www.SheikEmpowerment.com
321 430 8211

CLIENT INFORMED CONSENT

I consent to receive counseling/therapy from ***Manijeh Sheik, MA, LMHC,*** who is a licensed mental health counselor. I acknowledge that I am here voluntarily and that I may terminate treatment at any time. I understand that, as with all effective treatments, there are benefits as well as possible risks to counseling/therapy. I understand that benefits will depend on the treatment goals that I establish together with my therapist. I understand that risks may include problems temporarily worsening or the conflict/problem not being resolved or changed. I realize that there is no guarantee of improvement in my condition. I acknowledge that any treatment will be a cooperative effort between me and **Manijeh**. I agree to actively participate in our counseling/ therapy sessions.

I further acknowledge that the counseling/ therapy session is only one part of the process of change. Following through with the activities and trying the new behaviors agreed upon between sessions in most cases has a two-fold effect; increasing the opportunity for success and decreasing the number of sessions needed to begin to feel relief and see the desired change. The following are the basic rights of individuals participating in counseling/therapy:

The right to be informed of the various steps and activities involved in receiving services

The right to confidentiality under federal and state laws

*I cannot speak even in general to anyone about my clients, i.e. “I saw this person today and you can’t believe what they told me…” –this is against the law and the ethics of my field.

*We may live in the same community and even find ourselves in social settings together. In these cases, I will not greet you in order to preserve your confidentiality, as others know what I do for a living. If you choose to greet me, I will follow your lead.

The right to humane care and protection from harm, abuse and neglect.

The right to make an informed decision regarding whether to accept or reject treatment.

The right to contact and consult with and select practitioners of my choice and at my expense.

I understand that confidentiality of records or other information collected about me will be held or released in accordance

with state laws regarding confidentiality of such records and information. I understand that the confidentiality of my record may be breached under the following circumstances:

1. If I sign a waiver requesting release of information.
2. If a court orders the release of my records.
3. If a mental status or competency should arise in a legal proceeding.
4. Refer to LIMITS OF CONFIDENTIALITY form for details on confidentiality limits specific to the field of Mental Health Counseling, Social Work, and Marriage and Family Therapy.
5. If Counselor should become unavailable due to serious illness or death. This would only be for the purpose of finding client contact information.

I understand that if I or anyone else, with proper release of information, ask my counselor to prepare paperwork for an outside party, I will be charged $75 for each document. I also understand that if my counselor is asked to attend any court hearings or meetings, I will be charged $150 per hour for every hour outside of the office to include travel time, with a minimum of four hours or $600. The minimum fee will be paid in advance, and any balance due will be billed to credit card provided at the time of the subpoena. When the documents/testimony is involving children seen by a counselor, both parents must consent. When the documents/ testimony is regarding anything involving sessions with more than one person, all persons present in the sessions must consent.

I understand that my clinician does not provide emergency services. When my clinician is unavailable, I understand that I will be able to leave messages. I understand that my clinician will make every effort to return my call within 24 hours, with the exception of weekends and holidays. I understand that if I am in crisis and am unable to wait for my clinician to contact me, I should go to the nearest emergency room or call 911.

I understand that I may also call the Lifeline of Central Florida, the 24-hour crisis hotline, at 407-425-2624 for immediate assistance. I understand that if my clinician will be unavailable for an extended period of time (e.g. vacation), he/she wil**l** provide me with the name of a colleague to contact, if necessary.

Initial: _____

I have read and understood the above: _____
Parent or Guardian of Client Under 18

_____ _____
Client Signature Counselor Signature

_____

Signature of Parent or Guardian of Client Under 18

LIMITS OF CONFIDENTIALITY

Therapy is considered a confidential relationship. Neither verbal information nor written records about a client can be shared with another party without the client's written consent. The following are EXCEPTIONS:

1. Duty to Warn and Protect

When a client expresses intentions or a plan to harm another person, mental health professionals are required by law to warn the intended victim and to report this information to law enforcement. In the case of a client who discloses a plan for suicide, the mental health professional is required to make reasonable attempts to notify the family or significant other of the client. In both cases, it is the duty of the mental health professional to assure the client or victim's safety. This may include using the Baker Act in the State of Florida, which allows for up to 72 hours of involuntary commitment to a mental health facility for those deemed a danger to themselves or others by a qualified mental health professional.

2. Abuse of Children or Vulnerable Adults

If a client states or suggests that he or she is abusing a child or vulnerable adult (or has recently done so),or indicates knowledge of a child or vulnerable adult being in danger of abuse; the mental health professional is required to report this information to the appropriate social service and or law enforcement authority.

3. Prenatal Exposure to Controlled Substances

Mental health professionals are required to report admitted ongoing prenatal exposure to controlled substances.

4. Minor/Guardianship

Parents and legal guardians of non-emancipated minor clients have the right to access the clients' records.

5. Administrative Staff

Administrative staff are employed and other mental health professionals are practicing within this office. In most cases, the need to share protected information with these individuals is for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside the practice.

