212
Winter Park, FL 32789
(407) 539-0047

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)