



INFORMED CONSENT FOR COUNSELING AND/OR PSYCHOTHERAPY SERVICES

Last Name	First	Middle	Social Security No.
Name you prefer to be called: _____ Date of Birth (MM/DD/YYYY): _____ Age: _____			
Local Address		City	State Zip Code
Is it okay to write you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Phone: _____ - _____ - _____		Secondary Phone: _____ - _____ - _____	
<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other: _____		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other: _____	
Is it okay to call you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is it okay to call you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is it okay to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is it okay to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email: _____		Is it okay to e-mail you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who referred you to my office? _____		Is it okay to thank this person for referring you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In case of emergency, please contact:			
Name	Relationship		Phone Number
Address		City	State Zip Code

**CLIENT'S RIGHTS AND RESPONSABILITIES, PROFESSIONAL FEES,
 AND CONSENT FOR TREATMENT**
for the Office of Luis G. C. Ortega, LMHC

IMPORTANT: *Please read carefully and initial or sign where indicated*

CLIENT'S RIGHTS

As a client, you have the right to receive available services individualized to your specific needs and provided in the least restrictive manner. You have the right to seek information about and to approve of therapeutic practices. You also have the right, at any time and for any reason, to decide you do not wish to continue counseling.

With limited exceptions, information discussed and recorded is confidential. You will be asked to provide written consent if information is to be released to third parties. The exceptions to this written consent and strict maintenance of confidentiality include: 1) information that is shared on a need to know basis during clinical supervision of the therapist's work; 2) imminent physical danger to self or others; 3) child abuse; 4) information legitimately ordered by a court of law; and 5) information required by your insurance company in order to process a claim made by you.

PLEASE INITIAL: _____

It is important for you to know that engaging in psychotherapy has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

PLEASE INITIAL: _____

I am away from the office several times in the year for extended vacations. I will tell you well in advance of any absences. I am available for brief between-session phone calls during normal business hours (9am-5pm, weekdays). If you are experiencing an emergency when I am out of town, or outside of my regular office hours (after 5 pm weekdays or over the weekend), you can call Lifeline of Central Florida at 407-425-2624. In emergency situations you can also go to your local emergency room and ask for the Psychologist or Psychiatrist on call or you can call 911. If you call my office number when I am out of town, outside of my regular office hours, or over the weekend, I cannot guarantee I will be able to get back to you until I return to work, the next business day (on weekdays) or until the start of the next work week (weekends and after vacations).

PLEASE INITIAL: _____

APPOINTMENTS AND CANCELLATIONS

Appointments can be scheduled as my time becomes available. Sessions last for 45 minutes unless we agree otherwise. 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 than 48 hours notice, you must pay for that session in full.** My voicemail records the time and date of message which will keep track of the time of cancellation. **Insurance will not reimburse late cancellations or missed sessions, thus you must pay for my full fee. The information you provide in the Pre-Authorized Payment Form as part of this Informed Consent may be used to collect any fees related to missed sessions or late cancellations.**

PLEASE INITIAL: _____

PROFESSIONAL FEES AND INSURANCE

Responsible Part

You are responsible for the fees that you incur with Luis G. C. Ortega, LMHC, and NOT your insurance company or other third party. Thus, if your insurance company fails to pay in whole or in part for whatever reason within the time limits described below, you must pay any remaining balance. You are also always responsible for any co-payment and deductible. Parents/guardians are responsible for payment of a minor. If you fail to pay on your account, we have a right to turn your account over to a collection agency or attorney for collection. **If this account is assigned to an outside collection agency, an additional fee of 20% of the total amount owed will be added.**

PLEASE INITIAL: _____

Payment Due and Insurance

Payment is due in full at the time of service. Payments may be made in cash, check, or credit card. **There is a \$35.00 charge for checks returned for insufficient funds.**

My fee for the first session is \$150.00. My fee for ongoing sessions (standard duration 45-50 minutes) is \$120.00 for individuals and \$150 for couples/families. If we decide to meet for a longer session, you will be billed prorated, rounded to the next half hour, and in accordance to the appropriate session fee (Example: \$60 for 25 minutes of individual counseling). Emergency phone calls of less than 10 minutes are normally free. However, if we spend more than 10 minutes in a week on the phone, if you leave more than 10 minutes worth of phone messages in a week, I will bill you on a prorated basis (rounded to the next 30 minutes) for that time.

