Life Transitions Counseling
6000-A Sawgrass Village Circle, Suite 14, Ponte Vedra Beach, FL 32082
Jason Hosch, PhD, LMHC, LCCC

PATIENT INFORMATION

PLEASE PRINT

Patient Information

Patient's Last Name: _____ First Name: _____ MI: _____

Patient's Social Security Number: _____ - _____ - _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Male Female

Email Address: _____

Marital Status: Single Married Divorced Other

Employment Status: Full-time Part-time Retired Other

Employer / Occupation: _____

Referred By: _____

Spouse or Parent Information

Spouse/Parent's Last Name: _____ First Name: _____

Spouse/Parent's Social Security Number: _____ - _____ - _____

Spouse/Parent's Date of Birth: _____ Male Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Male Female

Email Address: _____

Employer / Occupation: _____

Emergency Contact

Emergency Contact Person: _____

Relationship: _____ Phone: _____

Payment Responsibility

Payment for services is due at the time of the appointment. Patient will provide a valid copy of their credit card (or a check) to be kept confidentially on file while services are being rendered. Patient will be charged a session fee for any missed appointments, and will be required to provide at least 24 hours notice for any cancellations or rescheduled appointments to avoid this fee (see Appointments/Cancellation Policy for details). There will be a $150.00 per hour fee for any non-court-related written correspondence, including treatment summaries, completion of FMLA, disability, or other applications. This includes time required to review case notes, if applicable. Court services and any court-related time will be billed at the rate of $350.00 an hour. All of these and other pertinent fees are detailed in the Schedule of Fees. Any balances remaining unpaid will be charged to the credit card on file, and may be sent to collections if charges are declined. I understand and agree to payment of all services rendered.

Printed Name: _____ Date: _____
Signature:_____

Consent for Treatment

I hereby provide my consent for treatment to work in counseling with Dr. Hosch.

Printed Name: _____ Date: _____
Signature:_____

Life Transitions Counseling
You were called to be free...

6000-A Sawgrass Village Circle, Suite 14, Ponte Vedra Beach, FL 32082
Phone: 904-386-9518 • www.lifetransitions.cc

KEEPING APPOINTMENTS / CANCELLATION POLICY

Due to increased demand for appointments we have established a policy for No-Show and Late Cancellations. Please call at least 24 hours prior to your appointment to cancel in order to avoid the charge of a session. A copy of your credit/debit card will be kept on file and will be kept confidential by Dr. Hosch while services are being rendered. In the event that this happens and you have booked several appointments out, Dr. Hosch reserves the right to cancel any future appointments you may have scheduled and offer them to other clients. If this happens and you are receiving services through an EAP, Dr. Hosch reserves the right to discontinue your EAP services, charge a normal session fee for the missed appointment, and require that any future appointments be billed at the normal session rate. Dr. Hosch will give you a courtesy call or email to notify you if this happens. You will be provided with automated email and text reminders for your appointments, which you may opt out of if you choose. However, it remains your responsibility to remember your appointment dates and times and let Dr. Hosch know if you cannot keep them. Thank you for your co-operation and understanding in this matter as it is Dr. Hosch's desire to serve our community and families with their limited and busy schedules.

Signature: _____ Date: _____

Life Transitions Counseling
You were called to be free...

6000-A Sawgrass Village Circle, Suite 14, Ponte Vedra Beach, FL 32082
Phone: (904) 386-9518 • www.lifetransitions.cc

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO T HIS INFORMATION. PLEASE READ CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

- *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state, or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information: to a health oversight agency for activities authorized by law including but not limited to: response to a court or administrative order. If you are involved in a lawsuit or similar proceeding: 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.

We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION 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 a person or organization able to help prevent the threat.

Your written permission will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law.

You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that we restrict using and disclosing you PROTECTED HEALTH INFORMATION to family members and relatives, friends, or others you identify. We reserve the right to deny this request.

- You may request an amendment to your PROTECTED HEALTH INFORMATION.

- You may request alternative means or locations in which you receive confidential communications.

- You may request an accounting of disclosures of PROTECTED HEALTH INFORMATION beyond treatment, payment, and health care operations.

We are required by law to protect the privacy of your PROTECTED HEALTH INFORMATION and to abide by the terms of the *Notice of Privacy Practices*. We will make and post revisions to the *Notice of Privacy Practices* in accordance with the law. You may obtain a written copy of these changes by written request.

You may file a formal, written complaint with us at the address below or with the Department of Health and Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For information regarding our *Privacy Practices*, please contact:

- The Privacy Officer
  Jason Hosch, Director
  Life Transitions Counseling
  6000-A Sawgrass Village Cir., Ste. 14
  Ponte Vedra Beach, FL 32082

For more information about HIPAA or to file a complaint, please contact:

- U.S. Department of Health and Human Services, Office of Civil Rights
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  (877) 696-6775

Life Transitions Counseling
You were called to be free...

6000-A Sawgrass Village Circle, Suite 14, Ponte Vedra Beach, FL 32082
Phone: 904-386-9518 • www.lifetransitions.cc

Acknowledgment of Receipt of Privacy Practices Notice

I acknowledge that I received a copy of Life Transitions Counseling's Notice of Privacy Practices.

Name: _____

Address: _____

City, State, Zip Code: _____

Signed: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____