Designing Success Counseling

Felicia Alphonse, MS, RMHC
Psychotherapy, Sexual Addictions Counseling, Pre-marital, Marital, Relationships, Women's Issues, Assessments & Group Therapy

ADULT INTAKE QUESTIONAIRE

CLIENT INFORMATION

Name: _____ Date: _____

Address (include City and State): _____

_____

Home Phone: _____ May I leave a message? ☐ Yes ☐ No

Cell Phone: _____ May I leave a message? ☐ Yes ☐ No

Work Phone: _____ May I leave a message? ☐ Yes ☐ No

Email Address: _____ May I email you? ☐ Yes ☐ No

***Please note that Email is not considered to be a confidential form of communication.**

Date of birth: _____ Age: _____ Gender: _____

Relationship Status: ☐ Single ☐ Living with Someone ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Other _____

Emergency Contact/Relation to Client: _____
Provide name and phone number

Who lives at your address: List names and relationship: _____

_____

_____

EDUCATION/EMPLOYMENT

What is the highest year of education completed? _____

What is the highest degree or certification you hold? _____

Are you currently employed? _____ If yes, please list name of employer, title, type of work and number of years with this company. _____

_____

_____

If no, are you primarily responsible for the house and/or children? _____

_____

_____

If you are not employed, when and what was the last job you held? What is the reason you are no longer in that position? _____

_____

_____

Have you ever served in the military? If yes, please explain when, for how long, position, current status, reason for leaving, and if deployed when and where. _____

_____

_____

_____

MEDICAL/HEALTH HISTORY

List any allergies and/or current medical conditions for which you are or have received treatment in the past (include any operations, head injuries, accidents, and hospitalizations): _____

_____

_____

_____

_____

Name of Primary Care Physician, address and phone number: _____

_____

Please list all current medications and dosages:

Name of medication Dosage Doctor Prescribing When did you start taking it?

_____

_____

_____

_____

_____

Women: Have you ever been pregnant?____Number of births____Miscarriages_____Abortions_____

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MENTAL HEALTH HISTORY

Have you ever been in counseling? _____ When and what was your overall experience with therapy?_____

Are you being prescribed medication for any mental health issues? If yes, what is the name and dosage of medication, list any previous medications you have been on and the name and phone number of the prescribing physician. _____

Have you ever been hospitalized in a psychiatric facility? What were the circumstances in which you were hospitalized. Please identify when, where, how many times, and for how long. What treatment did you receive? Were you given a diagnosis? What was the recommendation following discharge? _____

Have you ever or are you currently intentionally hurting yourself? If yes, please explain._____

Have you ever or are you currently experiencing suicidal thoughts? Suicide attempts? If yes, please explain.

How many drinks do you average in a week? Month? Do you have a history of drug use/abuse? Have you ever been treated for substance abuse? Please explain. _____

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FAMILY HISTORY

Who raised you? Who did you live with? Are your parent(s) alive? _____

Please list any siblings, half or step siblings (alive or deceased, ages, where they live and frequency of contact):_

Do any of your biological relatives suffer from any medical or mental health conditions? Please explain who, their relationship to you and their problems and their diagnosis (include any family history of substance abuse):

Please briefly describe childhood. What did your parent's do for work; relationships; any separations/divorces; any deaths; history of domestic or childhood abuse; major changes and/or moves: _____

Please add anything about your history that you think is significant to assisting you today. _____

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SYMPTOM LIST: PLEASE CHECK ALL THAT APPLY

_____Depressed mood
_____Low energy/enthusiasm
_____anxiety
_____panic attacks; fear
_____obsessive thoughts
_____intrusive thoughts
_____compulsive rituals or behavioral patterns
_____engaged in illegal activities
_____can't fall asleep
_____ending a relationship
_____difficulty focusing
_____difficulty concentrating
_____weight loss
_____weight gain
_____social isolation
_____increase drinking alcohol
_____missing work
_____missing school
_____experienced physical abuse
_____experienced mental abuse
_____suffering from post traumatic symptoms
_____experienced sexual abuse
_____family problems
_____increase in crying
_____perfectionism
_____worry a lot/ruminate
_____sexual promiscuity
_____using illegal drugs/abusing drugs
_____recent health problems
_____phobias
_____recently arrested
_____can't stay asleep
_____difficulty staying in relationships
_____poor self-esteem
_____poor body image
_____irritability
_____anger management problems
_____stress management problems
_____ parent/child relationship problems
_____issues in primary relationship
_____recently separated
_____recently divorced
_____recent loss of a loved one
_____lost job
_____involved with the legal system as a victim
_____ in transition; having trouble making a decision
_____ other _____

What are your main 3 stressors (marriage, work, personal life)?

