Julie A. Teeling, MA, LMHC, NCC
813.416.8094

Name: _____

Age: _____ Date of Birth: _____

Marital status: _____ Number of children: _____

Spouses Name: _____ Occupation: _____

Address: _____

_____

Email Address: _____

Phone:
Home _____ Work _____

Cell _____ Best place to leave a message_____

Employer: _____

Referral source (please circle or specify) Internet site _____
Friend _____

*In case of emergency contact _____
*Client signature below consents that the above named person can be contacted in case of an emergency.

Emergency contact phone: _____ Relationship: _____

Reason for engaging in treatment at this time (this can be brief) _____

_____

_____

Client signature: _____ Date: _____

Julie A. Teeling, MA, LMHC, NCC

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Information on Services

I am a Licensed Mental Health Counselor and Nationally Certified Counselor I received my Masters in Counseling from the University of South Florida. I have worked with a broad range of difficulties including depression, anxiety, trauma, relationships, and occupational problems. I have extensive training in relationships and trauma.

Theoretical Orientation
I work primarily with Cognitive Behavioral Theory although I blend many other theories for an individualized approach with the use of homework in therapy. I am a firm believer that what you do outside the session is just as important as what transpires in the time we are together.

Confidentiality
All services are confidential unless under extenuating circumstances including risk of harm to yourself or someone else. For me to speak to someone or provide information to other sources, I need a written release from you. This release can be revoked anytime.

Emergencies
I am not equipped for after hour emergencies. In the event of an emergency and you are unable to get in touch with me, please call the Hillsborough County Crisis Line at 813-234-1234 or 911.

Cancellation Policy
It is important that you give me at least 24 hours notice of any cancellation or change to appointments. If you do not show up or cancel within 24 hours of your appointment time, you will be **charged for the full amount of the session**.

Fee Schedule
All therapy sessions are 50 minutes in length. You are welcome to schedule a longer time if needed. The fee schedule is as followed (initial intake session is $160);

1 Individual Session	50 Minutes	$120.00
1 Couples Session	50 Minutes	$140.00

Fees for evaluations, client records or court cases depends on time needed to complete. Upfront fees will be required for court related costs ($1,500.00 daily minimum).

Electronic Transmissions
Due to the lack of security of electronic transmission, only hard copies will be accepted of personal information other than contact info. or scheduling, the sender takes on the risk of unintended discloser or breach.

*Please let me know if you have any questions about the above information or if you have any other concerns entering into the counseling relationship.

Julie A. Teeling, MA, LMHC, NCC

813.416.8094

Consent for treatment

By signing below, I am consenting to engaging in a therapeutic relationship with Julie A. Teeling, Licensed Mental Health Counselor, Masters in Mental Health Counseling. It has been explained to me the nature of treatment, my rights as a client, and the limitations in confidentiality.

Client signature: _____ Date: _____

FEE AGREEMENT AND CANCELLATIONS

I understand that the agreed upon session fee is $160 (for intake)/ $120 (for individuals)/ $140 (for couples) and that I am responsible for paying this when services are rendered. I am also aware that **I need to cancel any appointments 24 hours in advance or I will be charged the full session fee for the missed appointment, except in an emergency situation**. It is assumed that without a phone call, if you are more than 20 minutes late for a session that you will not be attending.

Client signature: _____ Date: _____

EMERGENCIES

I understand that Teeling Counseling Services is not available to monitor clients 24 hours a day. I understand that in the event that Julie A. Teeling is unavailable, I can reach the crisis line at 234-1234 or 911 in the event that someone is in danger.

Client signature: _____ Date: _____

CONFIDENTIALITY

I understand that I have a right to confidential treatment except under certain conditions. These conditions are described in the Notice of Policies and Practices to Protect the Privacy of Your Health Information. I have reviewed and understand this document.

Client signature: _____ Date: _____

ELECTRONIC TRANSMISSIONS

I understand that due to the lack of security and confidentiality of mobile messaging, email, and internet messaging I will not send any sensitive or personal information other than for scheduling and/or basic contact information. All personal information transmissions will be in **hard copy** form only otherwise I take the risk of unsecure transmission and do not hold Teeling Counseling or Julie Teeling, LMHC responsible for unintended discloser or breach. **Please initial _____ if text reminders are acceptable.**

Client signature: _____ Date: _____

Julie A. Teeling, MA, LMHC, NCC

813.416.8094

Psychosocial History

Name: _____ Date:_____

This is only a brief introduction in order to obtain some history surrounding your situation. You may leave anything blank that you wish.

INITIAL INFORMATION

What is your reason for seeking treatment at this time? _____

_____

Has someone suggested that you seek treatment? If so, who and why? _____

_____

How long has this been a problem for you? _____

Have you ever sought treatment before? If so, where and what were the outcomes? _____

_____

HISTORY

Have you ever been hospitalized for any psychiatric reason? If so, when and why? _____

_____

Have you ever been diagnosed with a psychiatric disorder? If so, when and by whom? _____

_____

Have you ever taken medication for any psychiatric reason? If so, for how long and why did you stop? ___

_____

_____

What would you say has troubled you most in the past? _____

_____

Do you struggle with or have you survived any of the following (remember you do not have to answer if you prefer not to)

_____Anxiety	_____Depression	_____ Obsessive Compulsion
_____Mania	_____ Alcoholism	_____ Marital Discord
_____Addiction	_____ Low Self esteem	_____ Eating Disorder
_____Panic Attacks	_____Sexual Abuse	_____ Physical Abuse
_____Emotional Abuse	Other: _____	

Anything else that you struggle with that you feel is important? _____

_____

_____

Is there any major losses in your life, if so, who or what?

_____

_____

FAMILY HISTORY

Does anyone in your family (including grandparents, great aunts and uncles, etc) suffer from a mental illness? If so who, and what do they suffer from? _____

_____

PHYSICAL HISTORY AND MEDICATIONS

Do you have any physical limitations? _____

Do you have any physical diseases or disorders that are chronic?_____

How was your health as a child? _____

Please list all medications you are currently taking (even if they are not related to any emotional problems.)

_____

_____

THE COUNSELING RELATIONSHIP

What are you looking to get out of therapy? _____

_____

What do you look for in a therapist? _____

Have you had any bad experiences with therapists? If so, what was so negative about it?

_____

In your opinion, what is the worst thing a therapist can do? _____

Any additional information you would like me to know? _____

_____

Julie A. Teeling, MA, LMHC, NCC

813.416.8094

FLORIDA NOTICE FORM **(For your records)**

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

I 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* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 my 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 my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I 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) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.

- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- **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. 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.

- **Health Oversight:** If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

- **Worker's Compensation:** If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and Psychotherapist'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 about you. However, I am 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 seeing me. Upon your request, I 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 my mental health and billing records used to make decisions about you for as long as the PHI is

maintained in the record. On your request, I will discuss with you the details of the request 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. I may deny your request. On your request, I 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 regarding you. On your request, I 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 me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will mail a letter to you indicating a change has been made and provide you a copy of the update notice.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Teeling counseling Services at 813.416.8094.
If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to Julie A. Teeling at 333 S. Plant Ave, Tampa, Fl 33606.

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

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2016.

I reserve the right to make changes in this notice, any changes to this notice will be mailed to you as well as posted in my office