New ________ Change ________
Diagnosis ______________________
Therapist Name ________________
Physician Name ________________

PATIENT REGISTRATION FORM

Please complete the following form prior to your first session. It will contain information that will be useful to your treatment. If you are filling this out for a child or relative, please fill in the form about the patient to the best of your knowledge.

PATIENT INFORMATION

PATIENT NAME

Street Address

City, State, Zip Code

Phone Number

Date of Birth

Cell Phone Number

Social Security Number

Check Gender:
☐ Male
☐ Female

Email Address

Patient Employer

Employer Address

Employer Phone

Name of Spouse

Check Status:
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

BILLING INFORMATION *(If same as patient, omit)*

RESPONSIBLE PARTY FOR BILL

Street Address

City, State, Zip Code

Email Address

Responsible Party's Employer

Responsible Party's Employer Address and Phone Number

Nearest Friend or Relative *(Not at same address)*

Relationship

Address and Phone Number of Above

New Tides Counseling will bill the insurance company as a courtesy to the client. The client is ultimately responsible for the payment of all services. Appointments canceled with less than 24 hours notice will be billed to the client. Insurance companies and EAPs do not pay for missed appointment charges.

FEE: Your fee will be ______ per 50–60 min. session.

PRIMARY INSURANCE

Policyholder Name

Date of Birth

Insurance Company Name

Insurance Street Address

City, State, Zip Code

Insurance ID Number

Group #

PRIMARY INSURANCE

Policyholder Name

Date of Birth

Insurance Company Name

Insurance Street Address

City, State, Zip Code

Insurance ID Number

Group #

Authorization/Assignment of Benefits: Please sign by the 'X' for release of your records to your insurance for medical information necessary to process insurance and for payment to New Tides Counseling by your insurance. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as the original copy. I understand that partial payments made by insurance carriers are not accepted as full payment for the services rendered and I will be responsible for any charges not covered by insurance. I agree to the stated fees and I understand that I am financially responsible for all charges, including interest accrued on unpaid balances. I hereby authorize said assignee, New Tides Counseling, to release all information to secure payment on my behalf.

Signature ______________________________ Date ____________________

NEW TIDES
COUNSELING
422 5th Avenue, Indialantic, Florida 32903

INITIAL INTAKE ASSESSMENT SYMPTOMS

PATIENT NAME ____________________

SYMPTOMS

1. Check areas in which you've noted difficulties or changes:

▢ sleep	▢ appetite	▢ crying
▢ concentration	▢ weight	▢ social interaction
▢ sexual activity	▢ physical pains/sickness	▢ panic
▢ unusual behavior	▢ depressive thinking	▢ frightening thoughts
▢ suicidal thoughts		

2. Have you experienced any significant life changes in the past year?

____

3. Have you previously been in therapy? ▢ Yes ▢ No

List any treatment ____________________

5. Have you ever been hospitalized? ▢ Yes ▢ No Dates and Reason ____________________

6. Do you use alcohol? ▢ Yes ▢ No Beverages consumed per week: ____________________

7. Do you use tranquilizers? (Including: valium, librium, xanax, narcotics, cocaine, marijuana, amphetamines, or other substances) ▢ Yes ▢ No

Describe ____________________

8. Do you use tobacco? ▢ Yes ▢ No How often per day: ____________________

YOUR FAMILY (as you experienced them growing up)

9. Mother's Name ____________________ Any Health Concerns? ____________________

10. Father's Name ____________________ Any Health Concerns? ____________________

11. Check any boxes that applied to your experience as a child:

▢ happy childhood	▢ neglected	▢ family moved frequently
▢ physically abused	▢ sexually abused	▢ few friends
▢ over/under weight	▢ parents divorced	▢ family fights
▢ poor grades	▢ drug or alcohol abuse	▢ depressed
▢ anxious	▢ spoiled	▢ not allowed to grow up
▢ attention problems	▢ anger problems	

