Mail:
P. O. Box 24002
Fort Lauderdale, Florida 33307

Office:
120 East Oakland Park Blvd., Suite 201
Fort Lauderdale, FL 33334

MICHAEL S. RHODES, M.S., M.DIV., LMFT
Licensed Psychotherapist
Florida Qualified Supervisor of MFT Interns
Counseling & Hypnotherapy

Phone: (954) 294-2077
Fax: (954) 337-0195
E-mail: Michael@MichaelSRhodes.com
Website: www.MichaelSRhodes.com

Confidential Client Information

The following information and all information in your client record is considered confidential according to Florida Statute 491.0147: "Confidentiality and privileged communications—Any communication between any person licensed or certified under this chapter and her or his patient or client shall be confidential." See the Psychotherapy Services Agreement for the limits of client-psychotherapist confidentiality.

Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ ☐ OK to leave message Work Phone _____ ☐ OK to leave message Cell _____ ☐ OK to leave message

☐ Call my cell phone first. ☐ Do Not Call home. ☐ You may call me at work. E-mail _____

Relationship/Marital Status ☐ Never married ☐ Single ☐ Significant Other ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Birth Date _____ Employer _____ Occupation _____

Spouse/Partner's Name _____ Birth Date _____ Phone _____

How did you hear about my practice? _____ May I contact this person to thank them? ☐ Yes ☐ No

IMMEDIATE FAMILY INFORMATION (AND OTHERS RESIDING IN YOUR HOME)

Name	Relationship to You	Birth Date	Living at home?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Briefly describe why you seek therapy and your goal(s) for therapy: _____

Are you currently under the care of a physician? ☐ Yes ☐ No Physician's name: _____

Any medications that you are currently prescribed: _____

Do you take your medications as prescribed? ☐ Always ☐ Usually ☐ Sometimes not ☐ Not often

Have you ever been hospitalized? ☐ Yes ☐ No If yes, please specify approximate date(s) and for what reason: _____

Have you ever been in counseling before? ☐ Yes ☐ No If yes, approximately date(s) and for what reason: _____

➔ ***PLEASE CONTINUE AND COMPLETE OTHER SIDE*** ←

Have you ever seriously considered or attempted suicide? ☐ Yes ☐ No If yes, approximately date(s): _____

Have you ever seriously attempted to harm another person? ☐ Yes ☐ No If yes, approximately date(s): _____

EMERGENCY CONTACT

Completion of the information below authorizes the therapist to release the minimum amount of information necessary to provide for the client's needs in an emergency.

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Fees for services provided by Michael S. Rhodes, LMFT, will be paid by ☐ Self/Client or ☐ Person listed below:

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

_____ _____

Signature of client or personal representative, or if under the age of 18, guardian's signature Date

_____

Print Name and, if other than client's name, description of personal representative's authority

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Psychotherapy Services Agreement

Welcome to my practice. This document contains important information about my professional services, my business policies, and how I protect the privacy of your health information. Please read it carefully and discuss any questions you may have with me. When you sign this document, you will be acknowledging that I provided you with this information. This represents an agreement between us and documents your consent for psychotherapy with me.

Psychotherapy Services: Psychotherapy varies depending on the therapist (me), the client (you), and your goals. I may use many different methods to deal with your particular situation. For therapy to have the best outcome, you must invest energy in the process and things we discuss both during, and between, our sessions.

The benefits of psychotherapy may include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in feelings of distress. There are also risks, however, which can include experiencing feelings such as sadness, guilt, anger, anxiety, or frustration when discussing aspects of your life. Although I expect a positive outcome, there are no guarantees of what you may experience along the way.

In our first session or two, I will evaluate your situation and we will discuss your goals for therapy. During this time, you will find out what working together will be like and we can both decide whether I am the best person to work with you. It is important that you are comfortable with me. If you are not comfortable with me, please let me know. I will provide you with references for other therapists and/or other appropriate resources that may better serve your needs.

Scheduling Sessions: Client sessions are 50 minutes. Most clients have one session per week, but if you wish, I will meet with you more or less often. If you arrive late for an appointment, we will only meet for the remaining time of our scheduled 50 minutes. If you need to cancel a scheduled therapy session, please inform me at least 24 hours in advance. If you miss a scheduled session without canceling within 24 hours of the scheduled session, you must pay $100. (See *Missed Appointment Fee* for more information about missed appointments.)

Session Payments: Payment for sessions is due at the time of each session, unless we agree otherwise in advance. I accept cash, check, debit, or credit card as payment for services.

Missed Appointment Fee: Regardless of your usual fee for session, you will be charged $100 for any appointment that you do not cancel 24 hours in advance, unless we both agree that you were unable to attend due to circumstances beyond your control.