_____

_____

_____

What are 2 goals you have for counseling?

_____

_____

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INFORMED CONSENT FOR BEHAVIORAL HEALTH ASSESSMENT/TREATMENT

I, _____ (PLEASE PRINT NAME OF CLIENT) am a competent adult and am voluntarily seeking behavioral health assessment/treatment/services through Felicia Alphonse, who is pre-licensed/qualified to practice under qualified supervision, as a Psychotherapist, Registered Mental Health Counselor in the State of Florida.

The fees for my services are: $_____for an Initial Assessment/Evaluation and $_____ per a 50 minute session of service, payable at the beginning or end of each session. I understand that, except in the event of extreme emergency, advance notice of 24 hours is required if I am not able to keep a scheduled appointment. I understand that, except in the case of dire emergency, I will be charged for the missed session without providing a 24 hour cancelation notice; my counseling services will be terminated if I miss two consecutive appointments without providing a 24 hour notice.

I understand that, although therapy is expected to be helpful in resolving my problems, no guarantee has been made about the usefulness or effectiveness of treatment.

Because of the laws of this state and the guidelines of the therapist's profession, these privacy rules will be followed:

1. All information will be held confidential and privileged unless the psychotherapist has suspicion that I have neglected or abused a child, a senior citizen or a disabled person, in which case a report will be made as required by law to the appropriate law enforcement and social welfare agencies.
2. All information will be held confidential and privileged unless I report suicidal or homicidal ideation, intent or plan, in which case a report will be made as required by law to the appropriate law enforcement and social welfare agencies.
3. Other information may be released in accordance with the Health Insurance Portability and Accountability Act as described in the Notice of Privacy Practices, which I have received a copy.

My signature below means that I understand and agree with all of the points above.

_____ /___/___

Client Signature Date

I have discussed the issues above with the client. My observations of this client's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent or lacks capacity in decision making to give informed and willing consent.

_____ /___/___

Provider Signature Date

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RELEASE OF INFORMATION

I,_____, (client) a legally competent adult, hereby authorize, Felicia Alphonse, RMH to engage in conversation with and to release information contained in clinical record to:

I approve and authorize release of the following:

- ☐ Entire Record
- ☐ Psychotherapy Summary Report
- ☐ Case Notes
- ☐ Treatment Planes
- ☐ Telephone Contact Reports
- ☐ Mental Status Report(s)
- ☐ Baker Act Summary Evaluation
- ☐ Client-generated social history, self-reports and/or homework assignments
- ☐ Work-readiness recommendation to work supervisor (Mandated EAP clients only)
- ☐ Other (specify)_____

The above information will be used for the following purposes:

- ☐ Planning Appropriate Treatment
- ☐ Continuing Appropriate Treatment
- ☐ Case Review
- ☐ Determining Eligibility for Benefits or Programs
- ☐ Proof of participation in and/or completion of counseling (Mandated EAP only)
- ☐ Other (specify)_____

I understand that I may revoke this consent at any time by providing written notice and at the termination of treatment this consent automatically expires.

Release of Information is valid for the following dates:

_____ /__/____

Signature of the Client(s) **Date**

_____ /__/____

Felicia Alphonse **Date**

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CLIENT NAME	DOB	MR#
DATE:	GENDER MALE / FEMALE	

THE BURNS ANXIETY INVENTORY*

Place a check (√) in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

Category I: Anxious Feelings	0 Not at All	1 Somewhat	2 Moderately	3 A Lot
1. Anxiety, nervousness, worry, or fear				
2. Feeling that things around you are strange or unreal				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, "uptight," or on edge				
Category II: Anxious Thoughts	**1 Not at All**	**1 Somewhat**	**2 Moderately**	**3 A Lot**
7. Difficulty concentrating				
8. Racing thoughts				
9. Frightening fantasies or daydreams				
10. Feeling that you're on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of physical illnesses or heart attacks or dying				
14. Concerns about looking foolish or inadequate				
15. Fears of being alone, isolated, or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen				

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THE BURNS ANXIETY INVENTORY (Continued)

