



COUPLES INTAKE FORM

(Please Print)

Date: / /		How did you hear about us?				
<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	Full Name (<i>Last</i>)	(First)	(Middle)		
<input type="checkbox"/> Ms.	<input type="checkbox"/> Dr.					
<input type="checkbox"/> Miss.	<input type="checkbox"/> Rev.					
Nick Name:		Name You Prefer:		Birth date:	Age:	Sex:
				/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian/Power of Attorney: (if applicable)		Social Security# (Insurance clients only)		Race:		
		- -		<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hispanic		
CONTACT INFORMATION						
Street address:			Suite/Apartment Number:			
City:		State:	ZIP Code:	May We Send Mail Here: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mailing Address or Post Office Box:						
City:		State:	ZIP Code:	May We Send Mail Here: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Home Phone:	()				May We Leave a Message Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mobile Phone:	()				May We Leave a Message Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Phone:	()				May We Leave a Message Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address:	()				May We Send Email Here: <input type="checkbox"/> Yes <input type="checkbox"/> No	
EMERGENCY CONTACT						
Name:			Relationship:			
Home Phone: ()			Mobile Phone: ()			
EMPLOYMENT INFORMATION						
Employer:			Length of Employment:			
Occupation:			Average Hours Worked Per Week:			
Annual Combined Household Income :		<input type="checkbox"/> Below \$80,000	<input type="checkbox"/> \$80,001 to \$90,000	<input type="checkbox"/> \$90,001 to \$100,000		
		<input type="checkbox"/> \$100,001 to \$110,000	<input type="checkbox"/> \$110,001 to \$120,000	<input type="checkbox"/> \$120,001 to \$130,000		
		<input type="checkbox"/> \$130,001 to \$140,000	<input type="checkbox"/> \$140,001 to \$150,000	<input type="checkbox"/> Above \$150,000		
EDUCATION INFORMATION						
(Circle) Last Year of School Completed: 9 10 11 12 GED			College: 1 2 3 4		Other: _____	
Are You Currently in School? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, What School: _____			
RELATIONAL INFORMATION						
Current Status:				Are You Content with Your Current Status? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Single <input type="checkbox"/> Dating <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living together				If No, Briefly Explain: _____		
If Married, How Long: _____		Number of Previous Marriages for You: _____		For Your Partner: _____		
If Separated or Divorced, How Long: _____		If Widowed, How Long: _____				



Partner's Name (<i>Last, First, Middle</i>): _____	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.
	<input type="checkbox"/> Ms.	<input type="checkbox"/> Dr.
	<input type="checkbox"/> Miss.	<input type="checkbox"/> Rev.

How long Have You Known Your Partner: _____	Age: _____	Preferred Name: _____
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Partner's Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hispanic	Partner's Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Partner's Occupation: _____ Average Hours Worked Per Week: _____
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(Circle) Last Year of School Partner Completed: 9 10 11 12 GED	College: 1 2 3 4	Other: _____
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What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Partner Doesn't Know	With Whom Do You Currently Live (<i>Check All that Apply</i>): <input type="checkbox"/> Alone <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Girlfriend <input type="checkbox"/> Roommate <input type="checkbox"/> Parent(s) <input type="checkbox"/> Sibling(s) <input type="checkbox"/> Other: _____
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CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You <i>(Natural, Adopted, Step)</i>	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: Yes No If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: Yes No If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, & Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You <i>(Mom, Dad, Sibling, Step)</i>	Occupation	Describe Him/Her



PRIMARY PHYSICIAN INFORMATION

Primary Physician:		Phone: ()	
Address:		City:	Zip:
Specialty (e.g. Family Practice, OB/GYN, Internal Medicine):			Date of last physical:
Are You Currently Receiving Medical Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Please Specify: _____	
List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (Use Back if Necessary): _____			

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ Improves Prevents Controls: _____

Medication: _____ Dosage: _____ Improves Prevents Controls: _____

Are You Taking these Medication(s) According to Your Doctor's Recommendations: Yes No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Dizziness ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Stomach Trouble ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Visual Trouble ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Sleep Trouble ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Trouble Relaxing ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Weakness ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Tension ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Rapid Heart Rate ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Difficulty Breathing ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Intestinal Trouble ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Hearing Noises ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Change in Appetite ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Tiredness ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Pain ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Hearing Voices ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Seeing Things ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Other ----- <input type="checkbox"/> Past <input type="checkbox"/> Present

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You:

