Turning Point
Center for Psychological and Family Growth, LLC

NEW CLIENT INTAKE Today's Date _____

Client's Name _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Age _____ DOB: _____ Marital Status: Single Married Divorced Separated Widowed

Client's e-mail _____

Social Security # _____ Home Phone # _____

Occupation _____ Work Phone # _____

Employer _____ Cell Phone # _____

Spouse/Significant Other Name _____ SS# _____

Spouse/Significant Other Employer _____ PH# _____

INSURANCE INFORMATION

Company Name and Address	Name of Policy Holder	Policy #
_____	_____	_____
_____	Name of Group	Group #
_____	_____	_____
2nd Company Name/Address	Name of Policy Holder	Policy #
_____	_____	_____
_____	Name of Group	Group #
_____	_____	_____

Referral Source: ___ Doctor (Name?) ___ ☐ ___ Ins Co. ☐ Friend ☐ Yellow Pages ☐ Other?) ____

When confirming appointments, whom should we call? _____

At What phone number? _____

If you do not wish to receive an appointment confirmation call, please let the office staff know at each appointment. If we call, and you are not available, may we leave a message: YES ☐ NO ☐

In the case of an emergency, whom should we contact? _____

Phone Number _____

FAMILY INFORMATION:

IF CLIENT IS A MINOR (Please complete the following):
Name of Parent or Legal Guardian: (Please Circle One):_____

Adults and children living in child's primary residence

Name	Age	Relationship	SSN(parents)	Work/cell phone#
R				

Adults and children living in child's secondary residence, if applicable

Name	Age	Relationship	SSN	Work/cell phone#

IF CLIENT IS AN ADULT (Please complete the following):

Father:		Age:	Occupation:
Mother:		Age:	Occupation:
Stepmother:		Age:	Occupation:
Stepfather:		Age:	Occupation:
Siblings:		Age:	M/F (circle one)
		Age:	M/F
		Age:	M/F
		Age:	M/F
		Age:	M/F
Children:		Age:	M/F
		Age:	M/F
		Age:	M/F
		Age:	M/F
		Age:	M/F

Describe the client's home environment during childhood_____

Is there a history of any of the following in your current family or your family of origin? Please Explain:

Alcoholism/Drug Abuse Y/N _____
Mental Illness Y/N _____
Physical/Sexual Abuse Y/N _____
Domestic Violence Y/N _____
Emotional Abuse Y/N _____
Legal Problems Y/N _____
Severe Physical Illness Y/N _____

EDUCATION
Degree or highest grade completed _____
School _____
Average Grades _____
Currently in school? Where? Goal? _____

MEDICAL HISTORY
Primary physician _____
Other current physicians' _____

Current medications and prescribing M.D. _____
_____
_____

Current medical conditions/problems/symptoms _____
_____
_____

History of surgery _____
_____
_____

Pharmacy you use, phone #/location _____

Disability? Y/N Type _____

History of inpatient or outpatient psychiatric care/counseling? Y/N _____
When, where, nature of problem, outcome: _____

Any history of suicide attempts: Y/N When? _____

Any history of violence? Y/N Arrests? Y/N Please explain _____
_____

Any History of Birth Defects or Developmental Delays? Y/N _____

Current legal conflicts: Y/N Please explain _____

_____

Please rate each of the following **current symptoms** on the following scale:
0 (Absent), 1 (Mild), 2 (Moderate), 3(Severe):

____Moodiness
____Worrying
____Panic Attacks
____Phobic Fears
____Trauma Memories
____Flashbacks
____Obsessions
____Compulsive Rituals
____Nightmares
____Emotional Numbing
____Perfectionism
____Social Isolation
____Excess Dependency
____Self centered
____Overly Controlling
____Overly guilty
____Binge Eating
____Purging/Vomiting
____Laxative use
____Excess dieting

____Low self esteem
____Depressed mood
____Loss of pleasure
____Poor or excess sleep
____Poor or excess appetite
____Low energy
____Poor concentration
____Memory problems
____Suicidal thoughts
____Racing thoughts
____Rapid speech
____Elated mood
____Poor impulse control
____Anger
____Blaming
____Homicidal thoughts
____Headaches
____Other bodily pain
____Bodily preoccupation
____Epilepsy

____Suspiciousness
____Delusions
____Hallucinations
____Paranoid thinking
____Grandiosity
____Strange thinking
____Strange behavior
____Confusion
____Disorganized thinking
____Sexual Trouble
____Relationship Problems
____Work Problems
____Academic Problems
____Legal Problems
____Alcohol Abuse
____Abuse of Street Drugs
____Abuse of Prescribed Drugs
____Nicotine Use (amount?) ____
____Caffeine Use (amount?)____
____Other _____

Reasons for seeking help _____

_____

Therapy goals _____

_____

Personal Strengths _____
Personality Type _____

Any other information your therapist should know _____

_____

_____

I, THE UNDERSIGNED PARTY, DO HEREBY GIVE MY CONSENT TO _____, OF TURNING POINT CENTER FOR PSYCHOLOGICAL AND FAMILY GROWTH, LLC FOR ASSESSMENT AND/OR PSYCHOTHERAPEUTIC TREATMENT OF _____.
Client's Name

