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Please take the time to print out and complete all of the forms in this document and bring them with your to your appointment.

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CHANGE YOUR THOUGHTS, CHANGE YOUR BEHAVIORS, CHANGE YOUR LIFE!

Introduction Packet

Welcome!
The following papers involve information necessary for you to review and questions for you to answer. Some of the information is required by law, other information is required by your insurance company, and the other information is helpful for me to assist you in your treatment planning and goals. We will review the information and you may ask questions at any time during our sessions which will last approximately 45-50 minutes. The information provided by you is voluntary; however, if you limit the information you share, the quality of service provided to you may be impacted. Thank you for your patience with this process and I look forward to meeting you personally.

CHANGE YOUR THOUGHTS, CHANGE YOUR BEHAVIORS, CHANGE YOUR LIFE!

Your Rights as a Patient

Therapist-client relationship works in part because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to become empowered to change. As my patient, you have certain rights that are important for you to know about because this is your treatment, whose goal is your well-being. There are also certain legal limitations to those rights that you should be aware of. As your therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific situations described below, you have the absolute right to the confidentiality of your treatment. I cannot and will not tell anyone else what you have told me or even that you are in treatment with me without your prior written permission. I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act to protect your privacy even if you do release in writing authorization to share information about you. You may direct me to share information with whomever you chose, and you can change your mind by revoking permission at any time. You may request anyone you wish to attend a session with you.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect unless it is an emergency and I can't reach you:

If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 72 hours.

If I believe that you are in imminent danger of harming yourself, I may legally
break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step.

If you are filing a complaint or are a plaintiff in a lawsuit where you bring up the
question of your mental health, you will have already automatically waived your right to the confidentiality of these records in the context of the complaint or lawsuit. In spite of that, I will not release information without your signed consent or court order. We can also discuss obtaining a protective order to help maintain confidentiality of records. Please let me know if you are in this kind of situation so that I can take the utmost care possible to protect your privacy in my records.

1 of 4 Initials ________.

II. Record-keeping

I will keep your records according to the provisions of the Health Care Information Act of 1992. You have the right to request that I make a copy of your file available to you or any other health care provider at your written request. I maintain your records in a secure location in my office which cannot be entered by anyone else. I will discuss any concerns you may have regarding the recording keeping completed on your treatment progress.

III. Collaboration with other clinicians/physicians

Under some circumstances you may be receiving treatment by other medical or mental health professionals. In those cases, it may be in you interested to sign a release to allow coordination of care and reduce duplication of services. If you will be receiving additional therapy by another mental health provider the respective responsibilities of each clinician will be discussed with you.

IV. Diagnosis

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the DSM-IV; I have a copy in my office and will be glad to let you borrow it and learn more about what it says about your diagnosis.

V. Other Rights

You have the right to ask questions about anything that happens during your treatment. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave treatment at any time, however it is not recommended to do so without consultation.

VI. Managed Mental Health Care

If a managed care firm pays me for services in full or in part, there are usually further limitations to your rights as a patient imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete treatment with me, etc. Such firms also require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment, and assist you in advocating with the manage care company as needed.

2 of 4 Initials ________.

VII. Availability

Each psychotherapy "hour' usually lasts approximately 50 minutes. We will schedule our sessions cooperatively for mutual convenience. Outside of session, if necessary, you can reach me at my office number 954-437-7072. At times my practice will be covered by another clinician, please follow his/her recommendations until I am available. There may be times when I have to return your call from a location other than my office, therefore, if you are requesting I return your call, you must disengage your caller ID block in order to receive my return call. Also note that if you are calling from a cellular phone, I will request your location/address at the time of the crisis call in order to assist with the possibility of getting emergency personnel to you. If at any time my telephone system fails please call Memorial Regional Hospital Psychiatric Emergency Room at 954-986-6310 or First Call For Help at 211 and they will give you further instructions. If you are in an emergency/crisis situation call 911.

Your Responsibilities as a Patient

You are responsible for coming to the appointments on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling or cancel with less that twenty-four hours' notice, you must pay for that session at our next regularly scheduled meeting. The answering machine has a time and date stamp that will keep track of time of cancellation. I cannot bill these sessions to your insurance. The only exception to this rule is if you would endanger yourself by attempting to come (for instance, driving under adverse weather conditions) or when you are facing a real emergency and are not able to call the office.

