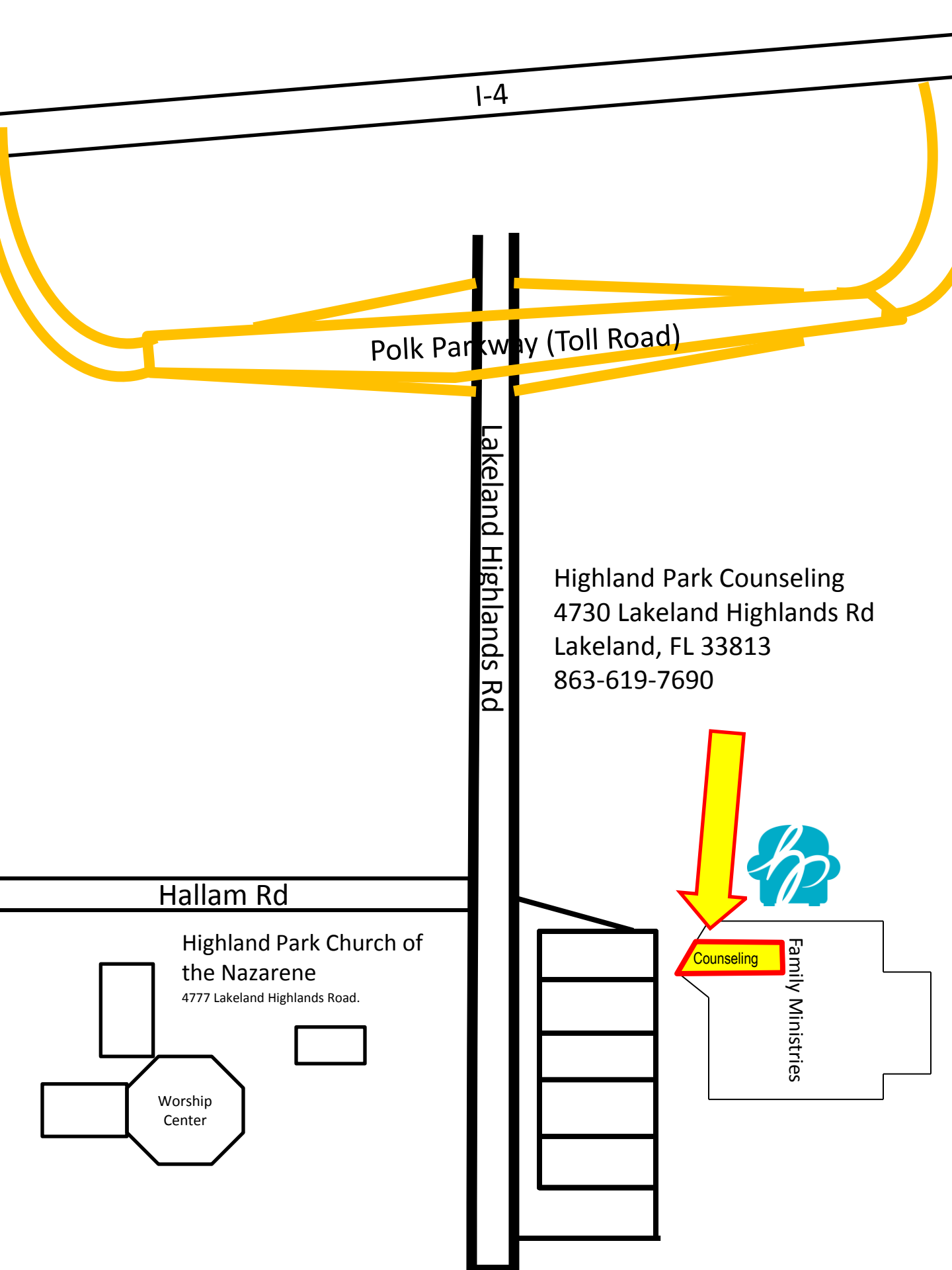
I-4
Polk Parkway (Toll Road)
Lakeland Highlands Rd
Highland Park Counseling
4730 Lakeland Highlands Rd
Lakeland, FL 33813
863-619-7690
Hallam Rd
Highland Park Church of the Nazarene
4777 Lakeland Highlands Road.
Worship Center
Counseling
Family Ministries

3. Uses and disclosures of PHI from mental health records that don't *require* a Consent or Authorization

The law lets us use and disclose some of your PHI without your consent or authorization in some cases. Here are examples of when we might have to share your information.

When required by law
There are some federal, state, or local laws which require us to disclose PHI.
• We have to report suspected child abuse.
• If you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request, or other lawful process we may have to release some of your PHI. We will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.
• We have to disclose some information to the government agencies which check on us to see that we are obeying the privacy laws.

For specific government functions
We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment. We may disclose your PHI to Workers Compensation and Disability programs, to correctional facilities if you are an inmate, and for national security reasons.