Client Signature _____ Date Signed _____

Parent/Guardian Signature _____ Date Signed _____

Witness _____ Date Signed _____

Turning Point

Center for Psychological and Family Growth, LLC

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we will be pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important at the outset of our professional relationship, in order to minimize any later misunderstandings. Please ask if you have any questions about our fees. Services are rendered on a "PAY AS YOU GO" basis. We accept cash, checks, debit cards and Visa/MasterCard/Discover. If you have insurance, we will file for you; however, we do expect you to pay your deductible and co-payment at the time of services. Please realize, also, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

You are responsible for payment for all professional services rendered at Turning Point, including services that are not covered or paid by your insurance carrier. In accepting your insurance, we agree to modify our fee and accept the "allowable charge" permitted by your insurance carrier or managed care company. However, not all services are covered benefits in all contracts. Some insurance companies select certain services which they will not cover (e.g., some do not cover family therapy and most place limits on psychological testing).

In addition, **insurance companies generally will not pay fees for missed appointments, administrative fees, telephone consultations, or for written correspondence.** Turning Point professionals will, in most cases, provide requested information to medical and mental health professionals free of charge to you. However, we will charge our hourly fee for the time required to review records and compose letters that you request us to send to others. Likewise, telephone consultations are typically not covered by insurance carriers. Nonetheless, contact with your therapist may be sought in emergencies and certain other situations. We will charge our hourly fee for all after hours phone consultations, and for any extended (over 5 minutes) phone contact during office hours.

We must emphasize that as mental health providers, our relationship is with you, not your insurance company. While the filing of insurance is a courtesy that we extend to our clients, all charges are your responsibility from the date the services are rendered until the account is satisfied in full. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we ask that you contact us promptly for assistance in the management of your account. We can usually work out payment arrangements with you, but we ask that you make any such payments on a timely basis. Consistent failure to pay may result in your account being sent to collections, if all other efforts to collect the balance due have failed. Your home address and other identifying information, as well as your payment history, will be released during the collection process.

Please keep in mind that appointments are contracted time. If you fail to show for an appointment, or do not give sufficient advance notice of cancellation of appointments, we cannot

use that time to help someone else. Given the frequency of such occurrences, we have had to implement a very strict policy. We understand that situations may arise that require you to cancel an appointment. We ask that you do so by **3 P.M.** the business day prior to your scheduled appointment. Please keep in mind that the business day prior to your appointment may be more than the actual day before, when considering weekends and holidays. Failure to cancel your appointment by **3 P.M.** the business day before your appointment will result in a flat $35.00 charge, escalating to $50.00 for the second incident, $65.00 for the third, and $80.00 for each subsequent late cancellation. Failure to show up (FTS) or cancel your appointment more than one hour prior to your appointment time will result in a flat $50.00 charge, escalating to $65.00 for the 2nd FYS, and $80.00 for the 3rd FTS and thereafter. In the event to two successive late cancellations or failures to show up/cancel appointment, fees will need to be paid before being allowed to reschedule, and future appointments will be taken out of the schedule if these fees are not paid within 48 hours of the second missed appointment. New patients will need to pay their copayment for their first appointment prior to scheduling, with the understanding that this fee will be forfeited if they fail to show up for that appointment, or cancel it by 3 p.m. the day before. Consideration will of course be given for emergencies. **A $30.00 fee will be charged for returned checks.** If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you, and want to make sure that the sometimes difficult issue of financial arrangements is clearly understood at the outset of our relationship.

I have read and do understand the above, and agree to abide by the provisions of this financial policy. By accepting services, I accept the fee charged as a lawful debt and promise to pay said fees outlined above, whether or not covered by insurance, including the cost of collections, attorney fees, and court costs if such are necessary. I understand that the current collection fees range from 33% to 50% of any unpaid balance. I hereby authorize my insurance carriers to pay mental health/medical benefits directly to Turning Point Center for Psychological and Family Growth, LLC for all mental health services provided to me.

I acknowledge full responsibility for any charges denied by TriCare or other insurance companies due to failure to file claims through any existing primary insurance coverage that may have been in effect on the date of my services at TP.

_____ _____

Witness Responsible Party

_____

Date

Revised: 9/15/15

Turning Point

Center for Psychological and Family Growth, LLC

124 East Miracle Strip Parkway, Suite 302 Phone: (850) 243-8086
Mary Esther, Florida 32569 Fax: (850) 243-2702

Updated: 09/23/2013

POLICY REGARDING RELEASE OF CONFIDENTIAL PSYCHOLOGICAL AND MEDICAL INFORMATION

Turning Point Center for Psychological and Family Growth, LLC places high emphasis on client's rights, including confidentiality. Many precautions are taken to ensure confidentiality. Client information will be released only under one of the following circumstances.