12. Members of Your Current Household: (List name/relationship and any personality/health issues)

____

____

13. How many times have you been married? ________ Age of first marriage: ____________________

14. Describe any typical problems experienced in past or current marriages or co-habitation relationships:

____

INITIAL INTAKE ASSESSMENT SYMPTOMS, PART 2

HEALTH

15. Primary Care Physician's Name and Phone Number: ______________________

16. Check all that you've experienced:
    - ▢ recent surgery
    - ▢ head injury
    - ▢ seizures
    - ▢ thyroid problems
    - ▢ neurological issues
    - ▢ drug/alcohol abuse/treatment
    - ▢ chronic pain
    - ▢ headaches
    - ▢ diabetes
    - ▢ miscarriage
    - ▢ hormonal problems
    - ▢ infertility

17. List any other chronic problems: ______________________

18. How many hours of sleep in an average night? __________ Date of last physical: ______________

19. Please list current medications: ______________________
    Name/Why Prescribed Dosage
    ____
    Name/Why Prescribed Dosage
    ____
    Name/Why Prescribed Dosage

WORK/EDUCATION

20. Select all that apply:
    - ▢ currently working full/part time
    - ▢ currently searching for work
    - ▢ currently in school

21. Highest level of education so far: ______________ Favorite subject in school: ______________

22. How many hours do you typically work per week? ______________

23. In what field do you usually work? ______________________

FOR MINORS ONLY

24. How many schools have you attended? __________ Do you attend any special education classes? __________

25. Have you received any testing or counseling in school? ______________________

26. How do you get along with classmates? ______________________

27. How do you get along with teachers? ______________________

28. What chores and responsibilities do you have? ______________________

29. How many close friends do you have? Male: ______________ Female: ______________

30. Please list hobbies, clubs and sports: ______________________

31.How do you use your free time? ______________________

32. Check your living situation:
    - ☐ both parents
    - ☐ one parent
    - ☐ shared custody
    - ☐ guardian/foster

______________________________ ______________
Person filling out form, if not patient Date

New Tides Counseling

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: December 1, 2022

Your Protected Health Information, or PHI, is your individually identifiable information.

- It's about your past, present, or future health or condition.
- It's the provision of health care to you.
- It's regarding the payment for health care.

We are required to

- extend certain protections to your PHI
- give you this Notice
- explain how, when, and why we may use or disclose only the minimum necessary to accomplish the intended purpose of the use or disclosure.

We must have your written authorization for anything other than treatment, payment and operations, unless the law permits or requires us to make the use or disclosure without your authorization.

If we disclose your PHI to an outside entity, it will extend the same degree of privacy protection that we must apply to your PHI.

We may use or disclose your PHI as follows:

For treatment: We may wish to disclose your PHI to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition. We will do so only if you have signed a Release of Authorization for us to provide such information.

To obtain payment: We may disclose your PHI in order to bill and collect payment for your healthcare services. For example, we may release portions of your PHI to the Medicaid/Medicare program and/or an insurance insurer, and HMO, or PPO to get paid for services that we delivered to you.

For health care operations: We may disclose your PHI in the course of operating our operations. For example, we may use your PHI in evaluating the quality of services provided, or disclose to our accountant or attorney for audit purposes.

Appointment reminders: Unless you provide us with alternative instructions, we may call you with appointment reminders and send materials that may be of interest to you to your home.

We are required to have your written authorization for uses beyond treatment, payment and operations purposes. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action.

Exceptions NOT Requiring Your Consent or Authorization:
The law provides that we may disclose your PHI from mental health records without consent or authorization in the following circumstances:

When required by law: We may disclose PHI when a law requires that we report information about suspected abuse, neglect or violence, or relating to planned criminal activity, or in response to a court requirement.

For health oversight activities: We may disclose PHI to the agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents, and monitoring of the Medicaid program.

Relating to decedents: We may disclose PHI relating to a death to state medical examiners.

To avert threat to health and safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

see PART 2

HIPAA NOTICE OF PRIVACY PRACTICES, PART 2

You have the right to ask that we limit how we use or disclose your PHI.