As a courtesy, we may accept your insurance and file your insurance claim if you discuss this with your therapist and get approval. **HOWEVER, if your insurance company fails to pay for any reason any portion of the claim within 60 days after we send the claim, you must pay any remaining balance.** Insurance companies will not accept a claim for services without a mental health diagnosis. Like any medical diagnosis, your mental health diagnosis and treatment will become a permanent part of your medical records. If you have concerns about your confidentiality or how this might affect you, please consult with your therapist.

PLEASE INITIAL: _____

CONSENT FOR TREATMENT

I have read the above statement of "RIGHTS AND RESPONSIBILITIES AND PROFESSIONAL FEES" for the Office of Luis G. C. Ortega, LMHC. I understand its contents and conditions, give my consent to such, and agree to be bound by them. I, the undersigned, have voluntarily sought and agree to participate in counseling and/or psychotherapy services. Please indicate your understanding and acknowledgement of the foregoing information by signing below:

CLIENT/PARENT NAME

SIGNATURE

TODAY'S DATE

WITNESS

Consent for Treatment when Client is an Unemancipated Minor

I hereby certify that I am the parent/guardian of the below named client, who is under 18 years of age, and consent to the terms of this 'Informed Consent' form for the client. (Note: If parent are divorced, the form must be signed by custodial parent or, in the case of joint custody, by one parent. Custodial parents and legal guardians must provide photocopies of legal letters of guardianship or custody order as the case may be.)

Client's Name: _____ Date of Birth: _____ (mm/dd/yy)

Parent/Guardian's Name: _____ Relationship with Minor: _____

PARENT/GUARDIAN SIGNATURE

TODAY'S DATE

Please, provide the following information **ONLY IF you will be using your health insurance to cover your counseling and/or psychotherapy expenses**. Remember to provide the counselor with your insurance card for verification.

INSURANCE INFORMATION

Insurance Company: _____

Insurance Company Address (for Claims Processing):

_____ Street

_____ City State Zip

Phone No.: _____

Client's Insurance ID #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's Insurance ID #: _____

Policy Holder's Address on File with Insurance Company:

_____ Street City, State, Zip

Client's Name: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any information on my medical file to my insurance for the purpose of validating and determining benefits payable.

CLIENT'S SIGNATURE

TODAY'S DATE

Luis G. C. Ortega, LMHC, NCC
Licensed Mental Health Counselor
2170 W. State Road 434, Suite 214 • Longwood, FL 32779 • 407-252-6109

PRE-AUTHORIZED PAYMENT FORM

As part of my **CLIENT-THERAPIST PROFESSIONAL AGREEMENT (Informed Consent)** with Luis G. C. Ortega, LMHC, I authorize the practice of Luis G. C. Ortega, LMHC to keep my signature on file and charge my credit card account for:

- Charges for missed appointments, including: (1) those not canceled within 48 hours and (2) no-shows..... Client's initials: _____
- Charges for all appointments attended (fees for services rendered) Client's initials: _____
- Denied insurance claims due to: (1) lapse or changes in the client's health insurance policy coverage, (2) application of the claim to the client's insurance policy deductible, or (3) the denial of payment for a valid claim for services rendered..... Client's initials: _____

I understand all language in this agreement, and agree to these policies. I understand that I may revoke this agreement at any time by providing a request in writing.

Client Name: _____

Cardholder's Name: _____
As it appears on the card.

Cardholder's Billing Address:

Street City State Zip

Credit Card: Visa MasterCard American Express Discover

Account Number: _____

Expiration Date: _____

Signature: _____

Today's Date: _____

Luis G. C. Ortega, LMHC agrees to charge only for reasons stated above at agreed upon rates and as disclosed in your Informed Consent for Counseling/Psychotherapy Services.



Luis G. C. Ortega, LMHC
Licensed Mental Health Counselor

Counseling Services
2170 W. S.R. 434, Suite 214 • Longwood, FL 32779

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name: _____ Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Luis G. C. Ortega's "Notice of Privacy Practices." I understand that if I have any questions regarding the "Notice" or my privacy rights, I can contact Luis G. C. Ortega, LMHC at 407-252-6109.

Signature of Client

Date

Signature of Parent, Guardian or Personal Representative*

Date

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

_____ Client Refuses to Acknowledge Receipt:

Counselor's Signature

Date

CONFIDENTIAL CLIENT INFORMATION QUESTIONNAIRE

Client's Name: _____ Age: _____ Date of Birth: _____

Gender: Male Female Transgender

SOCIOCULTURAL BACKGROUND:

Racial/Ethnic Background:

- White/Caucasian African-American Black African Asian-American Asian or Pacific Islander Hispanic-American
 Latino/Latin American/Hispanic Arab/Middle Eastern-American Arab/Middle Eastern Native American/Alaskan Native
 Multiracial / Other Specify: _____

How much do you identify with your ethnic heritage?

