Therapeutic Oasis OF THE PALM BEACHES

CLIENT INFORMATION

Today's Date _____/_____/_____ **Therapist**______________________________

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Gender Identity:

❑Male ❑Female ❑Trans Man/FTM ❑Trans Woman/MTF ❑Genderqueer ❑Choose not to disclose ❑Other

Street Address	City	State	ZIP Code	Cell Phone No. ( ) May we leave message? Y N
Mailing/Billing Address (if different)	City	State	ZIP Code	Home Phone No. ( ) May we leave message? Y N

Occupation	Employer	Work Phone No. ( )

Who referred you to our office?

Email Address:	☐ Check here if you do NOT want to receive email reminders for upcoming appointments

PAYMENT INFORMATION

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance?	❑ Yes ❑ No	Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other: ______________________

MEDICAL PROVIDERS

List your Primary Care Physician and any other doctors/therapists you are seeing:	Specialty	Phone No.
	Primary Care Physician	

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

IMPORTANT MEDICAL INFORMATION

Please list all known allergies and any important medical information here:

851 Broken Sound Parkway NW, Suite 250
Boca Raton, FL 33487
Phone: (561) 278-6033 Fax: (561) 278-6023
www.TherapeuticOasis.com

Therapeutic Oasis
OF THE PALM BEACHES

Client Name: ______________________________ **Date:** ________________

Please check any of the following that apply to you:

	Headaches		Difficulty Sleeping		Less energy than usual
	Palpitations		Hard to concentrate		More energy than usual
	Don't like weekends		Quick change of moods		Can't relax
	Problems with my breathing		Nervous/tense		Restless/can't sit still
	Marital stress		Hard to control anger or urges		Shaky/trembling
	Family problems		Feeling suicidal		Hard to trust anyone
	Relationship problems		Feeling worthless		Hard to control my thoughts
	Problems at work/school		Drawing away from people		Stomach or bowel problems
	Health problems		Lack of interest/enjoyment		Sweating
	Financial problems		Too many drugs		Lightheaded/dizzy
	Legal problems		Too much alcohol		Worry too much
	Sad/depressed		Feel negative about the future		Too many fears
	Loss of appetite		Hard to make friends		Feel guilty
	Loss of weight		Feeling lonely		Feeling angry/frustrated
	Gaining weight		Sexual problems		Nightmares
	Other (please describe):				

Medical History: Have you ever had or do you now have any of the following? (Check all that apply)

	Chronic Pain		Communicable disease		Stomach problems
	Back or neck problems		Headaches		Sexual problems
	Anemia		High blood pressure		Surgery
	Pneumonia		Asthma		Diabetes
	Tuberculosis		Arthritis		Night sweats
	Skin problems		Sexually transmitted disease		Weight loss/gain
	Auto or other accident		Cancer		Allergies
	Tachycardia (increased pulse rate)		HIV		Convulsions
	Withdrawal symptoms or blackouts		Miscarriage		Kidney trouble
	Heart problems		Hepatitis		Rheumatic fever
	Stroke		Parkinson's disease		
	Other (please describe):				

Please briefly describe any previous counseling, psychological, or psychiatrist services:

OFFICE POLICIES AND CONSENT FOR TREATMENT

Please read, initial each page, and sign at the end stating you read and understand the information contained in this document.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Therapeutic Oasis of the Palm Beaches offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed professional counselors, registered dietitians, licensed clinical social workers, doctors of psychology, and interns. Effective therapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: We provide counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if you both agree that your Therapist can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The goal of Therapeutic Oasis of the Palm Beaches is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

PROFESSIONAL CONSULTATION: If you are seeing multiple service providers at Therapeutic Oasis of the Palm Beaches, those providers may consult with one another as needed about your care in order to provide the level of services necessary for your treatment.

YOUR APPOINTMENT: Appointments are typically scheduled on a weekly basis and are approximately 45-60 minutes long. Nutrition Therapy sessions are typically 60 minutes for the initial session and 30-45 minutes thereafter. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist.

Please plan on arriving at least 5 minutes before your scheduled appointment time so that you can make payment and take care of any administrative items. Please turn your cell phone to silent mode and finish your phone calls before you enter the building. It should go without saying that weapons of any kind are not permitted on the premises. Furthermore, alcohol or drugs are not permitted, nor should you arrive to your appointment under the influence.