1. A release of information is signed by the client or the client's legal guardian. The release of information will state to whom the information will be released. The release is valid for up to a year, or longer if you agree, unless written revocation by the client is given prior to expiration date. A spouse or relative of an adult client cannot obtain or release records without the client's written consent. Information from couple's sessions will not be released without the consent of both partners.
2. Turning Point will release pertinent information to the proper authorities to protect a person's life in the event of uncontrolled suicidal or homicidal urges.
3. Turning Point will obey court orders to release information.
4. Florida law requires than any evidence of child or elder abuse or neglect be reported to the Department of Children and Family Services.
5. Insurance and managed care companies require client records for various purposes, including authorization of services, determination of medical necessity of treatment, auditing to ensure appropriate record keeping, and other purposes. Client records are provided for such purposes, and the client agrees to such release of information as a precondition for use of insurance to pay for services.
6. You have the right to restrict disclosure of your personal protected health information to your health plan/insurance company if that information pertains solely to healthcare for which you (or a person on your behalf) paid for the testing or treatment in full, out of pocket. You must continue to pay out of pocket for subsequent care related to the restricted disclosure and all care received under the restricted disclosure cannot, at any time, be filed for reimbursement to a third party carrier such as your health insurance plan.
7. Only the client's name, identifying information and payment history will be released in the event that consistent nonpayment requires the client's financial account to be sent to collections.
8. HIPAA mandates release of information when a patient is committed to or returning from a state mental health facility.
9. Your signature on the attached HIPAA form also allows for automatic release of information to other health professional without additional consent. Our policy is more restrictive at Turning Point; we will seek your written consent for such disclosures, except in the case of hospitalization or other emergency situations.

I have read, understand, and agree to the above provisions for release of information. I understand that once released, information can no longer be protected by Turning Point.

_____ _____

Client's Signature Date

Turning Point Center for Psychological and Family Growth, LLC.
NOTICE OF PRIVACY PRACTICES

Effective Date: 4/14/2003 Updated 9/23/2013

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

Each time you visit a physician, hospital, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. Your record represents Protected Health Information.

We are *committed* to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice applies to all Protected Health Information, as defined by federal regulations, which is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAYS WE USE AND DISCLOSE HEALTH INFORMATION

For Treatment: We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to other health professionals who contribute to your care (such as doctors, nurses, technicians, or other personnel who are involved in taking care of you).

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it, unless you exercise your right to restrict**

For Healthcare Operations (Business Associates): There are some services provided in our office through contracts with business associates. Examples include transcription of your dictated health information, a copy service making copies of your health records, e-Prescribing service, a person who provides data transmission services, computer software vendor, and subcontractors that create, receive, maintain or transmit your medical information on behalf of the contracted Business Associate as required by Omnibus HIPAA Rule compliance. When services such as these are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information as required by HIPAA regulations.

Communication with Family or Friend: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

For Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

For Research, Marketing, and Fundraising: Our office does not sell your protected health information. Any activity for research, marketing, and fundraising requires your written authorization.

We may also use and disclose medical information to/for the following:

* to remind you that you have an appointment
* to assess your satisfaction with our services
* Food and Drug Administration
* Organ and Tissue Donation Organizations
* Health Oversight Agencies
* Funeral Directors, Coroners, Medical Directors
* Protective Services for the President of the United States
* to notify or assist in notifying a disaster relief entity so that your family can be notified about your health status
* Public Health Authorities
* Workers Compensation Agents
* Legal Authorities
* Military Command Authorities
* National Security & Intelligence

*for law enforcement purposes as required by law or in response to subpoena

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies. In compliance with Florida Law you may request a summary of your records, a fee will be charged for this service.

Amend: If you feel that medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment; and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or healthcare operations.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food & Drug Administration, work-related injury, and OSHA compliance.

**Restricted Disclosure: You have the right to restrict disclosure of your personal protected health information to your health plan/insurance company if that information pertains solely to healthcare for which you (or a person on your behalf) paid for the testing or treatment in full, out of pocket. You must continue to pay out of pocket for subsequent care related to restricted disclosure.

Genetic Information: Your genetic information is treated as Protected Health Information. It cannot be used to discriminate against you for the provision of health insurance or for underwriting purposes.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (for example, at work, or by U.S. Mail). We will grant this request only if it is submitted in writing. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

Breach: You will be notified within sixty days if a reportable breach of your protected health information occurs.

A Paper Copy of This Notice: You may ask us to give you a copy of this Notice.

If you have any questions about this Notice, please contact our Privacy Officer at our office, telephone :(850) 243-8086

We reserve the right to change this notice and to make the new provisions effective for all Protected Health Information we maintain from the first date of your health record. The current notice will be posted and include the effective date.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office at 124 E. Miracle Strip Pkwy, Suite 302, Mary Esther, FL 32569. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgment of Receipt of Notice of Privacy Practices
Office of Turning Point Center for Psychological and Family Growth, LLC

By signing this document, I acknowledge that I have read a copy of this office's Notice of Privacy Practices.

_____ _____ _____

PRINT Name Signature Date

Office Use Only:
Date Acknowledgment received _____ by _____
OR reason Acknowledgment was not obtained _____

Source: ECHA