We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

- **You have the right to choose how you're contacted.**
  You may ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.
- **You have the right to inspect and request a copy of your PHI.**
  Unless your access to your records is restricted for clear and documented treatment reasons, you have a right to see your protected health information upon your written request. We will respond within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have the right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- **You have the right to request an amendment of your PHI.**
  If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is: (1) correct and complete; (2) not created by us and/or not part of our records, or; (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **You have the right to find out what disclosures have been made.**
- **You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released** other than instances of disclosure: for treatment, payment, and operations; or pursuant to your written authorization. We will respond to your written request within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
- **You have the right to receive a paper copy of this Notice** and/or electronic copy by email upon request.
- **You have the right to complain about our Privacy Practices.**
  If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. We will take no retaliatory action against you if you make such a complaint.

To contact us for information, or to submit a complaint: If you have questions about this Notice or any complaints about our privacy practices, please contact New Tides Counseling, 422 5th Avenue, Indialantic, FL 32903.

→ **Patient/Client Signature** ______________________ Date ____________

Parent/Guardian Signature ______________________ Date ____________

Therapist Signature ______________________ Date ____________

NEW TIDES
COUNSELING
422 5th Avenue, Indialantic, Florida 32903

INFORMED CONSENT TO TREATMENT

1. The benefits of psychotherapy are to help alleviate your presenting problems and symptoms. As a client, you will be involved in the creation and evaluation of your treatment plan throughout the therapy process.

2. Psychotherapy is conducted in a professional and appropriate manner between a psychotherapist and patient/client talking about the presenting problem.

3. If there are any expected side effects from psychotherapy (or medication when that is a consideration), they will be discussed with you.

4. The psychotherapist will suggest alternative treatment methods and will make referrals to other psycho therapists when appropriate or necessary.

5. The possible consequences of not receiving psychotherapy may be discussed.

6. What you say to your therapist, as well as any case notes or other records are confidential and generally will not be shared with others unless you provide written consent. However, there are exceptions to this.
   • Sound ethical treatment as well as state mental health policy requires periodic review of psychotherapy performed by your therapist. The review will be done by other mental health professionals in consultation.
   • If your therapist has reason to believe you or someone else may be in danger of physical harm, state law and professional ethics require your therapist to take steps to protect you and/or other persons in volved. This may include notification of appropriate social service and legal agencies.
   Examples of such instances include:
   - Danger of suicide or other self-injurious behavior
   - Danger of causing physical harm to another
   - Occurrence of suspicion of child abuse or neglect

CLIENT RESPONSIBILITIES

1. The client will devote time and energy to therapy. The client will follow through with treatment recom mendations, which strengthens the chances of reaching the goals of treatment.
2. Refrain from physical or other types of abusive behavior to yourself, to others or to any property.
3. Be honest regarding your thoughts and feelings about your treatment.
4. Keep appointments made. Cancellations with less than 24 hour notice will be charged to your account.
5. Stay current with your bill. Full payment is expected at time of service.

EMERGENCIES

In emergencies, I will call 911 or go to my local emergency room. My therapist can be contacted during business hours and will return calls within one business day.

INFORMED CONSENT

I have read the above statements regarding my rights and responsibilities. I hereby give my consent to be assessed and treated by New Tides Counseling. I have discussed any concerns I might have about the above statements. I understand that this statement of consent is in effect for twelve months from the date below unless I wish to revoke it earlier.

Patient/Client Signature ______________________ Date __________

Parent/Guardian Signature ______________________ Date __________

Therapist Signature ______________________ Date __________

NEW TIDES
COUNSELING
422 5th Avenue, Indialantic, Florida 32903

ONLINE SESSION GUIDELINES

It's important to maintain a setting similar to being in an office together.