6. Personal Electronic Devices and Email

It is important to note that personal electronic devices (such as cell phones, tablets, etc.) as well as emails are not considered ‘secure’. While we make every effort to make them as secure as possible (encryption, etc.) they still pose their own unique risks. Land lines and faxes are considered secure and HIPAA compliant.

YOUR SIGNATURE BELOW INDICATES YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.
I agree to the above Limits of Confidentiality and understand their meanings and ramifications.

_____ _____
Client Signature (Parent/Guardian if under 18) Date

_____ _____
Parent/Guardian if under 18 Date

GENERAL AND FINANCIAL POLICIES

SCHEDULING:

Appointments will be scheduled in advance either once a week, twice per week, every two weeks, or one time per month as agreed by patient and therapist to be the most effective approach to treatment. These appointments will occur at the same agreed upon time. Manijeh sees clients on Mondays and Thursdays.

CLIENT CANCELLATIONS AND SCHEDULE CHANGES:

If something comes up and I am not able to attend my designated appointment time I will notify the therapist 24 hours in advance by calling 321-430-8211

If the therapist is notified 24 hours in advance no fee will be incurred.
If Manijeh is able, she will reschedule my appointment for another time the same week.

If she is not able to accommodate me the same week she will see me at my next scheduled appointment as per our original scheduling agreement.

Failure to notify Manijeh of a cancellation 24 hours in advance or simply not showing up for an appointment will result in me being charged the full session fee.

Manijeh understands that emergencies occur and will waive the cancellation fee in case of an emergency.

Initials: _____

THERAPIST INITIATED CHANGES

Manijeh may deviate from this schedule due to her own scheduling conflicts. She too will provide advance notice as often as she is able. In the case of vacations, she will notify me in advance. Manijeh will offer additional availability in order to accommodate her clients when appointments are missed due to her scheduling conflicts.

SESSION LENGTH AND FEE SCHEDULE

Session length is 50 minutes.

Scheduling and payment info would have been taken care of on the initial appointment and will not be managed during regular 50 minute sessions unless there are necessary changes that must be discussed. Please let Manijeh know on the onset of the appointment in order to make sure that there is enough time at the end of session to take care of any housekeeping. The therapist will collect payment after each session using the credit card provided by the patient. The fee per 50 minute individual session will be: $135. The fee per 50 minute family session (2

or more individuals) will be $150. The initial intake is $150. Sessions are currently offered both in-person and via tele-therapy.

Initials:_____

I have a few slots that I reserve for people with financial hardships. Please call/email to apply for reduced fee sessions.

I hereby authorize Manijeh Sheik, MHCi, to charge my credit card for full services provided or for any appointments that I cancel within 24 hours or I fail to show up to session as outlined above per our scheduling agreement.

Cardholder name (please print): _____

Cardholder signature: _____

Card type: **VISA** **MASTERCARD** **AMEX** **DISCOVER**

Card number: _____

EXP date: _____

Security Code: _____

Billing zipcode: _____

Initials: _____

Client Signature (Parent if client under the age of 18):_____

Date: _____

Initials: _____

Patient Consent To The Appointment Scheduling and Cancellation Policy

I have read and understand the information provided above regarding the appointment scheduling, cancellation, and payment policy, and if necessary have discussed it with Manijeh Sheik, MHCi and all of my questions have been answered to my satisfaction.

Name of Patient:_____

Name of Guardian/ Parent (if applicable): _____

Signature: _____ Date:_____

CLIENT RECORD OF COMMUNICATION

In general, the HIPPA privacy rules give the individual the right to request confidential communications or that communication be made by alternate means. We wish to clarify how you do and do not wish for us to communicate with you.

I GIVE PERMISSION TO BE CONTACTED IN THE FOLLOWING MANNER
(PLEASE CHECK ALL THAT APPLY FOR YOU AND CIRCLE YOUR PREFERRED METHOD):

Name (please print):_____

_____ Home Telephone: __(_____)_____

_____ Ok to leave a message with detailed information

_____ Leave a message with call back number only

_____ Written Communication

_____ OK to mail to my home address

_____ OK to fax to this number: __(_____)_____

_____ Cellular Phone: __(_____)_____

_____ Ok to leave voice message with detailed information

_____ Ok to text detailed information

_____ Leave a message with a call back number only

_____ Work Phone: __(_____)_____ ext: _____

_____ Ok to leave a message with detailed information

_____ Leave a message with call back number only

_____ Email:_____

_____ Ok to send email with follow-up information from sessions

_____ Ok to Email Newsletter from LIFE SKILLS RESOURCE GROUP

CLIENT RECORD OF REFERRAL

We would really appreciate if you would take just a moment to answer a few questions about where you learned of us or how you were referred to Sheik Empowerment Therapy.