Stress ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Nervousness ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Anxiety ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Panic ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Unhappiness ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Depression ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Guilt ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Apathy ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Terminal Illness ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Recent Death ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Grief ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Hopelessness ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Inferiority Feelings ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Defective Feelings ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Loneliness ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Shyness ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Fears ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Friends ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Marriage ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Communication ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Physical Abuse ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Emotional Abuse ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Verbal Abuse ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Sexual Abuse ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Temper ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Anger ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Aggressiveness ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Bad Dreams ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Concentration ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Racing Thoughts ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Unwanted Thoughts ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Memory ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Loss of Control ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Impulsive Behavior ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Self-Control ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Compulsivity ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Sexual Problems ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Pregnancy ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Abortion ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Legal Matters ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Trauma ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Eating Problems ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Drug Use ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Alcohol Use ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Trouble with Job ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Career Choices ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Ambition ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Making Decisions ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Children ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Being a Parent ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Finances ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Recent Loss ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Disaster ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Smoke Cigarettes ----- <input type="checkbox"/> Past <input type="checkbox"/> Present
Self-Harm ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Hi Risk Behavior ----- <input type="checkbox"/> Past <input type="checkbox"/> Present	Zoning/blanking out ----- <input type="checkbox"/> Past <input type="checkbox"/> Present

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1 = Very' Little Distress; 10 = Extreme Distress):

1 2 3 4 5 6 7 8 9 10

Are You Currently Having Any Suicidal Thoughts? Yes No Have You Having Them in the Past? Yes No

Have You Ever Attempted Suicide: Yes No If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: Yes No

If Yes, When and Who: _____



PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling (i.e. What Are Your Issues, Problems?): _____

Why Have You Decided to Come for Counseling Now: _____

What Do You Hope to Gain or Change by Coming for Counseling: _____

How Long Do You Believe Counseling Should Last: _____

Activities, Interests and Strengths:

1. What are your Strengths? _____
2. What are your Needs? _____
3. What are your Abilities? _____
4. What are your Preferences, if any? _____

What issues could inhibit progress towards treatment? _____

During the last 12 months, any behaviors concerning to you when trying to stop/cut down on spending? Describe briefly: _____

During the last 12 months, have you experienced challenges with avoiding family/friends from observing how much you are spending? Describe briefly: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (*Use Back If Necessary*):

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

Please describe your religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of? _____

Church attendance? If so, what is the name? _____

Would you like spiritual principles incorporated into your counseling? Yes No

If yes, at what level? Minimally Occasionally Often Very Often Intensively

TERMS OF SERVICE

I hereby give Milestone Counseling permission to provide counseling services for the patient mentioned above:

Signed: _____ Date: _____



RELATIONSHIP QUESTIONNAIRE

This questionnaire is intended to estimate the current satisfaction with your relationship. Circle the number between 1 (completely satisfied) to 10 (completely unsatisfied) beside each issue. Focus on the present & not the past.

1. List the things that your partner does that please you:

2. What would you like your partner to do more often?

3. What would your partner like you to do more often?

4. How do you contribute to difficulties in the relationship?

5. What are you prepared to do differently in the relationship?

6. Is there a problem of alcohol/substance abuse?

7. Have you or your partner participated in any of the following activities:
 Swinging Masturbation
 Pornography Extra-Marital Affair
 Fetishes Compulsions/Addictions: (Specify) _____

8. Do you often try to anticipate your partner's wishes so that you can please them?

9. What are your goals or what do you hope to accomplish?



CIRCLE THE APPROPRIATE RESPONSE FOR EACH

1= Completely Unsatisfied	A Little Satisfied		5=Somewhat Satisfied			Mostly Satisfied		10= Completely satisfied		
General Relationship	1	2	3	4	5	6	7	8	9	10
Personal Independence	1	2	3	4	5	6	7	8	9	10
Spouse Independence	1	2	3	4	5	6	7	8	9	10
Couples Time Alone	1	2	3	4	5	6	7	8	9	10
Social Activities	1	2	3	4	5	6	7	8	9	10
Occupational or Academic Progress	1	2	3	4	5	6	7	8	9	10
Sexual Interactions	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
Financial Issues	1	2	3	4	5	6	7	8	9	10
Household/Yard Responsibility	1	2	3	4	5	6	7	8	9	10
Parenting	1	2	3	4	5	6	7	8	9	10
Daily Social Interaction	1	2	3	4	5	6	7	8	9	10
Trust in Each Other	1	2	3	4	5	6	7	8	9	10
Decision Making	1	2	3	4	5	6	7	8	9	10
Resolving Conflicts	1	2	3	4	5	6	7	8	9	10
Problem Solving	1	2	3	4	5	6	7	8	9	10
Support of One Another	1	2	3	4	5	6	7	8	9	10

TERMS OF SERVICE

I hereby give Milestone Counseling and its' staff permission to provide counseling services for the patient mentioned above:

Signed: _____

Date: _____



FINANCIAL POLICY

Payment Policy:

We are committed to providing you with the best possible care. Payment for service (including co-payments) are **due at the time of service.**

It is essential that you complete these forms in their entirety and provide Milestone Counseling with all the necessary information regarding ALL your insurance providers.