To Prevent a Serious Threat to Health or Safety
If we come to believe that there is a serious threat to your health or safety or that of another person or the public we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

4. Uses and disclosures where you to have an opportunity to object

We can share some information about you with your family or close others. We will only share information with those involved in your care and anyone else you choose such as close friends or clergy. We will ask you about who you want us to tell what information about your condition or treatment. You can tell us what you want and we will honor your wishes as long as it is not against the law.

If it is an emergency - so we cannot ask if you disagree - we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information, in an emergency, we will tell you as soon as we can. If you don't approve we will stop, as long as it is not against the law.

5. An accounting of disclosures

When we disclose your PHI we may keep some records of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

E. Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.
Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.

F. If you have questions or problems

If you need more information or have questions about the privacy practices described above please speak to the Privacy Officer whose name and telephone number are listed below. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, contact the Privacy Officer listed below. You have the right to file a complaint with us and with the Secretary of the federal Department of Health and Human Services. We promise that we will not in any way limit your care here or take any actions against you if you complain.

If you have any questions regarding this Notice or our health information privacy policies, please contact our Privacy Officer: Rowena Barnett, MA, LMHC. The effective date of this notice is April 14, 2003
Contact information: Highland Park Counseling Center, 4777 Lakeland Highlands Rd., Lakeland, Florida 33813 Phone: (863) 647-3518, ext. 206, E-mail address: rowena.barnett@hplakeland.com.

Counseling

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL (MENTAL HEALTH) INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Counseling

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL (MENTAL HEALTH) INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Privacy is a very important concern for all those who come to this office. It is also complicated because of the many federal and state laws and our professional ethics. Because the rules are so complicated some parts of this Notice are very detailed and you may have to read them several times to understand them. If you have any questions our Privacy Officer will be happy to help you understand our procedures and your rights. His or her name and address are at the end of this Notice.

A. Introduction - To our clients

The Counseling Center provides counseling sessions for members and attendees of Highland Park Church, as well as general members of the greater Lakeland/Polk County community. When you contact The Counseling Center you will provide information which individually identifies you, and you may provide health information. This Notice will tell you how we handle your information. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. Because the laws of this state and the laws of federal government are very complicated and we don't want to make you read a lot that may not apply to you, we have removed a few small parts. If you have any questions or want to know more about anything in this Notice, please ask our Privacy Officer for more explanations or more details.

B. What we mean by your medical information

Each time you visit us or any doctor's office, hospital, clinic, or any other what are called "healthcare providers" information is collected about you and your physical and mental health. It may be information about your past, present or future health or conditions, or the tests and treatment you got from us or from others, or about payment for healthcare. The information we collect from you is called, in the law, PHI which stands for **Protected Health Information.** This information goes into your **medical or healthcare record** or file at office.
In this office this PHI is likely to include these kinds of information:
• Your history. As a child, in school and at work, marriage and personal history.
• Reasons you came for treatment. Your problems, complaints, symptoms, or needs.
• Diagnoses. Diagnoses are the medical terms for your problems or symptoms.
• A treatment plan. A list of the treatments and any other services which we think will be best to help you.

•Progress notes. Each time you come in we write down some things about how you are doing, what we notice about you, and what you tell us.
•Records we get from others who treated you or evaluated you.
•Psychological test scores, school records, or others.
•Information about medications you took or are taking.
•Legal matters
•Billing and insurance information

This list is just to give you an idea and there may be other kinds of information that go into your healthcare record here.

We use this information for many purposes, we may use it:
•To plan your care and treatment.
•To decide how well our treatments are working for you.
•If we talk with other healthcare professionals who are also treating you such as your family doctor or the professional who referred you to us.
•To show that you actually received the services from us which we billed to you or to your health insurance company.
•For teaching and training other healthcare professionals.
•For medical or psychological research.
•For public health officials trying to improve health care in this area of the country.
•To improve the way we do our job by measuring the results of our work.
When you understand what is in your record and what it is used for you can make better decisions about whom, when, and why others should have this information.

Although your health record is the physical property of the healthcare practitioner or facility that collected it, the information belongs to you. You can read it and if you want a copy we can make one for you (but may charge you for the costs of copying and mailing, if you want it mailed to you). In some very rare situations you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing you can ask us to amend (add information to) your record although in some rare situations we don't have to agree to do that. If you want, our Privacy Officer, whose name is at the end of this Notice, can explain more about this.

C. Privacy and the laws

We are also required to tell you about privacy because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).The HIPAA law requires us to keep your Protected Healthcare Information (or PHI) private and to give you this notice of our legal duties and our privacy practices which is called the **Notice of Privacy Practices** (or **NPP).** We will obey the rules of this notice as long as it is in effect but if we change it the rules of the new NPP will apply to all the PHI we keep. If we change the NPP we will post the new Notice in our office where everyone can see. You or anyone else can also get a copy from our Privacy Officer at any time and it will be posted on our website at hplakeland.com.