Please check all that apply:

_____ Internet Search: What was the first link the internet search took you to?

_____ Psychology Today, Find-A-Therapist

_____ Life Skills Resource Group Website

_____ UCF Referral Directory

_____ Other (Please describe): _____

_____ Family, Friend, or Physician

_____

Can we thank them for the referral? Yes _____ No _____ (please initial)

_____

_____ Advertisement: Newspaper, Magazine

_____

HEALTH INFORMATION PRACTICES

RECEIPT AND ACKNOWLEDGEMENT OF NOTICE
CLIENT NAME:

_____

SOCIAL SECURITY #:

_____

DATE OF BIRTH:

_____

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND HAVE BEEN GIVEN AN OPPORTUNITY TO READ A COPY OF THE LIFE SKILLS RESOURCE GROUP, LLC NOTICE OF
HEALTH INFORMATION PRACTICES. I UNDERSTAND THAT IF I HAVE ANY QUESTIONS REGARDING THE NOTICE OF MY PRIVACY RIGHTS, I CAN CONTACT MY COUNSELOR OR
THE LIFE SKILLS RESOURCE GROUP MANAGING MEMBER, CINDY FABICO, AT 407-5042133.
Signature of Client:

_____

Date: _____

Signature of Parent, Guardian, or Personal Representative:

_____

Date: _____

Note: If you are signing this as a personal representative, please describe your legal authority to act for this individual and provide a copy of the documentation of same.
_____ HC Surrogate _____ HC Proxy _____ POA _____ DPOA
_____ Client refuses to acknowledge receipt

Signature of Staff:

_____

NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AND SIGN INDICATING THAT YOU HAVE READ AND UNDERSTAND THE NOTICE.

Understanding Your Health Record/Information

Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

Basis for planning your care and treatment

Means of communicating among the many health professionals who contribute to your care

Legal document describing the care you received

Means by which you or a third party payer can verify that services billed were actually provided

A tool in educating health professionals

A source of information for public officials charged with improving the health of the nation

A source of data for facility planning and marketing and

A tool with which we can assess and continually work to improve the care we render and the outcome we achieve

Understanding what is in your health record and how your health information is used helps you to:

Ensure its accuracy

Better understand who, what, when, where and why others may access your health information

Make more informed decisions when authorizing disclosure to others

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. Privacy Rules (PR) specify that you have the right to:

Request a restriction on certain uses and disclosures of your information as provided by PR 164.522

Obtain a paper copy of the notice of information practices upon request

Inspect and copy your health record as provided for in PR 164.524

Amend your health record as provided in PR 164.528

Obtain an accounting of disclosures of your health information as provided in PR 164.528

Request communications of your health information by alternative means or at alternative locations

Revoke your authorization to use or disclose health information except to the extent that action has already been
taken

PLEASE NOTE: The Final HIPPA Privacy Rule defines psychotherapy notes as an official record, created for use by the

mental health professional for treatment, “recorded in any medium…documenting or analyzing the contents of conversation
during a private counseling session or a group, joint or family counseling session that are separate from the rest of the individual’s medical record…” 45 C.F.R. 164.501 (65 Fed. Reg. at 82805) (emphasis added).
According to the American
Psychological Association (APA), “This kind of information is not typically needed by anyone other than the treating [Mental
Health Professional] to care for the patient, and is not needed for payment or health-care operations.” Therefore, “…these
notes about communication in psychotherapy, when kept separately from the rest of the record and not disclosed to anyone, would remain private under the Rule.”
-taken from Psychotherapy Notes Provision of HIPPA Privacy Rule; APA Doc. Ref. No. 200201 Additionally, please be aware that we do employ a receptionist during business hours, who answers phones, books appointments, makes referrals, bills insurance, etc. This person is either a Masters level Counselor or a Counselor in training.
He/she was carefully screened upon being hired and is held to the same ethical standards as anyone in our Practice.

Our Responsibilities:

This organization is required to:

Maintain the privacy of your health information

Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

Abide by the terms of this notice

Notify you if we are unable to agree to a requested restriction

Accommodate reasonable requests you may have to communicate health information by alterative means or at alternative locations

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain.
We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information, or to Report a Concern:

If you have questions and would like additional information, you may contact the Owner, Manijeh Sheik at 321-430-8211.
If you believe your privacy rights have been violated, you can file a complaint with the Managing Member of Sheik Empowerment Therapy, LLC. There will not be retaliation for filing a complaint. Examples of Disclosure for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by your mental health
counselor will be recorder in your record and used to determine the course of treatment that should work best for you. Your counselor will document in your record his/her expectations of your treatment.

We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The

information on or accompanying the bill may include information that identifies you, as well as your diagnosis.

We will use your health information for regular health operations. For example: Members of the counseling staff may use information in your health records to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the counseling services we provide. Other Uses and Disclosures

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Counselors in best judgment may disclose to a family member, or other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law. Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena.

There are specific exceptions to confidentiality as provided in state and federal law, where a counselor can release information without your consent. These exceptions include possible threat of harm to self, harm to others, child abuse and neglect situations, aging adult abuse and neglect.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.