You are responsible for paying for your session at the time of services unless we have made other arrangements in advance. If we decide to meet for a longer session, I will bill you prorated on the hourly fee. Emergency phone calls are normally free. However, if we regularly spend more than 10 minutes weekly on the phone, of if you leave regular long phone messages, I will bill you on a prorated basis for the time talking on the phone and listening to long messages. If you require a report or formal summary of treatment at times there will be a minimal charge to cover for the clerical expenses and time associated with the preparation.

If you have insurance that I am a provider, you are responsible for providing me with the information I need to send in your bill. You must pay me your deductible if it applies and any co-payment. You must arrange for any pre-authorizations if necessary. I will bill your insurance company directly for service fees other than your co- payment You must provide me with any forms, completely filled out as needed, your complete insurance identification information, and the complete address of the insurance company. If a check is mailed to you, you are responsible for paying me that amount at the time of our next appointment.

If you find that you are having a hard time paying for treatment, please discuss it with me. I have a percentage of slots in my practice reserved for lower-fee patients, and if one of those is open, I would make it available. If your financial circumstances improve, please let me know so that I could make the low-fee slot available to someone else. If you eventually refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency.

Complaints
If you are unhappy with your treatment, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my actions to the State of Florida Department of Professional Regulations.

Patient Informed Consent
I have read all four pages of this statement. I have had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and I understand it. I hereby
voluntarily agree to enter into treatment with Suzanne Leitner, LCSW.

Print Name: ____

Signed Patient:____

Guardian or Responsible family member:__________________________________

Witness:______________________________ Date: __________________________

Clinician: Suzanne Leitner, LCSW

PATIENT INFORMATION

Date:____________________

Name: ____
Last Name First Name Middle

Social Security # :__________________________

Date of Birth:________________________ Age:______________________

Address: ____

City: _________________________________ State:______________ Zip:___________

Home Phone:_________________________________ Work Phone:___________________________________

Cellular:______________________________________ Email:_______________________________________

As a function of office procedures we may call and confirm you appointments as a courtesy reminder to you. We may also return calls to the above numbers unless you explicitly instruct us to do otherwise. Messages left on machines will be brief and general. We may also use your email address for those purposes unless you indicate N/A (not applicable) in the email request line.

Employed by:_________________________________ Occupation:_____________________________________

Whom may we thank for referring you:____

In the case of an emergency, who should be notified?______________________________

Relationship:_______________________ Telephone: _____________________________

Assignment and release:

_____ I, the undersigned certify that I (or my dependent) have insurance coverage with __________________________
Name of insurance company
and assign to Suzanne Leitner insurance benefits,I understand that I am responsible for all charges whether or not they are paid by the insurance company. I hereby authorize S.L. Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____I, do not have insurance coverage and agree to be responsible for the fees related with my services.

________________________________ ________________________________
Responsible Party Signature Print Name

ADULT INTAKE

Last name: ________________________ First:________________________Middle:________

D.O.B.:____________ Age:_________ Sex:___________

PRESENTING PROBLEM

Please describe the problem that brought you to this office:

____

____

____

Describe current feelings about problem:____

____

____

What steps have you taken to correct the problem? ____________________________________

____

____

Please give any other information that might be relevant:_____________________________

____

____

____

FAMILY HISTORY

Please list the significant people in your life (parents, siblings, and others), their relationship to you, and their age or date of birth.
Circle if applies. SA= substance abuse MI= mental illness VS= violence to self VO= violence to others.

NAME	RELATIONSHIP	AGE		Leave Blank
____________	______________	_______	SA MI VS VO	__________
____________	______________	_______	SA MI VS VO	__________
____________	______________	_______	SA MI VS VO	__________
____________	______________	_______	SA MI VS VO	__________
____________	______________	_______	SA MI VS VO	__________
____________	______________	_______	SA MI VS VO	__________

Patient Name:____

With whom do you currently reside?__________________________________

What is your family's attitude regarding your problem?________________________

Please give the names of family members, including yourself who are currently, or in the past, have been under the care of a mental health professional/ substance abuse treatment program:

Name Problem Who Seen & When

____
____
____
____

Do you have a history of self injurious behavior? Yes No ________________
Do you have a history of suicide attempts? Yes No ________________
Do you have a history of assaultive behavior? Yes No ________________
Do you have a history of fire setting? Yes No ________________
Do you have a history of animal cruelty? Yes No ________________
Have you ever been involved in an abusive relationship? Yes No ________________

Describe benefits you obtained through previous treatment: ____________________________________
____

PERSONAL HISTORY
Place of birth:____
Please list previous places in which you lived: ____________________________________
____