D. How your protected health information can be used and shared

When your information is read by me or others in this office and used by us to make decisions about your care, that is called, in the law, "**use**." If the information is shared with or sent to outside this office, that is

called, in the law, "**disclosure**." Except in some special circumstances, when we use your PHI here or disclose it to others we share only the **minimum necessary** PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, how it is used and to have a say in how it is disclosed (shared) and so we will tell you more about what we do with your information.

We use and disclose PHI for several reasons. Mainly, we will use and disclose it for routine purposes and we will explain more about these below. For other uses we must tell you about them and have a written Authorization from unless the law lets or requires us to make the disclosure without your authorization. However, the law also says that there are some uses and disclosures that don't need your consent or authorization.

1. Uses and disclosures of PHI in healthcare *with your consent*

After you have read this Notice you will be asked to sign a separate **Consent form** to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for our services, or some other business functions called health care **operations**. Together these routine purposes are called TPO and the Consent form allows us to use and disclose your PHI for TPO. Take a minute to re-read that last sentence until it is clear because it is very important. Next we will tell you more about TPO.

1a. For treatment, payment, or health care operations.

We need information about you and your condition to provide care to you. You have to agree to let us collect the information and to use it and share it to care for you properly. Therefore you must sign the Consent form before we begin to treat you because if you do not agree and consent we cannot treat you.

When you come to see us, several people in our office may collect information about you and all of it may go into your healthcare records here. Generally, we may use or disclose your PHI for three purposes: treatment, obtaining payment, and what are called healthcare operations. Let's see what these mean.

For treatment

We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of our services.

We may share or disclose your PHI to others who provide treatment to you. We are likely to share your information with your personal physician. If you are being treated by a team we can share some of your PHI with them so that the services you receive will work together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record and so we all can decide what treatments work best for you and make up a Treatment Plan. We may refer you to other professionals or consultants for services we cannot provide. When we do this we need to tell them some things about you and your conditions. We will get back their findings and opinions and those will go into your records here. If you receive treatment in the future from other professionals we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment

We may use your information to bill you, your insurance, or others so we can be paid for the treatments we provide to you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we meet, your progress, and other similar things.

For health care operations

There are a few other ways we may use or disclose your PHI for what are called health care operations. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

1b. Other uses in healthcare

Appointment Reminders. We may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work or prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment Alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

Other Benefits and Services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Research. We may use or share your information to do research to improve treatments. For example, comparing two treatments for the same disorder to see which works better or faster or costs less. In all cases your name, address and other personal information will be removed from the information given to researchers. If they need to know who you are we will discuss the research project with you and you will have to sign a special Authorization form before any information is shared.

Business Associates. There are some jobs we may hire other businesses to do for us. In the law, they are called our Business Associates. Examples may include a copy service to make copies of your health records or a billing service that figures out, prints, and mails our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy they have agreed in their contract with us to safeguard your information.

2. Uses and disclosures require your *Authorization*

If we want to use your information for any purpose besides the TPO or those we described above we need your permission on an **Authorization form.** We don't expect to need this very often.
If you do authorize us to use or disclose your PHI, you can revoke (cancel) that permission, in writing, at any time. After that time we will not use or disclose your information for the purposes that we agreed to. Of course, we cannot take back any information we had already disclosed with your permission or that we had used in our office.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receiving a copy of the current Notice of Privacy Practices, established by Highland Park Counseling Center. This signed, dated form will form will become a part of the client record. If you have any questions regarding this form or the attached Notice, please contact the Privacy Officer at the phone number given below.

You may refuse to sign this form without any penalty.

Please print your name and date of birth and then sign below.

_____ _____

Printed Name (client) Date of Birth (client)

_____

Signature (client)

_____ _____

Printed Name (client) Date of Birth (client)

_____

Signature (client)

_____ _____

Printed name of legal representative if client is under 18 Relationship to Client

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hearby authorize Highland Park Counseling Center to release to the following:

_____

- ☐ All mental health treatment information
- ☐ Financial Information
- ☐ Appointment Times

_____

- ☐ All mental health treatment information
- ☐ Financial Information
- ☐ Appointment Times

For office use only

I was unable to obtain the client or representative's signature because:

- ☐ emergency treatment
- ☐ client refused to sign
- ☐ client discontinued treatment before form was presented
- ☐ Other _____

_____

Counselor's Signature and Credentials

Privacy Officer: Rowena Barnett, M.A.,LMHC
Physical Address: 4730 Lakeland Highlands Rd., Lakeland, Florida 33813
Telephone: (863) 619-7690

MISSION AND POLICY STATEMENTS

Dear Client,

We want to welcome you to the Counseling Center at Highland Park Church. This document is intended to inform you of our policies, state and federal laws, and your rights and responsibilities as a client. Please read this overview carefully, indicate you have read and understand our policies by signing your name and initialing in the spaces provided. All participants, including children, should be made aware of these policies.

MISSION STATEMENT

Our mission is to assist individuals with emotional, mental, relational, and spiritual needs in order to achieve their dreams, meaning and purpose in life, and to improve their overall quality of life. We do so by providing cost-effective, professional counseling within a holistic, Christian environment.