CANCELLATION POLICY: In fairness to both our clinical providers and other clients we kindly ask that should you need to cancel or reschedule your appointment, you do so no less than **48 business** hours before your scheduled appointment time (Friday by 12:00pm for Monday & Tuesday appointments). To cancel or reschedule your appointment, we ask that you call our office at (561) 278-6033 as soon as possible and inform the front desk. This will free your appointment time for another client. **If your appointment is missed or cancelled with less than 48 hours notice, we will charge your credit card on file for the full rate of the scheduled appointment. Please note that insurance will not cover missed appointments.**

GROUP THERAPY: A commitment is required for all Group Therapy. Groups must be is pre-purchased for a pre-determined number of consecutive weeks. Missed groups cannot be made up, nor can they be refunded.

CREDIT CARDS ON FILE: After the initial appointment, all clients must put a credit card on file to cover missed appointments, late cancels, and any phone sessions should they be required. It is your responsibility to inform the Front Desk staff should your credit card information change at any time during your treatment here. You may also authorize Therapeutic Oasis to use the credit card on file for regularly scheduled office visits or other services if you desire.

APPOINTMENT REMINDERS: Therapeutic Oasis of the Palm Beaches sends email reminders to clients as a courtesy. It is your responsibility to keep your appointment whether or not you receive any reminder from us.

LATE APPOINTMENTS: If you are more than 15 minutes late, your appointment may be forfeited and a late cancel fee will be charged.

Please note that frequent cancellations, no-shows or late appointments will require pre-payment of future appointments.

PHONE CALLS: Occasionally, you may need to contact your therapist for a brief consultation or to ask a question about your treatment. Such phone calls will be returned as soon as practical during regular business hours. Phone calls lasting more than 10 minutes will be considered a phone appointment and will be billed at the regularly scheduled hourly fee. Most insurance companies (including Medicare) do not cover phone appointments.

REFERALS: Upon request we may suggest you seek treatment from a clinical professional outside of Therapeutic Oasis. Should we provide you with the name and number of another professional, it is merely a suggestion. We do not endorse or recommend these professionals nor do we receive any compensation for referring to them.

EMAIL & TEXT MESSAGES: Email and text messaging are not recommended as an effective method of communication between you and your therapist. It may take up to 72 hours for your therapist to respond to an email or text message. Furthermore, it is important to understand that in spite of your therapist's best efforts to maintain confidentiality, any email or text message may be intercepted by outside sources and therefore may not be completely confidential and cannot be guaranteed as such.

PAYMENT: Payment of fees, including any Medicare copayment, is expected at the time of each appointment. We request that payment be made before your session begins. Full payment for group therapy must be made before attending the first session. Refunds will not be issued for individual or group services.

INSURANCE BENEFITS: Therapeutic Oasis of the Palm Beaches does not participate in any insurance plans. If you have out-of-network insurance benefits, Therapeutic Oasis of the Palm Beaches will either submit claims on your behalf to your insurance company or provide you with a monthly Superbill that contains the necessary information to file a claim with your insurance company.

EMERGENCIES: At some point, you may encounter a situation that requires prompt attention. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. Otherwise, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. When your Therapist is out of town, you will be advised and given the name of an on-call Therapist.

CONFIDENTIALITY: Therapeutic Oasis of the Palm Beaches follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. Additionally, we may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name(s) Telephone Number

____________________________________ ____________________________

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of my Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this document. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Therapeutic Oasis of the Palm Beaches will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

____

CLIENT NAME – PLEASE PRINT

____________________________________ ____________________________

Signature – Client or Parent/Legal Guardian Date

____________________________________ ____________________________

Signature – Spouse/Partner/Parent Date

AUTHORIZATION TO BILL INSURANCE: I understand that Therapeutic Oasis of the Palm Beaches is an out-of-network provider. If I choose to utilize my out-of-network insurance benefits, Therapeutic Oasis of the Palm Beaches will either:

(1) Provide a monthly superbill so that I may file a claim directly with my insurance company or

(2) Authorize Therapeutic Oasis of the Palm Beaches to file out-of-network claims on my behalf.

I understand that the office will not be responsible for communicating with my insurance company regarding any claim denials or discrepancies. I will assume full responsibility for all communication with my insurance provider.

If you would like our office to file claims on your behalf, please sign in area below:

I hereby authorize the release of necessary medical information, including diagnosis code, for insurance reimbursement purposes.

____ ______________________________

Signature – Client or Parent/Legal Guardian Date

IMPORTANT NOTE: You are entitled to a copy of this document. If you are not offered a copy at the conclusion of your appointment, please notify your therapist.