Marital Status: ______________ Number of times married:________________
List children and locations:______________________________________
____
Please describe your feelings regarding your current marital status:________________________________
____
____

Please describe your educational history: (highest grade completed, certificates, trainings) __________________
____
____

Military History: NO YES War Veteran:________Discharge type:____________________
Occupation:__________________Employer:____
Please list the types of jobs you have had: ____
____

Patient Name:___________________________

Please list religious affiliations you have or have had in the past: ____
____

List any cultural beliefs that may interfere with your treatment:________________________________

Height: ___________ Weight: ___________________ Last Physical Exam:____________________

Primary Care Physician:___________________________ Phone Number:__________________________

Current Psychiatrist:_______________________________ Phone Number:__________________________

Current Health Problems: Treating Physician:

____
____
____

ALLERGIES:____

Current Medications: ____
Are you compliant with your Prescribed Medications? YES NO ______________________
Previous Health Problems(Past illnesses and surgeries): ____
____
____
____

Hospitalizations: (Medical and Psychiatric) ____
____
____

SUBSTANCE USE INFORMATION

Do you drink Caffeine?______ Cups per day:____
Do you smoke? ___________ How much? ____

How much alcohol do you consume a week? ____
Use of other drugs: YES NO: If yes, what drugs______________________________________
Date of Last Use (Alcohol or drugs):____

PEER INTERACTION AND SELF PERCEPTION

In the past few years have you had difficulty getting along with others?______________________
What feedback do you get about yourself from others?______________________
How do you handle your anger? ______________________
Has your anger ever gotten you in trouble? If so, how?______________________
What are your strengths?______________________
Weaknesses?______________________
What do you do for fun?______________________

Patient Name:______________________________

PROBLEM AREAS

Study Habits	Making Decisions	Suicidal Thoughts	Chronic Pain	Repeating Thoughts
Nervousness	Depression	Marital Problems	Acute Pain	Racing Thoughts
Shyness	Sexual Problems	Alcohol Use	Nightmares	Self Mutilation
Fears	Finances	Self Control	Habits	Legal Problems
Friends	Anger	Panic	Relationships	History of Abuse
Sleep	Stress	Tiredness	Concentration	Distressing Thoughts
Relaxation	Occupational	Weight	Appetite	Hearing Voices
Memory	Ambition	Loneliness	Energy	Paranoia
Inferiority	Career Choice	Appearance/Health	Drug Use	Resentment
Separation	Love/Affection	Family	Unhappiness	Revengeful Thoughts
Parenting	Stomach Trouble	Bowel Trouble	Eating Habits	Elevated Mood
Motivation	Gambling	Seeing things	Mood Swings	Impulsive
Submissive	Headaches	Muscle Tension	Shopping	Isolation

COPING LEVEL:
On a scale from 1-10 with 10 being the best what is your current level of coping?______________________________
What is your highest level of coping in the last year?____

List goals for self improvement:

1.__________________________________
2.__________________________________
3.__________________________________
4.__________________________________

I hereby request that Suzanne M. Leitner, L.C.S.W. provide services for me and/or my family.

Signature __________________________________ Date _____/_____/_____

For the purpose of coordination of care between treatment providers, your insurance company may request that we contact your Primary Care Physician. You have the right to refuse this request and/or change your mind at any time, however, this may create limitations to the quality of the care provided to you. Please indicate your preference by initialing on the line that represents your choice. If at any time in the future you change your mind and wish to revoke your permission, you must communicate your desire directly to Suzanne Leitner verbally or in writing.

_______ YES, you may contact my Primary Care Physician. Provide the necessary information.

______________________________ ______________________ ___________________________

Doctor's Name Telephone Number Fax Number

_______NO, Do not contact my Primary Care Physician.

NATIONAL ASSOCIATION OF SOCIAL WORKERS DOCUMENT D2
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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 about you that may identify you and that 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 and the NASW Code of Ethics. 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 and 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, 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. We may contact you to provide appointment reminders, no shows, or information about treatment alternatives or other health-related benefits. We will use all numbers you have provided us unless you request in writing to revoke any telephone number to be used to contact you.

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.

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 the 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 PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Offi cer at S.L. Therapy, 2250 N.W. 136 Avenue, Suite 104, Pembroke Pines, FL, 33028 (954) 437-7072

• 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.

• 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.

• 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 our Privacy Officer at S.L Therapy, 2250 N.W. 136 Avenue, Suite 104, Pembroke Pines, FL, 33028 (954) 437-7072 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 fi ling a complaint.

The effective date of this Notice is April 14, 2003.

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