We believe all matters of faith and conduct must be evaluated on the basis of the Holy Bible, which is our infallible guide (2 Timothy 3:16-17). Since the Bible does speak to the nature of human beings and their sexuality, it is imperative that we correctly understand and articulate what the Bible teaches on these matters. We are committed to home and family as set forth in our Holy Scripture.

We believe that God has ordained and created marriage to exist between one man and one woman, with absolute marital fidelity. The Bible does set forth specific home and family values. Highland Park Counseling Center agrees with the guidelines of the Covenant of Christian Conduct from the Manual of the Church of the Nazarene and the Articles of Faith presented in the Manual of the Church of the Nazarene. It is also our firm conviction that we uphold the dignity of each individual as we embrace the unchanging and longstanding principles of truth.

POLICIES

Therapy:
All counseling sessions are approximately 45-50 minutes in length (although the first session may take a little longer). Follow-up appointments vary in schedule from weekly, biweekly, monthly, or bi-monthly and are determined on a case-by-case basis. You may discontinue counseling at any time; however we recommend you attend a final session for closure.

Counselor Experience and Credentials:
Our professional counselors are licensed or licensed-eligible in the State of Florida, meaning they hold a minimum of a Master's Degree in Counseling with 1,000+ hours of clinical experience. Our counselors are required to follow biblical standards of morality and the guidelines of conduct established in the Manual of the Church of the Nazarene, as well as state laws and codes of ethics established within the professions and respectfully represent Highland Park Church to the community. Please read your counselor's **Professional Disclosure Statement** for more information regarding their experience and credentials.

Counseling Benefits and Fees:
Services are provided on a fee-for-service basis. Highland Park Counseling Center does not file insurance claims for services rendered. It is the client's responsibility to contact insurance companies regarding possible coverage options. Session fees range from $90 to $115. Counseling services are offered at reduced rates for members of the congregation. Sessions are 45-50 minutes long. Counseling materials such as workbooks or recommended books are not included.

Payment:

It is customary to pay for professional services when rendered, which is consistent with Scriptural principles (Romans 13:7-8). Consistent payment must be made or services may be discontinued. In the event an individual cannot make payment for a particular session, he/she should discuss with the counselor in advance in order to work out a solution. Payment may be made in the form of **credit card, cash** or **check** made payable to Highland Park Church (**HPC**). In the event of checks returned due to insufficient funds, a $25.00 service charge will be billed to the client and counselors may require future sessions to be paid in cash.

Client's Rights:

Each individual who seeks counseling has certain individual rights afforded to him or her. They are:

- The right to be fully informed about the counselor's qualifications, training and experience.
- The right to have the counselor available at the appointed time agreed upon in advance.
- The right to question the counselor in regard to his or her style and method of counseling.
- The right to discontinue counseling at any time. Please schedule a termination session.

Client's Responsibilities:

Each client who seeks counseling has certain individual responsibilities. Clients are responsible to:

- Arrive for the counseling session on time to receive maximum benefit from the full session. The 45-50 minutes begins and ends at the designated appointment time, even if the client is late, and the clients will be required to pay the full fee.
- Engage in the counseling process: Attending sessions on time, developing and implementing treatment plan and recommendations, completing assigned homework, and attending referral appointments (if applicable).
- Pay for services rendered.
- Call and reschedule a new appointment if they cancel.
- Attend sessions and terminate counseling appropriately.

Missed Appointments and Last Minute Cancellations:

Please make every effort to attend scheduled appointments. If you need to cancel an appointment, please give notice **at least 24 hours prior to your appointment. If you cancel the same day as your appointment or do not show up for your appointment, you will be charged your full session fee or $55, whichever is less.** Please be advised that in order to make your first appointment, you will be required to authorize a valid credit card to be kept on file. This credit card will be maintained in strict confidentiality. If you have a "No Show" or late cancellation, your credit card will be automatically charged. If you accrue an outstanding balance or missed appointment fee, payment must be received prior to scheduling your next appointment. If two appointments are missed without proper notification, the counselor reserves the right to discontinue counseling due to noncompliance. This policy is not meant to be punitive, but instead is to request consideration for the professionals who are providing you and the community a valuable service. Your appointment time is reserved for you at the exclusion of others who may be waiting to see the counselor. Since Highland Park Counseling Center is a fee for service provider, your late cancellation or failure to show for an appointment may result in a loss of income for the counselor and also may keep others from getting the help they desire. In the even your counselor misses an appointment due to illness or emergency, your counselor will make up the session. **Initials:** _____

Children:

The counseling center is not staffed to provide supervision of children under the age of 18 while parents are involved in counseling sessions. If you have children, please find someone to care for your children while you are in session. If the client is a child and needs to be involved in the session, it may be necessary to have a friend or family member come along to sit with the child while parents are consulting with the counselor to have some conversations without the child present. Please discuss the best course of action with your counselor. **Initials:** _____

Confidentiality:
What you say in counseling is confidential, or secret. Counselors maintain a file on each client in accordance with Florida Law (See Notice of Privacy Practice for details). Information is stored in a locked filing cabinet in a locked office. All electronic documents are stored on a secure server. Your counseling records are protected under state and federal law. Specific exceptions to confidentiality are listed below:

- Potential threat of harm to self, harm to others, abuse and/or neglect situations involving children, aging adults or dependent individuals.
- Court orders or federal investigations.
- When you agree to the Couples/Family waiver in writing. When more than one person in a family is receiving therapy, each family member must agree to the waiver in writing. (Clients 12 years of age and over must also sign for themselves).
- Some counselors are under supervision as required by Florida law, and may speak with his or her supervisor regarding your case. The counselor will inform you if he or she is under supervision.

