Mireya Martin LMFT
12901 N. 56th Street
Tampa, Florida 33617

Consent to Treatment

I_____ give my permission and consent to Mireya Martin, Licensed Marriage and Family Therapist, to provide psychotherapy to me and/or _____, who is my spouse/ child/children/other (specify)_____.

While I expect benefits from this treatment, I fully understand that because of factors beyond our control such benefits and particular outcomes cannot be guaranteed. I understand that because of the counseling or Psychotherapy I/he/she/they may experience emotional strains, feel worse during treatment, and/or may make life changes which could be distressing.

I understand that Mireya Martin, LMFT cannot provide emergency services at any time, and I have been informed of whom to call in an emergency during business hours, evening hours, and on weekends. I understand the psychotherapist is a consultant and a professional resource only. Her interventions may be freely accepted or rejected by the client. Therefore, decisions made by the client during and after counseling are the responsibility of the client. I understand that regular attendance will produce the maximum benefits but I have been also informed that as the client I am/he is/she is/we are/they are free to discontinue treatment at any time.

I understand that conversations with the psychotherapist will be confidential **except** as allowed by Privacy Policy (HIPPA). I understand **there are limits to confidentiality** based on payment methods, wireless and electronic communication that I elect to utilize. I further understand that Florida law requires any psychotherapist who has reasonable cause to **suspect child or elder abuse, neglect, abandonment or exploitation to report such knowledge to the appropriate authorities**. I also understand that Florida law allows the **confidentiality** between the psychotherapist and client to be **waived** when there is a **clear and immediate probability of physical harm to the client, to other individuals, or to society. The psychotherapist is mandated to communicate the information only to the potential victim(s), appropriate family members, law enforcement or other appropriate authorities.**

I understand that I am financially responsible for this treatment and for all the fees. I also understand that I need to pay at the time of services and any arrangement for payments by third parties or delay payments will be approach and decide upon before the counseling session. I understand that I can request receipts for services and that I will receive them after the end of the month.

I understand that if I need documents to be produced by this office I will pay the same rate as I pay per session and the total amount I will pay depends on how make sessions it takes the psychotherapist to prepare and process such documentation. Additionally, I understand that if I interrupt services, and wish to come back to therapy I have to have at least 4 sessions before the psychotherapist can produce any documents.

I understand that this psychotherapist will not participate in court proceedings or produce documents destined to be used in court proceedings.

I understand that during each session the psychotherapist's time is exclusively mine for the duration or the scheduled appointment. Appointments are **50 minutes** in length unless otherwise arranged.

Cancellation of Appointments

To avoid paying for cancelled appointments, the undersigned agrees to call the psychotherapist at least 24 hours before the date of the appointment. If the appointment is canceled less than 24 in advance, the undersigned agreed to reschedule and keep the next appointment within the next five business days. If these terms are upheld by the undersigned, the psychotherapist agrees to waive the fee for the late cancellation, if they are not the undersigned agrees to pay for the late cancelation.

Missed Appointments

The undersigned agrees to pay in full any missed appointments (no shows) where there was no communication with the therapist ahead of time. I know of no reasons I/he/she/we/they should not undertake this therapy and I/he/she/we/they agree with the all of the term of this consent and agree to participate fully and voluntarily.

I have _____ received the Notice of Privacy Practices and I agree to read it and discuss any questions I may have with my psychotherapist. I understand and agree that this consent form will remain valid subsequent to my reading the Notice of Privacy Practices unless I advise otherwise.

Signature: _____ Date: _____
(Of client or person authorized to consent for client)

Mireya Martin, LMFT
12901 N. 56th Street
Temple Terrace FL 33617
813-361-8137
mmft55@yahoo.com

Client Information

Today date: _____

Client's Name: _____Age:_____

Client's Name: _____Age:_____

Address: _____ City _____State___ Zip_____

Phone Numbers to Contact/Leave Messages
_____ (Home / Work / Cell) client name: _____

_____ (Home / Work / Cell) client name: _____

_____ (Home / Work / Cell) client name: _____

_____ (Home / Work / Cell) client name: _____

Email Address: _____

Email Address:_____

Is there any person or persons with whom I may leave message for you? (Optional)

Name Number Relationship

_____

_____

_____

Referred by: _____

PSYCHOSOCIAL QUESTIONNAIRE

Client_____ D.O.B._____

In a few words, please explain why you have come to therapy:

_____

_____

_____

How have you tried to solve this problem?

_____

_____

_____

In a few words, please describe your talents, abilities and interests:

_____

_____

Areas of Personal Concern

Please Rate Only the Items You Are Currently Concerned About by Placing a Number in the Box Beside the Concern
1=Mildly Upsetting **2**=Moderately Severe **3**=Very Severe **4**=Extremely Severe **5**=Totally Incapacitating

Stress		Hopelessness		Physical Abuse (Past or Present)	
Anxiety		Suicidal Thoughts		Sexual Abuse (Past or Present)	
Mood Swings		Desire to Hurt Others		Emotional Abuse (Past or Present)	
Guilt		Marital Problems		Alcohol Use	
Fearfulness		Family Problems		Drug Use	
Forgetfulness		Financial Problems		Eating Disorders	
Grief		Work Problems		Self-Image/Acceptance	
Anger/Temper		Legal Problems		School Problems	

Medical or Physical Concerns

Please Rate Only the Items You Are Currently Concerned About by Placing a Number in the Box Beside the Concern **1**= Mildly Upsetting **2**= Moderately Severe **3**=Very Severe **4**= Extremely Severe **5**= Totally Incapacitating

Headaches		Muscle Tension		Mental Illness	
Sleeplessness		Nausea		Gynecological Problems	
Too Much Sleep		Constipation		Recent Weight Gain	
Breathing Difficulty		Diarrhea		Recent Weight Loss	
Chest Pain		Vomiting		ADHD	
Blurred Vision		Chronic Pain		Nightmares/sleepwalking	
Fatigue		Dizziness		Chronic illness	
Unable to Relax		Feeling Panicky		Difficulty Concentrating	

Allergies (Specify) :

How would you describe your eating habits?