_____
Initial

Professional Fees: My fee is $150 for each 50-minute session, unless or other arrangements made in advance. Additional time in session may be billed at $40 per 15-minute increment. For other professional services that you request outside of counseling sessions (such as telephone conversations lasting longer than 15 minutes, attendance at meetings—including travel time if outside of my office, consultation with other professionals that you have authorized, preparation of documentation, correspondence, or treatment summaries, and any other tasks that you request, I charge $50 per quarter hour ($200 per hour). Initial

If you become involved in legal proceedings that require my participation, you are responsible to reimburse me for my professional time, even if I am called to testify by another party. Because of the complexity of preparing for and participating in legal proceedings, I charge $500 per hour for preparation, travel time, and attendance at any legal proceedings. Payment for other professional services will be agreed to when you request them. Initial

Bank Charges: If you pay by check and it is returned for any reason, you agree to pay me the amount due for services rendered, PLUS you agree to pay me $50 for my time in resolving the issue, and reimburse me in full for any related bank fees that I am charged. Initial

Contacting me: I do not answer the phone when I am with clients. I will return your call as soon as possible (usually within a few hours and almost always within 24 hours). If you are difficult to reach, please leave me times when you will be available. When I may need to call or leave a message for you, please let me know in advance if I need to be more discreet than simply leaving my name and phone number. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact for your care in my absence.

In case of emergency: If you are in an emergency situation, call me. If you get my voicemail, leave a message. I will return your call as soon possible, but I may not be able to get back to you immediately. If I do not return your call within 5 or 10 minutes, please call 911 and tell the operator what is happening; or go to the nearest hospital emergency room and tell staff there what is happening.

Confidentiality: In general, the Florida Statute 491.0147 protects the privacy of all communication between a client and a psychotherapist. In ***most*** cases, **I can release information about your treatment to others only if you sign a written authorization**. You can revoke any such authorizations at any time, in writing. There are exceptions, however, when your authorization is NOT required for me to release information. Such situations are when I believe that:

- a client is in imminent danger of attempting serious physical harm to herself or himself. In such cases, I have an obligation to intervene by possibly having you hospitalized, and/or contacting family members, friends, or others who might help keep you from harm.

- a client is likely to attempt serious physical harm to someone else. I have a duty to call the police, warn the intended victim, and/or even have you hospitalized.

I must report to the appropriate authorities:

- any suspected physical or sexual abuse, or neglect of a child, under age 18;

- any suspected elder abuse, if the elderly person is not capable of reporting the abuse herself or himself;

- any suspected abuse of a special needs person who requires custodial care.

I am required to report suspected abuse immediately. Once I make such a report, I may be required to provide additional information.

NOTE: In situations where I may be concerned that you may harm yourself or others, or suspect abuse or neglect of a child, an elderly or a vulnerable person—where it would not delay my fulfilling the obligations of the law—I will attempt to discuss the situation with you before I take action. I will limit my disclosure to only what is necessary.

Lastly, I may use my records of our sessions to defend myself if you were to sue me.

Although I am not an attorney, please discuss any questions or concerns you have about confidentiality with me at any time. If you have specific legal questions about the laws regarding confidentiality, the exceptions, and how it may relate to your situation, please seek formal legal advice from an attorney.

I want to be clear that I am a psychotherapist (specifically, a Florida Licensed Marriage and Family Therapist). I am not a physician, psychiatrist, attorney, or a psychologist (professions with their own scope of expertise). As such, while we may discuss any issues of importance to you, I will not provide advice on medical, psychiatric, or legal matters, other than by means of referral. Furthermore, you understand that I will not be responsible in any way for the actions of any professionals to whom I might appropriately refer you.

Continuity of Care: In the event you wish to conclude therapy with me and desire additional professional support, I will provide you with the name and phone number of appropriate professionals who may be helpful to you. If you discontinue therapy or cease attending sessions with me for thirty (30) days without a formal discharge plan or referral, our therapeutic relationship will be considered terminated and I will close your file. You may resume therapy with me at any time you choose by scheduling an appointment.

Conclusion: I reserve the right to change the policies, practices, and procedures described in this agreement. I will notify you, in writing, of any significant changes. By signing below, you indicate that you have received and read the information in this document, that you have discussed the contents with me to your satisfaction, and that you agree to abide by its terms during the course of our professional relationship.

Client Name	Client Signature	Date
Client Name	Client Signature	Date
Client Name	Client Signature	Date
Michael S. Rhodes, LMFT Therapist Name	Therapist Signature	Date

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CREDIT CARD BILLING AUTHORIZATION FORM

If you decide to schedule additional sessions, this information will be used for payment only when you do not show for an appointment or cancel an appointment less than 24 hours in advance. This information is part of your file and held in the strictest confidence.

I, _____, authorize Michael S. Rhodes, LMFT, to charge
(Please print cardholder's name)

my credit card for professional fees on behalf of: _____
(Please print client's name)

Name as it appears on credit card _____

Credit card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ Debit card

Credit/debit card number _____

Expiration date (mm/yyyy) _____

CVS number (3-digit number on back of card; or, on Amex, the 4-digits on front of card above account number) _____

Billing zip code _____

Email address to receive receipts of transactions _____

Cardholder's phone number _____

_____	_____
Client's signature	Cardholder's signature, if different from client
_____	_____
Please print client's name	Please print cardholder's name, if different from client
_____	_____
Date	Date

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise!

Dear Client:

It is our desire to communicate to you that we are taking Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be made available to others outside of our office unnecessarily.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Client Acknowledgment

Client Name(s): _____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Client Signature

Date _____ / _____ / _____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from August 1, 2007 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from my office at any time. Contact Michael S. Rhodes, LMFT, at (954) 294-2077 or email Michael@MichaelSRhodes.com to obtain a copy.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

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