Client Communication:
Phone calls, email and text messages are only used for scheduling or canceling appointments. Counseling will not be conducted over the phone. Your counselor or the appointment scheduler will only leave a message in the event you have notified your counselor that it is a secure line.

Audio/Video Recording:
Counseling sessions may be recorded for training and/or review of the session. This will only happen with your consent, and your counselor will let you know in advance. Recordings may be reviewed by your counselor and/or his or her supervisor. All records are stored in a locked filing cabinet in a locked office. I grant permission to be audio/video recorded: ☐ Yes ☐ No **Initials:** _____

Coordination of Care:
Your previous mental health records are important in providing us with a complete picture of your past treatment. Please consider providing those records to your counselor at the intake appointment. You may request a **Release of Information** from the counseling office to expedite the retrieval of your records.
We trust your experience with Highland Park Counseling Center will be fruitful. God bless you in your journey!

"BUT TRUE WISDOM AND POWER ARE WITH GOD; COUNSEL AND UNDERSTANDING ARE HIS." JOB 12:13

By affixing My electronic signature below, I acknowledge that I have read and understand Highland Park Counseling Center's Mission and Policy Statements. This signed form will become a part of the client file. Children age 12 and over must also sign.

Please print your name and date of birth, and then sign on the line below.

_____ _____
Printed Name (Client/Legal Representative) Date of Birth (Client)

_____ _____
Signature (Client/Legal Representative) Today's Date

_____ _____
Printed Name (Client/Legal Representative) Date of Birth (Client)

_____ _____
Signature (Client/Legal Representative) Today's Date

(If you are the legal representative of the client, please print your name and relationship to client)
If client is under the age of 18, a parent/guardian must also sign below:

_____ _____
Parent/Guardian Signature Relationship to client Today's Date

Highland Park Church
4777 Lakeland Highlands Road • Lakeland, Florida 33813
863-647-3518 hplakeland.com highlandparkchurch

INFORMED CONSENT FOR TREATMENT

In response to my/our request for counseling services, this acknowledges that I/we have read, received and reviewed the Highland Park Counseling Center **Mission and Policy Statements**. I/We understand the expectations, policies, and procedures of Highland Park Counseling Center. I/We agree to accept and abide by the policies and procedures as I/ we obtain counseling services through Highland Park Counseling Center. I/We specifically understand and accept my/ our rights and responsibilities related to privacy, scheduling and cancellation of services, and payment of professional fees.

Court appearances: If for any reason, your counselor is asked to be a witness for any litigation or legal proceedings, I/we agree in advance that I/we will compensate the counselor, at the rate of $200/hour, for any and all time expended in response to the request for release of information, phone consultation, preparation of documents, court time, all travel time (portal to portal), plus cost of any legal services which he/she may employ.

By signing below, I/we **accept**, **understand**, and **agree** to abide to the contents and terms of this agreement, and I/ we consent to counseling services as provided by said Counseling Center. This signed form will become a part of the client file. Please print your name(s) and date(s) of birth, then sign below.

_____ _____
Printed Name (Client) Date of Birth

_____ _____
Signature (Client) Today's Date

_____ _____
Printed Name (Client) Date of Birth

_____ _____
Signature (Client) Today's Date

If client is under the age of 18, a parent/guardian must also sign below:

I/we consent that _____(client name) may be treated as a client by_____ (counselor name).

_____ _____ _____
Parent/Guardian Relationship Date

_____ _____ _____
Parent/Guardian Relationship Date

_____ _____
Counselor's Signature and Credentials Date

Highland Park Church
4777 Lakeland Highlands Road • Lakeland, Florida 33813
863-647-3518 hplakeland.com highlandparkchurch

FINANCIAL AGREEMENT

Client Name: _____ Date of Birth: _____

(Please Print Full Name)

Client Name: _____ Date of Birth: _____

(Please Print Full Name)

Our goal is to serve the community by providing high quality, professional counseling services at an affordable cost. In order to meet the needs of the community and for the Counseling Center to be self-sufficient, Highland Park Church has established reduced-fee rates based on client status (or client's legal guardian). At this time we require payment in the form of **cash, credit/debit card** or **check** made payable to **Highland Park Church.** The Counseling Center does not file insurance claims, but you may check with your insurance carrier and request out-of-network coverage for licensed providers. Fees for each session will be due and **payable at the time of check-in** unless a previous arrangement has been agreed upon. We reserve the right to discontinue treatment in the event of refusal to pay for services.

