



# Breakthroughs

Counseling & Recovery, Inc.

3810 Williamsburg Park Blvd Suite 3; Jacksonville, FL 32257

www.jaxtherapists.com

Phone: (904)419-6102 Fax: (904)739-2153

Client Name (Please Print)	SSN	Relationship Status S M D W	Gender	DOB	Age
Street Address	City, State	Zip Code	Phone Number	Email Address	
Client Employer or School Name (if minor)	Occupation or Student		How long employed?	Work #	
Spouse or Parent's Name (if minor)	Occupation		How long employed?	Work #	
Person Responsible for Payment	Phone Number		DOB	SSN	
Street Address	City		State	Zip Code	

Insurance Company	Primary on Insurance	DOB
Employee Assistance Program ( EAP) Name	Authorization Number	Number of Visits

Referred By	Street Address (City, State, & Zip Code)	
Phone Number	May we thank them?	Comments

\_\_\_\_\_  
Client/ Representative Signature

\_\_\_\_\_  
Date

## CONFIDENTIAL INTAKE FORM

Client name: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate client's reasons for seeking counseling:

\_\_\_\_\_

How long has the client been experiencing these issues?

\_\_\_\_\_

Has the client previously received counseling? ( ) Yes ( ) No

-If yes, please indicate reasons for previous treatment, approximate dates of treatment, and outcomes:

\_\_\_\_\_

Please indicate symptoms currently/ recently experienced by client:

- |  |   |  |  |
|--|---|--|--|
| <input type="radio"/> Changes in appetite            | <input type="radio"/> Changes in sleep patterns   | <input type="radio"/> Memory issues                      | <input type="radio"/> Substance abuse                      |
| <input type="radio"/> Depression/<br>Extreme sadness | <input type="radio"/> Anxiety/<br>Excessive worry | <input type="radio"/> Relationship Issues                | <input type="radio"/> Obsessive behaviors                  |
| <input type="radio"/> Paranoia                       | <input type="radio"/> Hallucinations              | <input type="radio"/> Unstable mood                      | <input type="radio"/> Sexual issues                        |
| <input type="radio"/> Difficulty concentrating       | <input type="radio"/> Impulsivity                 | <input type="radio"/> Aggressive behaviors               | <input type="radio"/> Domestic violence/<br>Physical abuse |
| <input type="radio"/> Panic                          | <input type="radio"/> Trauma-related issues       | <input type="radio"/> Thoughts of harming self or others | <input type="radio"/> Other: _____                         |

Is the client currently being treated for any mental health issues? ( ) Yes ( ) No

If yes, please indicate care provider (e.g., psychiatrist), diagnosis, and all medications the client is currently prescribed:

\_\_\_\_\_

Who referred the client for counseling?:

\_\_\_\_\_

## **COUNSELING SERVICES CLIENT CONSENT FORM**

**COUNSELING** is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

### **CONFIDENTIALITY:**

All interactions with Breakthroughs Counseling & Recovery, Inc., including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

### **EXCEPTIONS TO CONFIDENTIALITY:**

- The counseling staff works as a team. Your therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes.
- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety.
- Florida state law requires that staff of Breakthroughs Counseling & Recovery, Inc. who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to county child protection services.
- A court order, issued by a judge, may require the Counseling Services staff to release information contained in records and/or require a therapist to testify in a court hearing.

**I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the Breakthroughs Counseling & Recovery, Inc.**

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Client/ Representative Signature

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Date

## HIPAA PRIVACY AUTHORIZATION FORM

*Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)*

1. I authorize Breakthroughs Counseling & Recovery, Inc. to use and disclose the protected health information described below to:

\_\_\_\_\_ (name of insurance provider).

2. This authorization for release of information covers the period of healthcare from:

a.  \_\_\_\_\_ to \_\_\_\_\_.

**\*\*OR\*\***

b.  all past, present, and future periods.

3. I authorize the release of my complete mental health record (including diagnoses, treatment, outcomes, etc.).

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until \_\_\_\_\_ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_

Client/ Representative Signature

\_\_\_\_\_

Date

**FINANCIAL AGREEMENT**

*Please initial next to each item indicating your understanding and acceptance.*

\_\_\_\_\_ I understand that unless other arrangements have been made, payment is due at the time of service.

\_\_\_\_\_ I understand that I am fully responsible for any charges not covered by my insurance provider. This may include but is not limited to: denial of claims, copay, unmet deductible, etc.

\_\_\_\_\_ The insurance information I have provided represents a full disclosure of the insurance/ third party benefits to which I am entitled. I understand that failure to disclose pre-certification/ second opinion requirements for any and all plans to which I subscribe, may incur full liability for professional charges as a result of non-payment by any carrier.

\_\_\_\_\_ I understand that I will be charged a forty-five dollar (\$45) fee for missed appointments or appointments that are cancelled within 24 hours of scheduled appointment time.

\_\_\_\_\_ Unpaid balances for a period greater than one hundred twenty (120) days will be turned over to a collection agency.

\_\_\_\_\_ In the event of a returned check, I will be assessed a thirty-five dollar (\$35) processing fee.

\_\_\_\_\_ If I am requesting substance abuse-related services (e.g., court-ordered substance abuse evaluation) I may be required to submit to a urine screen. The cost for a urine screening is forty-five dollars (\$45) and may or may not be included in the cost of my services received.

\_\_\_\_\_  
Client/ Representative Signature

\_\_\_\_\_  
Date