



Thank you for making an appointment with one of our providers!
Here are some helpful reminders for your initial visit.

Address:

33 6th Street South, Suite 205

Saint Petersburg, FL 33701

(Same building as “City Gym”)

We are located in downtown St. Pete on the corner of 1st Avenue South and 6th Street. We are across from Hippo Popsicle and Cider Press Café.

Parking:

Parking available in marked spaces 52, 53, 54 (along the alley)

Please park in designated spaces ONLY, (the towing company is very aggressive)

Free 2-hour city street parking is also available.

Entrance:

The entrance to the building is on the east side (not the sliding glass doors side). If the door is locked, the code is **5030*** Take the elevator up to the 2nd floor. We are in suite 205 up the hall on the left.



INTEGRATED
CARE CLINIC

ADULT INTAKE QUESTIONNAIRE

Name: _____

Today's Date: _____

Age: _____

Date of Birth: _____

Address: _____

Home phone: _____

Ok to leave message? Yes No

Work phone: _____

Ok to leave message? Yes No

Cell phone: _____

Ok to leave message? Yes No

Email: _____

Referred by: _____

May we acknowledge the referral? _____

Reason you are seeking services:

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Present psychological difficulties – please check any that apply to you at this time.

Generalized Anxiety (across many situations)

Specific fears/phobias (list): _____

Panic attacks

Social Anxiety

Obsessive thinking or compulsive behaviors

Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)

Sadness or Depression

Emotionally overwhelmed

Frequent crying

Loss of energy

Loss of pleasure in life

Self-injurious / Self-harm behavior

Thoughts of suicide

Problems with eating, body image, or weight

Problems falling asleep

Problems sleeping through the night (middle of the night waking or early morning waking)

Trouble waking up

Fatigue/tiredness during the day

Nightmares

Problems with attention or concentration

Racing thoughts

Problems making or keeping friends

Problems controlling temper

Relationship/Marriage problems

Problems with intimacy

Problems with job

History of abuse (emotional, physical, sexual)

Alcohol/drug use/abuse

Financial problems

Legal situation

Other:

Describe any previous mental health services you have received (evaluations and therapy). Include the provider, any diagnoses, and length of treatment.

What do you wish to accomplish (what are your goals) in seeking services at this time?

FAMILY INFORMATION:

Marital Status (circle one):

Single Living with Partner Married Separated Divorced Widowed

Rate quality of present relationship/marriage (if applicable):

___ very good ___ good ___ fair ___ poor ___ very poor

Your occupation: _____

Occupation of Spouse/Partner: _____

Children and ages: _____

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If divorced, what are the custody arrangements?

Who currently resides in your home?

GENERAL HEALTH:

Your current health: _____ excellent _____ good _____ fair _____ poor

Primary Physician's name/address/phone number:

When was your last physical exam? Any relevant findings?

Are there any other physicians you see on a regular basis?

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (surgeries, etc.).

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List any medications (and the dosages) you take regularly. Include your prescriptions, over the counter medicines, vitamins, and supplements.

Any problems with sleep? Describe.

Any problems with eating? Describe.

Please rate the overall level of stress in your life:

____ Very Low ____ Low ____ Average ____ High ____ Very High

What do you consider to be the greatest source of stress at this time?

Rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY). _____

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Are you a past or present smoker? _____

Length of time, number of cigarettes and frequency: _____

Do you use alcohol? _____

Number of drinks and frequency: _____

Do you drink caffeinated beverages? _____

Number of drinks and frequency: _____

Drug History? _____

Current Drug Use: _____

Active in Recovery or Step Program? _____

FAMILY HISTORY:

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child):