Fees are based on client status and determined by HPC staff in accordance with current church records.

- [ ] Member/Regular Attender of Highland Park Church (verified with church records)
- [ ] Contracted Churches): i.e., TBA Church, etc. (agreement on file)
- [ ] Community

Initials	*Please initial in the appropriate area and sign below*	*Cost*
	Fee for Services Agreement: Based upon client status and my current financial situation, I agree to pay at least the following amount per session:	$
	Other: Counseling materials (eg. Workbooks, AD/HD and other clinical assessments)	$ Varies
	Other: Consultation Fee (eg. Meetings with School Counselors or other professionals)	$ Varies

I understand that payment is due for services rendered, and further agree that if my financial situation changes, either improved or worsened, I will contact my counselor and make further arrangements. I acknowledge that I will receive a copy of this contract upon my request and agree to pay for services as arranged.

By signing below, I agree to this Financial Agreement, and accept full responsibility for payment of services rendered.

_____ _____ _____

Client Signature (or legal representative of the client) Print Name Date

_____ _____ _____

Client Signature (or legal representative of the client) Print Name Date

_____ _____ _____

Witness Signature (or legal representative of the client) Print Name Date

In the event of checks returned due to insufficient funds, a $25.00 service charge may be billed to the client. Our fee is reduced from a reasonable rate of $125.00 per session, and based on 45-50 minute sessions. Once signed, this Financial Agreement is binding between client and HPC. Highland Park Counseling Center reserves the right to change this fee agreement at any time for new clients. No Shows, i.e. failure to cancel an appointment within 24 hours, will be billed at the rate of $55.00 per session missed.

Counseling

AUTHORIZATION TO KEEP CREDIT CARD NUMBER ON FILE

Client Name: _____

Card Type : ☐ Mastercard ☐ Visa ☐ American Express ☐ Discover

Card Number: _____

Expiration Date: _____ CVV/CCV _____ *(back of card)*

Billing Address for Card: _____

By signing or typing my electronic signature below, I certify that I am an authorized signer of the credit card detailed above. I authorize Highland Park Counseling Center to charge my card for late cancel/no-show fees as stated in the Mission and Policy Statement below.

_____

Signature

_____

Date

Mission and Policy Statement:
Please make every effort to attend scheduled appointments. If you need to cancel an appointment, please give notice at least 24 hours prior to your appointment. If you cancel the same day as your appointment or do not show up for your appointment, you will be charged your full session fee or $55, whichever is less. Please be advised that in order to make your first appointment, you will be required to authorize a valid credit card to be kept on file. This credit card will be maintained in strict confidentiality. If you have a "No Show" or late cancellation, your credit card will be automatically charged.

I wish to receive receipts: ☐ Yes ☐ No

I wish to use the credit card, listed above, to cover my session fee: _____ *(initial here)*

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Professional Disclosure Statement
Clifford J. Hurndon, Ph.D.
FL Licensed Psychologist
Qualified Supervisor (PY8587)

I am pleased that you have selected me as your mental health provider. This document is to provide you with information regarding my background and increase your understanding of our professional relationship.

I hold the following degrees & certifications:

- B.A. in Psychology, University of Notre Dame, 1975
- M.A. in Counseling Psychology, The Ohio State University, 1977
- Ph.D. in Counseling Psychology, The Ohio State University, 1979

I am currently active as a clinical supervisor of registered interns in mental health counseling, a consultant for local church-based counseling practices, and a part-time practicing psychologist in Central Florida. I retired as a Full Professor from the faculty at Southeastern University in 2019 after 13 years of teaching and administrative oversight of the graduate program in Counselor Education in the Department of Behavioral and Social Sciences. My prior 20 years of clinical experience as a licensed psychologist took place at a public institute for physical rehabilitation, a church-supported counseling practice, and other community practices in North Carolina. In all, I have been a licensed psychologist for over 40 years.

I have a passion for mentoring and supporting therapists who have both excellent clinical and professional competence and a desire to maintain and integrate their personal Christian faith in their given practice settings. I believe that for those who are called to this "ministry" of professional counseling, a Christian spiritual foundation and sound psychological and clinical preparation are not contradictory with a genuine life of faith. Rather, these integrated perspectives are important gifts to be used by Christians within or outside of church communities who need or desire mental health services.