Our fees:

- Your Sessions are _____ per hour per fee schedule and policies
- Groups are \$_____ per hour.
- Additional counselor Service: Treatment Summary Requests, Professional Letters, Emails or Phone/Conference calls, if requested, will be billed in 15minute increments at the your therapeutic rate listed above.
- Administrative Services by staff: Letters from the front office, insurance forms, authorization requests will be billed a \$15 per 15 minutes of billable services with a \$15 minimum.
- Court Appearances and Depositions are billed door to door at \$300 per hour with a minimum \$1000 retainer.
- Returned checks are subject to a \$30 fee.
- No-show fees are charged for appointments canceled or broken without 24 hours advance notice unless there is an emergency or illness. The no-show fee is equivalent to your normal session fee.
- Insurance clients who accrue 3 no call/late call (less than 24 hours notice) or no shows for appointments may have services terminated.
- In the event there are changes to the client's insurance plan(s), co-pays, deductibles, and/or charges not paid by insurance are the responsibility of the client. A credit/debit card authorization form will be provided to pay for these charges.

Policy on Insurance Reimbursement:

If you have Insurance that provides coverage for mental health counseling, we can help you receive your maximum allowable benefits.

We will be happy to provide you with a receipt to forward to your insurance company. You are responsible for generating the claim and mailing it to the insurance company and tracking your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are considered to fall within the acceptable range by most companies, called "Usual, Customary and Reasonable" (UCR). Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.

Rate Calculation Policy:

- Mandated counseling is subject to a \$20 per hour surcharge, couples & family counseling a \$10 per hour surcharge, below \$50,000 household income, & a \$20 per hour surcharge, above \$60,000 household income.
- Mediation services are billed at \$140.00 per hour.
- Late evening appointments, 6 p.m. & later, will be subject to a \$20 per hour surcharge
- Fees listed are for one clinical one hour. Longer sessions are calculated by .5 hour increments
- Hourly fees are calculated and based on previous year's total household income and/or support from all sources including, but not limited to, hourly wages, salaries, bonuses, investment income, Social Security, disability, retirement income, child support, alimony, welfare, unemployment compensation, food stamps, public or private childcare assistance, company vehicle, public or private housing assistance, board, etc.
- Proof of income may be required. All financial information kept confidential.
- Discounts for multiple clients or weekly sessions, from the same family, may be arranged on a case by case basis.

Signature _____ Date _____



Informed Consent & Release of Liability

This form is to document that I (please print) _____ give my consent and

permission for Milestone Counseling to provide mental health therapy services to myself and/or

(please print) _____, who is my child or for whom I am legal guardian, custodian, or legal Power of Attorney.

I understand the following:

- Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
- Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
- This therapist is not providing an emergency service, and I have been informed of whom to call in an emergency or during weekend and evening hours.
- Regular attendance will produce maximum benefits, but I am free to discontinue treatment at any time.
- Conversations with the therapist will be almost always confidential. However, the therapist, by law, must report actual or suspected child, spouse, or elder abuse to the appropriate authorities. The therapist also has a legal responsibility to protect anyone I may threaten with violence, harmful, or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. The therapist will make reasonable efforts to resolve these situations before breaking confidentiality.
- I am financially responsible for this treatment and any portion of the fees not reimbursed or covered by insurance are payable by me.
- I have been informed that for the protection of clients and therapists, all sessions with persons under the age of 18 may be videotaped.
- I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.
- I acknowledge that I have the right to request a printed copy of the Milestone Counseling Client Handbook.
- I have read and received the Office Policies & General Information Agreement for Psychotherapy Services and I agree to the policies. I have also received a copy of the HIPAA Notice of Privacy Practices. I have discussed any concerns about the policies with the therapist prior to signing this consent.

Signature: _____ Date: _____



NOTICE OF PRIVACY PRACTICES

This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIP AA) 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. HIP AA provides penalties for covered entities that misuse personal health information. As required by HIP AA, 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 purposes 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 included 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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

- You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:
 - The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
 - The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
 - The right to request an amendment to your PROTECTED HEALTH INFORMATION.
 - The right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate for filing a complaint.

For more information about our Privacy Practices, please contact:
The Privacy Officer of Milestone Counseling
205 Hatteras Ave.
Clermont Fl. 34711
352-348-8858

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C 20201
877.696.6775 (toll-free)

KEEP FOR YOUR RECORDS

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.

This authorization can be used to settle any outstanding balances due, co-payments, deductibles, fees and/or charges not provided by insurance.

For your convenience, this form can be used to pay for sessions in advance, out of office appointments and/or to create a payment plan. This form will remain on file until completion of therapy and payments have been fully processed.

Credit Card Information			
Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA	<input type="checkbox"/> Discover <input type="checkbox"/> AMEX
	<input type="checkbox"/> Other _____		
Cardholder Name (as shown on card): _____			
Card Number: _____			
Expiration Date (mm/yy): _____			
Cardholder ZIP Code (from credit card billing address): _____			

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.