- Not at all A little Somewhat Moderately Strongly

Do you identify yourself in other ways that are meaningful to you (e.g., cultural background, sexual orientation, class status, physical ability)? Please list: _____

Religious preference: _____ **Are you currently active in your religion?** Yes Somewhat No

Would you like to incorporate your religious/spiritual values and/or rituals into the counseling process? Yes No I Don't Know

ACADEMIC/ WORK BACKGROUND:

Place of employment: _____ **Hours worked per week:** _____

Position: _____ **Are you satisfied with your job?** Yes No I Don't Know

Highest Educational Degree: _____ **Major:** _____

Are you a student? Yes No **If yes, where are you studying:** _____ **Year/Class:** _____

RELATIONAL/ SUPPORT HISTORY:

Please indicate your current relationship status:

- Single In a Committed Relationship Living with Partner Married Separated
 Divorced Widowed Other: _____

Approximately how many significant romantic relationships have you had? _____

If you are in a romantic relationship, how long have you been in this relationship? _____ (e.g., 2 years)

Are you satisfied with your current romantic relationship? Yes No I Don't Know

Do you feel supported by your partner/spouse? ? Yes No I Don't Know

How would you rate the quality of your friendships?

- Very Poor Unsatisfactory About Average Good Excellent

Besides family members, how many people can you count on right now for friendship or emotional support? _____

FAMILY BACKGROUND:

Please list the members of your family currently living with you, their genders, their occupations, and their ages (e.g. father, M, Lawyer, 42; sister, F, teacher 29; son, M, student,12; partner, M, doctor, 35):

Family Member	Occupation	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Including yourself, please list any family members whom you believe had/have a serious emotional, mental, alcohol or drug abuse problem (e.g., mother's sister – depression – 1999):

Family Member	Emotional, mental, alcohol or drug abuse problem	When
_____	_____	_____
_____	_____	_____
_____	_____	_____

Your Family's Religious/Spiritual Background: _____

How much conflict do you currently experience with your family?

- Very little or none Some Moderate Strong Extreme

Who in your family do you currently feel closest to? _____

Most distant from? _____ In most conflict with? _____

PHYSICAL HEALTH:

How is your physical health at present? Poor Unsatisfactory Satisfactory Good Very good

When was your last physical examination? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

Do you have a disability ? No Yes Specify _____

Are you presently taking any prescribed medication ? Yes No

Please indicate all medications: _____

Name of your physician (Prescriber): _____

Are you having any problems with your sleep habits? No Yes

Are you having any difficulty with appetite or eating habits? No Yes

Do you have any problems or worries about sexual functioning? No Yes

How many times per week do you exercise? _____ For how long each time? _____

MENTAL HEALTH HISTORY:

Have you ever been a victim of:

- Emotional abuse as a child Physical abuse as a child Sexual molestation/abuse as a child
 Emotional abuse by a partner/spouse Physical abuse/assault by a partner/spouse Sexual abuse/assault as an adult
 Other Trauma Specify: _____

Have you received counseling here or elsewhere before? Yes No

If yes, where: _____ **When:** _____ **Duration:** _____

What was the focus of previous counseling? _____

Are you currently seeing a psychiatrist or have you seen a psychiatrist in that past? Yes No

If yes, where: _____ **When:** _____ **Duration:** _____

What was the focus of the psychiatric treatment? _____

Were you prescribed psychiatric medications? Yes No

What medications? _____

How often are you having suicidal thoughts presently? Frequently Sometimes Rarely Never

How often have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never

When: _____

How often are you having thoughts of harming others presently? Frequently Sometimes Rarely Never

How often have you had thoughts of harming others in the past? Frequently Sometimes Rarely Never

When: _____

Have you ever intentionally inflicted any harm upon yourself? Yes No Unsure

When: _____

Have you ever attempted suicide? Yes No **Date(s)** _____

Have you ever been hospitalized for psychological reasons? Yes No **Date(s)** _____

Reason: _____

ALCOHOL AND OTHER DRUG USE:

How often do you drink alcohol?

- Daily 3 or more times per week 1-2 times per week Weekly Monthly Less than monthly Never

In a typical week, on how many days do you have 4 or more drinks? _____

How often do you use other drugs (marijuana, cocaine, ecstasy, oxycotin, etc)?

- Daily 3 or more times per week 1-2 times per week Weekly Monthly Less than monthly Never

Do you or does someone else think that you may need to cut down or stop using other drugs? Yes No Maybe