Category III: Physical Symptoms	0 Not at All	1 Somewhat	2 Moderately	3 A Lot
18. Skipping, racing, or pounding of the heart (palpitations)				
19. Pain, pressure, or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded, or off balance				
30. Choking or smothering sensations or difficulty breathing				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak, or easily exhausted				
Total score on items 1-33 —>				

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Name:	DOB	MR#
Date:	Gender Male / Female	

THE BURNS DEPRESSION CHECKLIST*

Place a check in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

	0 Not at All	1 Somewhat	2 Moderately	3 A Lot
1. Sadness: Do you feel sad or down in the dumps?				
2. Discouragement: Does the future look hopeless?				
3. Low self-esteem: Do you feel worthless?				
4. Inferiority: Do you feel inadequate or inferior to others?				
5. Guilt: Do you get self-critical and blame yourself?				
6. Indecisiveness: Is it hard to make decisions?				
7. Irritability: Do you frequently feel angry or resentful?				
8. Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends?				
9. Loss of motivation: Do you have to push yourself hard to do things?				
10. Poor self-image: Do you feel old or unattractive?				
11. Appetite changes: Have you lost your appetite? Do you overeat or binge compulsively?				
12. Sleep changes: Is it hard to get a good night's sleep? Are you excessively tired and sleeping too much?				
13. Loss of sex drive: Have you lost your interest in sex?				
14. Concerns about health: Do you worry excessively about your health?				
15. Suicidal impulses: Do you have thoughts that life is not worth living or think you'd be better off dead?				
Total score on items 1-15 —>				

 Anyone with suicidal urges should seek immediate help from a mental health professional

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RELATIONSHIP SATISFACTION SCALE – Place a check in the box to the right of each category that best describes the amount satisfaction you feel in your closest relationship.

	0 - Very Dissatisfied	1 – Moderately Dissatisfied	2 – Slightly Dissatisfied	3 - Neutral	4 – Slightly Satisfied	5 – Moderately Satisfied	6 – Very Satisfied	Name:
1. Communication and openness								Date:
2. Resolving conflicts and arguments								DOB:
3. Degree of affection and caring								Mrs:
4. Intimacy and closeness								
5. Satisfaction with your role in the relationship								
6. Satisfaction with the other person's role								
7. Overall satisfaction with your relationship								
Total score on items 1-7								

NOTE: Although this test assesses your marriage or most intimate relationship, you can also use it to evaluate your relationship with a friend, family member or colleague. If you do not have any intimate relationships at this time, you can simply think of people in general when you take the test.

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Authorization of Use or Disclose Protected Health Information

Client Information

I, _____
Name

_____
Street Address City State Zip

hereby give permission to: _____
Name

Recipient Information

To (please check one or both as appropriate):

☐ DISCLOSE TO and/or

☐ OBTAIN information from: _____
Name

_____
Street Address City State Zip

Protected Health Information to be Used or Disclosed

Purpose of Disclosure: _____

The Following Information: _____

Expiration of Authorization

☐ This date (no more than 1 year from today): _____

☐ When this happens: _____

Your Rights

- You can end this authorization at any time by writing to the Name and Address below. If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You do not have to agree to this request to use or disclose your information.
- You have a right to a copy of this signed authorization.

Re-disclosure by Recipient

Information that is disclosed as a result of this Authorization Form may be subject to re-disclosure by the recipient. This office follows laws that protect your health information and confidentiality. Federal and/or state laws prohibits further disclosure of this information unless expressly permitted by written consent, however, this office is not responsible for re-disclosure by the recipient.

Signature

_____ _____ or _____ _____
Client Signature Date Authorized Representative Signature Date

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NOTICE OF PAYMENTS AND CO-PAYMENTS

I, _____, have been advised **Felicia Alphonse** will bill my insurance (s) directly for this service. I have been further advised that the payment could possibly be sent to me by the insurance company.

ACCORDINGLY, IT IS HERBY UNDERSTOOD AND AGREED THAT I HAVE NO RIGHT TO SAID FUNDS AS THEY ARE PAYMENT FOR SERVICES PROVIDED BY **Felicia Alphonse** AND THEREFORE, DO NOT BELONG TO ME.

Furthermore, In the event that said check or checks are made payable to me and are received by the Office, I herby give said Office a limited power of attorney solely and exclusively for the purpose of endorsing my name on my behalf so that I do not have to return to the office.