<u>Yes</u>	<u>Condition</u>	<u>Family Member(s)</u>
_____	Mental Retardation	_____
_____	Speech or Communication Disorder	_____
_____	Attention-Deficit / Hyperactivity / Impulsivity	_____
_____	Learning Problems / Disabilities	_____
_____	Autism Spectrum / Asperger's Disorder	_____
_____	Sleep disorders	_____
_____	Generalized Anxiety (across many situations)	_____
_____	Social Anxiety	_____
_____	Obsessive-Compulsive Disorder	_____
_____	Phobias	_____
_____	Depression	_____
_____	Manic-Depression / Bipolar Disorder	_____
_____	Suicide attempts / Suicide	_____
_____	Schizophrenia or other psychosis	_____
_____	Alcohol / Substance Abuse	_____
_____	Seizures or other neurological disorder	_____
_____	Eating Disorders or Disordered Eating Habits	_____
_____	Genetic Disorder (e.g., Down Syndrome, Fragile X)	_____

Family History Other:

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries?
Please list:

EDUCATIONAL HISTORY:

Your highest level of education completed: _____

Any problems with attention, learning, or behavior in school, special education placement?

Grades repeated and reason:

Additional Comments:

LEGAL HISTORY

Have you ever filed or been involved in any litigation? Please explain

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A. Problem

B. Diagnosis

C. Strengths and Weakness

D. Goals

E. Treatment Recommendation: Strategies or Interventions

- Cognitive Behavioral Therapy (CBT)
- Interpersonal Psychotherapy (IP)
- Family-Based Treatment (FBT/Maudsley Approach)
- Dialectical Behavior Therapy (DBT)
- Trauma Focused (TF-CBT)
- Solution-Focused Brief Therapy (SFBT)
- Narrative
- Structural Family Therapy

F. Treatment Recommendation: Type of Counseling & Frequency

- | | |
|---|-----------------------------|
| <input type="checkbox"/> Individual Therapy | Frequency: _____ x per week |
| <input type="checkbox"/> Family Therapy | Frequency: _____ x per week |
| <input type="checkbox"/> Couples Counseling | Frequency: _____ x per week |
| <input type="checkbox"/> Group Therapy | Frequency: _____ x per week |
| <input type="checkbox"/> Other _____ | |



NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT

Welcome to the Integrated Care Clinic. This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY:

Communication between you and your doctor/therapist is considered privileged and confidential. We will not release any information without your written release. The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes.

The only exception to these conditions may occur in situations such as child abuse, danger to life, or workers' compensation where by law other action is permitted. Please discuss this with your doctor/therapist.

OFFICE HOURS

The office staff are typically available from 9:00 a.m. to 6:00 p.m. Monday through Friday. When the office is not open, please call your therapist's number and leave a message. The first priority and our primary concern is your well-being. In an emergency, please go to the nearest hospital emergency room (ER) for help with your problem, and contact us by saying "This is an emergency!"

If your doctor/therapist is out of town or unavailable for some other reason, one of our other doctors/therapists will be on-call.

SCHEDULING APPOINTMENTS

An appointment can be scheduled by your doctor/therapist.

APPOINTMENT LENGTH:

Individual, couples, and family therapy are billed on the basis of a 50-minute hour. If an appointment runs longer, you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

The first session involves assessment and usually lasts for one to one and one-half hours. Your doctor/therapist will discuss with you any further assessment or testing that they feel is appropriate and necessary. The fees for these services will also be discussed at this time.

FEES SCHEDULE:

Payment is due at the time service is provided.

	<u>Staff Rates</u>	<u>Dr. Winton Rates</u>
Individual or Family Intake (90 Minutes)	\$250	\$310
Individual Therapy Session (50 Minutes)	\$190	\$250
Family Therapy Session (50 Minutes)	\$210	\$270
Family Meal (90 Minutes)	\$315	\$375

If an appointment runs longer, or you need to speak to your provider over the phone you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time (\$60 per 15-minutes).

MISSED APPOINTMENTS:

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from someone else in need.

Therefore, except in the case of an acute emergency or illness, we require a 24 hour notice of any cancellation; otherwise, your account will be charged for the visit. If our office is closed, leave a message on your therapist's voice mail to inform us of your cancellation so the time may be used appropriately.