- Your device must be on a steady surface throughout sessions, and not hand held, if it can be avoided. Place device in a set location and don't move about.
- Make sure that you are in a private location where you cannot be overheard by others. Adjust the volume to ensure your privacy. You must inform me if there is anyone in the room with you, or who you believe may over hear the session.
- Try to have proper lighting so that I can best communicate with you. You must be fully dressed and sitting in an appropriate setting for our session.
- If the connection is broken for any reason, I will call you to remedy the situation. The clinician will resume session via phone until internet-based therapy has returned.
- Minimize distractions, especially background noise. Turn off televisions, music, or other sounds. Please close the door to the room you are in. You should NOT be playing games, on social media, or working on other things during therapy. Make sure pets, children, household members, and roommates will not be distractions from treatment.
- You may not invite others into session without discussing this with me first.
- Online mental health therapy includes the diagnosis, treatment, and education using interactive audio, video, and/or data communication. The client will need to download an application to use this platform. They need to have broadband Internet connection or a smart phone device with a good cellular connection at the loca tion deemed appropriate for services.

SOCIAL MEDIA POLICY

EMAIL

Do not email content related to your therapy sessions, since email is not completely secure or confidential. If you choose to communicate by email, be aware that all emails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will look at these logs, they are available to be read by the system administrator(s) of the Internet provider. Emails received or sent become a part of the legal record.

FRIENDING

We don't accept friend requests from current or former clients on any social networking site. Confidentiality means we cannot tell others that you are our client. It may also blur the boundaries of our therapeutic relationship.

LOCATION-BASED SERVICES

Be aware of privacy issues using GPS tracking enabled on your device. Sites may passively "check in" to our office, from which others may draw conclusions.

INTERACTING

Please do not contact us by using SMS or messaging on sites such as Twitter, Facebook, or LinkedIn. These sites are not secure. We may not read these messages in a timely fashion. Do not use wall postings, @replies, or other ways of engaging me in public online since this can compromise your confidentiality.

If you need to contact us, the best way is by phone. The second best way is by direct email for issues like changing appointment times.

BUSINESS REVIEW SITES

If you find our clinic on rated business lists (Yelp, Healthgrades, Yahoo Local, Bing), this is not a request for a testimonial, rating, or endorsement as our client. Our ethics code prohibits us from soliciting testimonials. Keep in mind that what you share on the Internet is personally revealing in a public forum. Create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

422 5th Avenue, Indialantic, Florida 32903

CREDIT CARD AUTHORIZATION AGREEMENT

Your signature authorizes New Tides Counseling to bill the credit card listed below.
Two options apply to credit card clients.

1. Your credit card will be billed monthly between the 10th and 15th. (Recommended for self-pay clients that prefer to pay the entire balance in full every month.)

2. One-time only transactions can be made on the account at anytime. These transactions will be processed within 1-4 days of completing this agreement.

After service is discontinued and the account balance(s) are paid in full, this agreement will become null and void.

Select type of Credit Card:
☐ MasterCard ☐ Visa ☐ Discover

______________________ ______________________ __________
Credit Card Number Expiration Date CVV

____
Name of Credit Card Holder

____
Address of Credit Card Holder

____
Relationship to Client

______________________ ______________________
Signature on File Today's Date

Please Check One of the Boxes Below:
- ☐ 1. I opt to pay in full each month. Transactions will be processed between the 10th-15th each month.
- ☐ 2. I opt for a one-time credit card transaction.

______________________ ______________________
One-Time Transaction Amount One-Time Transaction Date:

Additional Payment Plans: ______________________

FOR MINOR PATIENTS ONLY

422 5th Avenue, Indialantic, Florida 32903

PERMISSION TO TREAT A MINOR

I hereby grant my permission to ______________________________
THERAPIST

to provide psychotherapeutic treatment to my child/protectee.

______________________________ ______________
CLIENT NAME DATE OF BIRTH

I have been informed of this client's rights and understand that as the guardian of the child/ protectee, I have the right to be informed and involved in the development of the treatment plan recommended for this individual.

______________________________ ______________
PARENT/GUARDIAN SIGNATURE DATE

______________________________ ______________
WITNESS DATE