I am open to serving individuals, couples, families, and older adolescents in the following areas:

- Depression
- Marital Counseling/Therapy
- Family Issues
- Grief/Loss
- Health and Disability Issues
- Anxiety and Stress
- Life Transitions
- Trauma Recovery
- Spiritual Issues
- Geriatric issues: Physical, Neurological, and Cognitive

PSYCHOSOCIAL HISTORY

*Please complete this form before your first appointment. All information will be held **confidential** in accordance with State and Federal Law. Please print legibly in **ink**. Use additional paper if necessary.*

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Race: _____ Gender: _____

History of the Problem

Please describe the primary reason you are seeking counseling (problem statement): _____
_____
Approximately when did this problem begin (estimated date of onset): _____
When is your problem absent or less severe? _____

Are you currently, or have you recently been having, thoughts of suicide? _____
Have you made any recent attempts on your life? _____
If yes, please describe: _____

Previous Treatment

Have you received counseling or medication for this *or other* issues (including support groups)?
Yes ____ No ____ If yes, please list Counselor/Doctor name, address, telephone number:
_____
Reason: _____ Approximate dates: _____
_____
Reason: _____ Approximate dates: _____

Have you ever been hospitalized for psychiatric reasons? Yes ____ No ____. If yes, please list:
Hospital/Treatment Center, City, State/Reason/Approximate Dates
_____
What would you like to accomplish in counseling? (Goals) _____
_____

How committed are you to working toward personal growth and change at this time?
Very Uncommitted ____ Uncommitted ____ Neutral ____ Committed ____ Very Committed ____

Substance Use:

Do you use caffeine?	Daily ____	Frequently ____	Sometimes ____	Rarely ____	Never ____
Do you smoke cigarettes?	Daily ____	Frequently ____	Sometimes ____	Rarely ____	Never ____
Do you drink beer or wine?	Daily ____	Frequently ____	Sometimes ____	Rarely ____	Never ____
Do you drink hard liquor?	Daily ____	Frequently ____	Sometimes ____	Rarely ____	Never ____
Do you use drugs?	Daily ____	Frequently ____	Sometimes ____	Rarely ____	Never ____

Please list any drugs you currently use or have used in the past: _____

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Counseling

Mental/Behavioral Health – Symptom Check

Have you or your family ever experienced (Indicate **P** for past, **C** for Current, & Family Member):

You (**P**ast/**C**urrent)	Family Member	You (**P**ast/**C**urrent)	Family Member
_____ Depression	_____	_____ Anger Management Problems	_____
_____ Low Energy	_____	_____ Anxiety/Panic Attacks	_____
_____ Poor Concentration	_____	_____ Job Stress/Career Issues	_____
_____ Low Self Esteem	_____	_____ Obsessive Thoughts	_____
_____ Feelings of Hopelessness	_____	_____ Compulsive Behaviors	_____
_____ Feelings of Worthlessness	_____	_____ Unresolved Grief Reaction	_____
_____ Excessive Guilt	_____	_____ Divorce/Separation	_____
_____ Sleep Disturbance	_____	_____ Appetite Disturbance	_____
_____ Excessive Worrying	_____	_____ Eating Disturbance	_____
_____ Thoughts of Harming Yourself	_____	_____ Sexual Problems	_____
_____ Suicide Attempt	_____	_____ Homosexuality Concerns	_____
_____ Thoughts of Harming Others	_____	_____ Use of Pornography (self/spouse)	_____
_____ Social Isolation	_____	_____ Adult Abuse	_____
_____ Communication Difficulties	_____	_____ Traumatic Experience	_____
_____ Family Conflict	_____	_____ Childhood Abuse/Neglect	_____
_____ Marital Problems	_____	_____ Excessive Use of Alcohol/Drugs	_____
_____ Legal Problems	_____	_____ Spiritual Concerns	_____

Please explain any items you marked above. Use the back of this form if needed.

_____

_____

Medical/Physical Health

Please list any current medical problems/diagnoses whether or not you are receiving treatment:

Medical Diagnoses/Condition: Medication/Treatment:

_____

_____

Please list **all major** surgeries, illnesses, head injuries, accidents, or hospitalizations **AND** dates:

_____

_____

Date and reason for last doctor's visit: _____

Who is your primary care physician (name/address)? _____

_____

Do you have any allergies or adverse reactions to medications? Yes ____ (List Below) No ____

_____

Please list all current medications and the prescribing Physician:

Physician _____ Medication _____ Dosage _____

Side Effects _____ Results: Good – Fair – Poor

Physician _____ Medication _____ Dosage _____

Side Effects _____ Results: Good – Fair – Poor

Please use back of this form to list multiple medications

Females only: Are you pregnant? Yes ____ No _____ Regular Menstruation? Yes____No_____

Number of pregnancies: _____Miscarriages: _____ Abortions: ____

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Family History

Marital Status with the year: Single _____ Married _____ Divorced _____ Widowed _____
Spouse's Name: _____ Spouse's Occupation: _____
How many children do you have? Boys: _____ Girls: _____
Do your children reside with you? _____ If no, with whom do they reside and why?
_____
Names of your children, ages and birthdates:
_____
_____
Are your parents still living? Mother _____ Father _____ Married _____ years/divorced
How many siblings do you have? _____ Names and ages: _____
Please list any immediate family members who have passed away, and the year: _____
_____

Social/Legal History

Are you involved in any social clubs or small groups (list) _____
List hobbies, recreational activities: _____
Have you ever been arrested, or convicted of a crime? Yes ____ No ____ If yes, please list date, crime committed, and current status of your case: _____
Do you have any other legal issues pending? _____