Patient Signature: _____Date: _____

Witness Signature: _____Date: _____

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Financial Agreement

The following is a statement of our **Financial Policy**, which we require that you read and sign prior to any treatment. Please understand this financial policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases. This also allows us to concentrate on what we do best...**taking care of you.**

Full payments of co-pay or session fees are due at the time of service. If full payment is not remitted your session will be rescheduled at a time in which full payment can be made.

We accept cash, checks, and all major credit cards.

Insurance:
We may accept assignment of insurance benefits; however, we do require co-payments to be paid at the time of service. The balance is your responsibility until paid in full. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract nor are we responsible for procedures that are not covered for any reason. We must have completed and up to-date insurance information in order to bill your insurance company on your behalf. In the event that your insurance company has not paid their portion within 60 days, the balance will be billed to you.

Initial _____

Billing Charges:
A billing charge will be applied to any account which has a balance 45 days past due. This monthly fee will equal 18% APR or a minimum of $5.00.

Initial _____

Collection Fees:
Accounts that remain unpaid after 45 days may be turned over to our internal collection department. These collection efforts will incur collection fees internally that may total up to 50% of the account balance. When an account becomes 90 days past due, collection action may be taken
In this event, you will be responsible for all collection and legal fees.

Initial _____

Missed Appointments:
Unless cancelled at least 24 hours in advance before the scheduled appointment time, the full session fee of $125.00 will be charged to your account. Hours of operation are Monday-Friday between 10:30am-2pm, excluding weekends. Please help us to serve you and other patients more efficiently by keeping scheduled appointments.

Initial _____

Returned Checks:
If a check is returned unpaid, there will be a $35.00 charge and check payments for your account will no longer be accepted. I, the undersigned, assume financial responsibility as stated above and responsibility for all collection and legal fees if my account becomes past due. I have read, understand, and agree to this Financial Policy.

X_____ _____

Client Signature Date

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Financial Agreement

Credit Card Number on File

Your therapist respects your time and sets aside time to see you when you make an appointment with her. A sessions usually lasts 60 minutes and payment is due at the time of treatment. It is important that clients respect the therapist's time as well. Clients wishing to cancel or change an appointment must give the counselor 24-hour notice. In most cases, the therapist will be able to accommodate another client if such notice is given. To impress upon clients the importance of giving advance notice when cancelling appointments, the counselor requires a credit card number and information on file. If a client no-shows or cancels at the last minute or without giving 24 hour notice so that the slot may not be taken by someone else who is waiting for therapeutic care, the credit card will be charged for the full cost of the missed appointment. Clients who make payments by check and their check is returned the owed amount will be charged to the credit card plus a $30.00 returned check fee.

Once again, you are notified that clients who miss appointments or cancel without 24 hour notice will be charged for a full missed appointment based on the hourly rate.

Please Circle preferred card:

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Name: _____

Address: _____

Credit Card #

Expiration date: Security Code #(3 numbers on back of card)

SIGNATURE:

(By signing this form I agree that my credit card may be charged for a missed appointment if I fail to give 24 hour notice prior to the scheduled appointment time.)

If you are sick and must miss an appointment, or experience a dire personal emergency, the counselor may forfeit the missed appointment fee, at her discretion, on a case-by-case basis.

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By signing this agreement you are guaranteeing payment for services rendered including remitting any insurance payments that are inadvertently sent to you or credited to you.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services.

These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's unusual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should be aware that your contract with your health insurance company requires that

Felicia Alphonse provide it with information relevant to the services that we provide to you. we may be required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, every effort will be made to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, **Felicia Alphonse** . has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report submitted, if you request it. By signing this Agreement, you agree that **Felicia Alphonse** can provide requested information to your carrier. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

YOUR SIGNATURE BELOW INDICTATES THAT YOU HAVE READ AND UNDERSTOOD THE PSYCHOTHERAPIST-CLIENT AGREEMENT, THAT YOU HAVE HAD A CHANCE TO DISCUSS ANY CONCERSNS WITH **Felicia Alphonse** . AND AGREE TO THE TERMS AND ALSO, SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE READ THE HIPPA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Signature Date

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CONSENT FOR TREATMENT

I, the undersigned, a client with **Felicia Alphonse** ; OR
I, the undersigned, a parent (if minor), guardian of, (or) guardian advocate of, _____.

The therapist assigned and I have discussed my/my child's case and I was informed of the risks, approximate length of treatment, alternative methods of treatment, and the possible consequences of the decided length of treatment which includes the following methods and interventions: stabilization, decreasing symptomatology, improving coping, problem solving and use of resources, development, grief resolution, stress management, behavior modification and cognitive restructuring. While I expect benefits from this treatment I fully understand and accept that because of factors beyond your control, such benefits and desired outcomes cannot be guaranteed.