PAYMENT:

Payment for professional services are due and payable at the time they are rendered. All clients are expected to take care of their fees as services are rendered. Any other arrangement is considered a special arrangement and must be discussed in advance with your therapist. Delinquent accounts may be referred to a collection agency. There is a \$25 fee per late payment. We accept cash, checks, Visa, and Mastercard, and American Express.

In all cases, collection of insurance benefits or any other arrangement regarding third party payment is the responsibility of the client (parent or guardian, if the client is a dependent child). An insurance receipt is available for your convenience in submitting your insurance claim for reimbursement. Additional copies of bills can be made for you on request.

I have read and understand these policies. I acknowledge responsibility for all fees incurred.

Date: _____

Client's Name

Signature of Responsible Party



INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to psychological services from _____
(Integrated Care Clinic Clinician)

This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that the potential benefits of receiving psychological services may include obtaining a professional opinion, reduction of psychological symptoms, and an increased understanding of psychological issues. I understand that potential risks may include possible disagreement with the professional opinions offered, possible emotional distress when addressing my child's difficulties, and limitations in the ability to make predictions based on results of psychological assessments (when applicable). I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with my services.

I understand that if my clinician is a Postdoctoral Fellow that they are not yet a licensed psychologist, and as a result are under the supervision of a licensed psychologist at Integrated Care Clinic.

I understand and agree that disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

1. where abuse or harmful neglect or children, the elderly, or a disabled or incompetent individual is known or reasonably suspected
2. where the validity of a will of a former patient is contested
3. where such information is necessary for the practitioner to defend against a malpractice action brought by the client
4. where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the practitioner
5. where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. where the client is examined pursuant to a court order.

I hold _____ harmless for releasing information under the above conditions.
(Integrated Care Clinic Clinician)

Client's Name: _____ Date of birth: _____

Client Signature: _____ Date: _____

Parent/Guardian (print name) _____

Parent/Guardian Signature: _____ Date: _____



INTEGRATED
CARE CLINIC

PERMISSION TO RELEASE AND OBTAIN INFORMATION

I do hereby authorize _____ to release and discuss the results of my
(Integrated Care Clinic Clinician)

___ All (no need to check other options)

___ Diagnosis

___ Medications

___ Phone Consultation

___ Treatment Updates & Recommendations

___ Psychological Evaluation

___ Dates of Counseling Sessions

___ Other _____

with the following individuals. I give those listed below my permission to discuss and release
information regarding myself to _____
(Integrated Care Clinic Clinician)

This release of information is valid from _____ (date) to _____ (date).
(If left blank, it will default to 365 days)

Individual	Agency	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Child's Name: _____ Date of birth: _____

Client Signature (print name) _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____



NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF HEALTH INFORMATION

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your *Protected Health Information (PHI)*, for treatment, payment, and health care operations purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
 - *Treatment* refers to when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* refers to when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our offices, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our offices, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* -If there is reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.

- *Adult and Domestic Abuse* -If we have reasonable cause to suspect you have been criminally abused, we must report this suspicion to the appropriate authorities as required by law.
- *Health Oversight Activities* -If we receive a subpoena or other lawful request from the Department of Health or the Florida Board of Psychology, we must disclose the relevant PHI pursuant to that subpoena or lawful request.
- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when a third party is evaluating you or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* - If you communicate a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious physical harm on yourself, we may disclose information in order to protect you.
- *Worker's Compensation* - We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- **Right to Request Restrictions** - You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are in therapy. On your request, we will send your bills to another address.)
- **Right to Inspect and Copy** - You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend**-, You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting** - You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- **Right to a Paper Copy** - You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you either in person or by mail.

V. Complaints

If you are concerned that one of us has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact the office at 33 6th Street South, Suite 200, St. Petersburg, FL 33701 telephone number (727) 490-8811 and if the situation cannot be resolved, you will be given further information about how to proceed with your complaint under the laws of the State of Florida.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. A person listed at the above location can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect on November 1, 2014

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in person or by mail.

I further acknowledge that I have received the first three pages of this notice and may keep them for my records.

Signature: _____ Date _____

Witness: _____ Date _____