Educational/Occupational History

How many years of school have you completed? GED ____ High School ____ Trade School ____
Certificate ____ Bachelors ____ Masters ____ Doctorate ____ Currently a student ____
What is your degree/major? _____
Who is your employer? _____
What is your current occupation? _____
How satisfied are you with your current occupation/career?
Very Dissatisfied ____ Dissatisfied ____ Neutral ____ Satisfied ____ Very Satisfied ____
Please list past occupations: _____
_____

Spiritual History

What is your religious affiliation/denomination? _____
Do you have a home church? Yes ____ No ____ If yes, church name: _____ Pastor: _____
How often do you attend church? _____
How often do you read your Bible/pray/meditate? _____
How satisfied are you with your spiritual life?
Very Dissatisfied ____ Dissatisfied ____ Neutral ____ Satisfied ____ Very Satisfied ____
What was the spiritual climate of your family growing up? _____
_____

Please add any additional information/comments that you think would be helpful on the back.

_____ _____
Client Signature *Date*

_____ _____
Counselor Signature *Date*

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Do you drink beer or wine?	Daily ____	Frequently ____	Sometimes ____	Rarely ____	Never ____
Do you drink hard liquor?	Daily ____	Frequently ____	Sometimes ____	Rarely ____	Never ____
Do you use drugs?	Daily ____	Frequently ____	Sometimes ____	Rarely ____	Never ____

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_____ Communication Difficulties	_____	_____ Traumatic Experience	_____
_____ Family Conflict	_____	_____ Childhood Abuse/Neglect	_____
_____ Marital Problems	_____	_____ Excessive Use of Alcohol/Drugs	_____
_____ Legal Problems	_____	_____ Spiritual Concerns	_____

Please explain any items you marked above. Use the back of this form if needed.

_____

_____

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Please list any current medical problems/diagnoses whether or not you are receiving treatment:

Medical Diagnoses/Condition: Medication/Treatment:

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Date and reason for last doctor's visit: _____

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_____

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Physician _____ Medication _____ Dosage _____

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_____
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Please list any immediate family members who have passed away, and the year: _____
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List hobbies, recreational activities: _____
Have you ever been arrested, or convicted of a crime? Yes ____ No ____ If yes, please list date, crime committed, and current status of your case: _____
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How many years of school have you completed? GED ____ High School ____ Trade School ____
Certificate ____ Bachelors ____ Masters ____ Doctorate ____ Currently a student ____
What is your degree/major? _____
Who is your employer? _____
What is your current occupation? _____
How satisfied are you with your current occupation/career?
Very Dissatisfied ____ Dissatisfied ____ Neutral ____ Satisfied ____ Very Satisfied ____
Please list past occupations: _____
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How satisfied are you with your spiritual life?
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What was the spiritual climate of your family growing up? _____
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Please add any additional information/comments that you think would be helpful on the back.

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Client Signature *Date*

_____ _____
Counselor Signature *Date*

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LIMITATION ON CONFIDENTIALITY WHEN PROVIDING THERAPY TO COUPLES OR FAMILIES

This written policy is intended to inform you, the participants in therapy, that when I, Clifford J. Hurndon, Ph.D., Licensed Psychologist, agree to treat a couple or family (the treatment unit) and there is a request for the treatment records of the couple or the family:

- I will seek authorization of all members of the treatment records of the couple or the family;
- I will seek authorization of all members of the treatment unit before I release confidential information to third parties;
- If my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as part of the work with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that:

- I will not release any confidential information to a third party unless I am required by law to do so, or unless I have your written authorization.
- Since those sessions can and should be considered part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, and if I am to effectively serve the unit being treated:

- I will use my best judgment as to whether, when, and to what extent, I will make disclosures to the treatment unit;
- I will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure.

Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For example, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

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We, the members of the _____(couple/family or other unit) being seen, acknowledge by our individual signatures below, that we, each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with **Clifford J. Hurndon, Ph.D.**, and that we enter couple/family therapy in agreement with this policy.

Signature:_____ Dated:_____

Signature:_____ Dated:_____

COUPLE/FAMILY AGREEMENT

We, _____, agree to be as honest as possible in our discussions as part of our attempt to improve our relationship. This may mean that difficult or embarrassing events may be discussed. The reason we are in counseling is to improve and save our relationship, and bring our relationship in focus. We agree to respect one another, and not to hurt one another as feelings are expressed in therapy. We agree to do all our assignments which our therapist may ask us to do during the times we are not in session. We understand that in order for our relationship to get better, it is up to us, and not the therapist. It is our job to rediscover the love in our family/marriage.

In the event of divorce, we agree not to use the therapy (progress) notes of Clifford J. Hurndon Ph.D. FL Licensed Psychologist against each other for any reason (e.g. child custody, divorce legal proceedings, etc.)

Signature_____
Dated:_____

Signature_____
Dated:_____

Witness _____ **Dated:**_____

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