I understand that the therapist is not providing emergency services and I have been informed of whom/where to call in an emergency or during the evenings or weekend hours. I understand that the therapist/intern is in session most of the day and agree to call one time, leave a message and await a return call. Multiple calls disrupt the time committed to other clients. I understand that regular attendance will produce the maximum possible benefits but that I or we am/are free to discontinue treatment at any time in accordance with the policies of the office.

I understand that I am financially responsible for any portion of the fees not covered by my insurance company or other third party. I have been informed of the limits of confidentiality, that by law, the therapist/intern must report any suspected abuse or neglect. I am not aware of any reason why I/we/he/she should not proceed with therapy and that I/we/he/she agree(s) to participate fully and voluntarily. I have had the opportunity to discuss all of the aspects of treatment fully, have had my questions answered and understand the planned treatment. Therefore, I agree to comply with the treatment and authorize the above named agency/clinician/intern to administer the treatment. I also agree to fully release and hold harmless the agency/clinician/intern for any liability arising in relation to this matter.

_____ Client	_____ Date	_____ Witness	_____ Date
_____ Parent/Guardian of Minor Or Guardian Advocate ____	_____ Date	_____ Witness	_____ Date

**The client of services shall always be asked to sign this authorization form. In addition, a parent, guardian or guardian advocate may be asked to give authorization.

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SOCIAL MEDIA POLICY
PUBLIC/COMMUNITY INTERACTION POLICY

This document outlines my office policies related to the use of Social Media and Public/Community Interactions. Please read it and understand how I conduct myself on the Internet and out in the community as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet and/or out in the community.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING

I do not accept friend requests or contact requests from current or former clients on any social networking sites (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

FOLLOWING / FANNING

I keep a Facebook page for my professional practice to keep up with updates with other professional Facebook users in my networking community. I do not accept clients as fans/followers on this page. I believe having clients as Facebook followers creates a greater likelihood of compromised client confidentiality and I feel that it is best to be explicit to all who may view my list of followers to know that they will not find client names on that list. In addition, I feel that the term "Fan" or "Following" comes too close to an implied request for a public endorsement of my practice.

INTERACTING

Please do not use messaging on any social networking sites (Facebook, LinkedIn, etc.) to contact me. These sites are not secure and I may not ever read these messages and/or read these messages in a timely fashion. Do not use wall postings, @replies, or other means of engaging with me in public online if we have an already established client-therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

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USE OF SEARCH ENGINES

It is NOT a part of my practice to search for clients on Google or Facebook or other search engines. I expect the same courtesy in return in order to keep our therapeutic boundaries clear as well as to not create preconceived notions towards you/me that may affect your treatment process and our therapeutic relationship. In extremely rare exceptions, I may use a search engine in reference to you during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (missed appointments, phone, email, etc.) there might be an instance in which using a search engine (to find you, to find someone close to you, or to check on your recent status updates) may become necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

GOOGLE READER

I do not follow current or former clients on Google Reader and I do not use Google Reader. If there are things you want to share with me that you feel are relevant to your treatment, whether they are news items or things you have created, I encourage you to bring these items of interest into our sessions.

BUSINESS REVIEWS SITES

You may find my practice on sites such as Yelp, HealthGrades, Yahoo, Bing, Google, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

Of course, you have the right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me whenever and with whomever you like.

Confidentiality means that I cannot tell people that you are my client and my ethics code prohibits me from requesting testimonials. However, you are more than welcome to tell anyone that you wish that I am your therapist or how you feel about the treatment I am providing/provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, I hope you will keep in mind that you will be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to you in any fashion for your own privacy protection.

Designing Success Counseling

Felicia Alphonse, MS, RMHC
Psychotherapy, Sexual Addictions Counseling, Pre-marital, Marital, Relationships, Women's Issues, Assessments & Group Therapy

ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY RULE AND NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of HIPPA Privacy Rule and our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the above.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of HIPPA's Privacy Rule and this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgement of receipt of HIPPA and our Notice of Privacy from this patient, but it could not be obtained because:

[ ] The patient refused to sign.
[ ] Due to an emergency situation, it was not possible to obtain an acknowledgement.
[ ] We weren't able to communicate with the patient.
[ ] Other (please provide specific details):

_____

_____ _____
Clinician's Signature Date