How would you describe your exercising habits?

Hospitalizations

Year	Hospital	Reason for hospitalization

Primary care physician: _____ Date of last physical examination:_____

Name of past/present psychiatrists or therapists:

Are you currently being treated for any physical or mental illness:_____ If yes, explain:

Substance Use History

Substance	**When used (Past, Present)**	**How much and how often**
Caffeine		
Tobacco		
Alcohol		
Marijuana		
Pain Killers		
Inhalants		
Cocaine		
Heroine		
Ecstasy		
Ice/Crystal Meth		
Other:		

Please list all medications/herbs/vitamins you are currently taking:

Do you regularly use laxatives or diuretics? _____ Explain:

Personal and Family History

Mark all that apply to you or family member (indicate which family member):

	Self	Family member		Self	Family member
Alcoholism			Anxiety Disorder		
Heart Disease			Depression		
Arthritis			Manic Depression		
Asthma			Schizophrenia		
Diabetes			Hyperactivity		
Cancer			Gambling Addiction		
Seizures			Chemical Addiction		
High Blood Pressure			Sexual Addiction		
Hyper/Hypo Thyroid			Sexual Dysfunction		
Cancer					

Current Family Children

(If a step-child, note with an *)

name	age	sex

Marital Status /Significant Relationships:

Single(never married)		Married		Widowed		Separated		Divorced	
Name of Spouse:									
Date of Marriage		Your Age (at time of marriage)		Spouse Age (at time of marriage)					

Describe your relationship:

Family of Origin

Father's Name					date of birth:	
Living:	yes		no		age:	
Education:					occupation:	
Describe his personality:						
How did he show love?						
Describe your relationship:						

Mother's Name					date of birth:	
Living:	yes		no		age:	
Education:					occupation:	
Describe her personality:						
How did she show love?						
Describe your relationship:						

Describe your parents' relationship:

Are they divorced?	yes		no		date:	

If your parents are divorced answer the following (if applicable)

Step-father's Name					date of birth:	
Living:	yes		no		age:	
Education:					occupation:	
Describe his personality:						
How did he show love?						
Describe your relationship:						
Describe their marriage:						

Step-mother's Name					date of birth:	
Living:	yes		no		age:	
Education:					occupation:	
Describe her personality:						
How did she show love?						
Describe your relationship:						
Describe their marriage:						

Brothers and Sisters

Name							
	living:	yes:		no:		age:	
	living:	yes:		no:		age:	
	living:	yes:		no:		age:	
	living:	yes:		no:		age:	
	living:	yes:		no:		age:	
	living:	yes:		no:		age:	
	living:	yes:		no:		age:	
	living:	yes:		no:		age:	
	living:	yes:		no:		age:	

Was favoritism shown to you or specific siblings? _____ Explain:

How was discipline handled?

Support System What are the significant relationships in your life? Who do you look to for support?

name	relationship

Professional History

Level of education completed:	
List any degrees or certifications:	
Occupation:	
Do you have any future career ambitions?	

Describe Your Relationship with God, both in the Past and Present (Optional)

Please Describe What You Would Like to Gain from Counseling:

Is There Anything Else You Feel Your Counselor Should Know? If So, Please Describe Here :

Notice of Privacy Practices
As Required by Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A CLIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION.
PLEASE REVIEW IT CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of this notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use (within the practice) and disclose (outside the practice) your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Client. Our practice may disclose PHI to the client who is the subject of the information. Our practice may obtain informal permission from the client for notification and other purposes. Our practice may contact the client to provide appointment reminders.
2. Treatment. Our practice may use your PHI to treat you. For example, we may disclose your PHI to physicians, psychiatrists, psychologist, and other licensed health care providers who provide you with health care services or are otherwise involved in your care.
3. Payment. Our practice may use your PHI to obtain and secure payment or reimbursement for services rendered. However, for the purpose of payment, we will not release your medical records or conditions without prior written authorization. For example, we may send billing statements to the address that you have given us or secure payment from a third party payor that you have verbally authorized, but we will not be able to submit claims with medical conditions to insurance companies without a separate prior written authorization.

4. Health Care Operations. Our practice may use and disclose your PHI to operate our business. For example, we may use and disclose your information for our operations; to evaluate the quality of the

care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

C. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we are permitted to use or disclose your PHI.

1. Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

2. Public Health Activities. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

3. Victims of Abuse, Neglect or Domestic Violence. Any person in our practice who knows or has reasonable cause to suspect child abuse, abandonment or neglect by a parent, legal guardian or other person responsible for the child's welfare is required by law to report such knowledge or suspicion to the appropriate authorities. The law also requires any person in our practice who knows or has reasonable cause to suspect the abuse, neglect or exploitation of vulnerable adults to report immediately such knowledge to the appropriate authorities.

4. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

5. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

6. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a victim or suspected victim of a crime, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify or locate a suspect, material witness, fugitive or missing person
- In an emergency or to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

7. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

8. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization is justified.

9. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to the extent necessary to warn any potential victim or communicate the threat to the appropriate law enforcement agency.

10. National Security and Military. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety, or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communication. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to t specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment and health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including

psychotherapy notes. You must submit your request in writing in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review or our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, you request must be made in writing. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures, you must submit your request in writing. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the U.S. Department of Health and Human Service's Office of Civil Rights (OCR). All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care.

Effective Date: April 24, 2006