CURRENT FEE SCHEDULE

Fees vary by service provider

Diagnostic & Evaluation Therapy Session .... $185 - $300
Regular Office Visits (55 minutes) (Individuals, Couples & Play Therapy) .... $185 - $300
Regular Office Visits (40 minutes) (Individuals, Couples & Play Therapy) .... $150 - $250
Family Sessions (55 minutes) .... $185 - $300
Nutrition Therapy (70 minutes Initial Session) .... $ 275
Nutrition Therapy (30 minute follow up) .... $ 100
Nutrition Therapy (45 minute follow up) .... $ 150
Standard Group Therapy (12 continuous weeks) .... $ 550 – $ 1,000
Weekend Appointment Surcharge .... $ 25
Program Service Fees (per week) .... $ 125 - $250
Program Support Services (per hour) .... $ 75
Outside Services/After Hours rate (billed hourly for inpatient visits,
Court appearances, crisis management, collaborative & legal services, etc) .... $ 450
Written Reports (insurance companies, supervisors, etc) .... $ Quoted
<u>DBT Skills Groups:</u>
Standard (24 Weeks) $3,000
Teen (24 Weeks) $3,000
Middle Path Parent Group (24 weeks) .... $ 1,000
Advanced (16 Weeks) $1,000
WiseUp (12 Weeks) .... $ 750
DBT Phone Coaching (per 15 minutes) .... $ 40 - $ 75
Returned check fee per check .... $ 35
Records copies .... $ 1/page for first 25 pages, $0.25 each additional page

Comprehensive treatment programs will be charged based upon scheduled services and may include additional charges for services not listed here.

Fees for services may change as necessary from time to time. If the fees associated with your services are changed, you will be given a minimum of 4 weeks notice before the fee increase becomes effective. You may request a current fee schedule at any time from the front desk staff.

Cancellation Policy:

In fairness to both our clinical providers and other clients we kindly ask that should you need to cancel or reschedule your appointment, you do so no less than **48 business** hours before your scheduled appointment time (Friday by 12:00pm for Monday & Tuesday appointments). To cancel or reschedule your appointment, we ask that you call our office at (561) 278-6033 as soon as possible and inform the front desk. This will free your appointment time for another client. **If your appointment is missed or cancelled with less than 48 hours notice, we will charge your credit card on file for the full rate of the scheduled appointment. Insurance will not cover missed appointments.**

Please note that frequent cancellations, no-shows or late appointments will require pre-payment of your appointment.

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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Lisa Ladomer at 561-278-0033:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions. .** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Lisa Ladomer, our Privacy Officer, at 851 Broken Sound Parkway NW, Suite 250, Boca Raton, FL 33487 (561) 278-0033 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is January 1, 2013.

Receipt and Acknowledgment of Notice of Privacy Practices

Client Name: ______________________ DOB: ______________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Therapeutic Oasis of the Palm Beaches' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at the address or phone listed in that document.

______________________________ ______________________________

Signature
Client or Parent, Guardian or Personal Representative*

Date

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

851 Broken Sound Parkway NW, Suite 250
Boca Raton, FL 33487
Phone: (561) 278-6033 Fax: (561) 278-6023

CREDIT CARD AUTHORIZATION AGREEMENT

Client: ________________________________ **Date:** ________

I authorize *Therapeutic Oasis of the Palm Beaches* to hold the credit card information listed below "on file" for the purposes listed in this agreement. *Therapeutic Oasis of the Palm Beaches* may not use this card for any other purpose unless instructed to do so in writing.

I, the cardholder named below, authorize *Therapeutic Oasis of the Palm Beaches* to charge the designated credit card for the amount(s) and purpose(s) listed below. I understand that if a scheduled appointment is missed or cancelled less than 24 business hours in advance, I will be charged the full fee for the scheduled appointment.

Please check all that apply:

- ☑ Regularly scheduled office visits.
- ☑ Phone sessions with Therapeutic Oasis Staff
- ☑ Appointments missed or cancelled with less than 24 business hours notice
- ☐ Group therapy sessions at Therapeutic Oasis of the Palm Beaches
- ☐ Books and services from Sacred Treehouse

Print name exactly as
it appears on credit card: ____

Card Number: ______________ - ______________ - ______________ - ______________

Security code: _________ Expiration Date: ____ /_____

Address where CC bill is mailed:

____ ____________________ _____ ____________
Street *City* *State* *Zip*

This agreement is valid until ______________ or until the expiration date listed above. I agree to inform Therapeutic Oasis within 14 business days should my credit card information change during this time.

I agree to the terms and conditions of this agreement:

_______________________________________ ________________
Signature of Cardholder *Date*