Gloria Rivera King, Ph.D.
Licensed Mental Health Counselor & Licensed Marriage and Family Therapist
2328 Medico Lane
Melbourne, FL 32940
Phone (321) 956-9477, Fax (321) 338-4515

CLIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

LAST 4 DIGITS OF SS NUMBER: _____

DATE OF BIRTH: _____ AGE: _____

MARITAL STATUS: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

ADDRESS: _____

CITY_____STATE_____ZIP_____

EDUCATION: _____OCCUPATION:_____

EMPLOYER: _____

IF APPLICAPLE FOR COUPLE/MARITAL COUNSELING:

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

LAST 4 DIGITS OF SS NUMBER: _____

DATE OF BIRTH: _____ AGE: _____

MARITAL STATUS: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

ADDRESS: _____

CITY_____STATE_____ZIP_____

EDUCATION: _____OCCUPATION:_____

EMPLOYER: _____

CONTACT NUMBER(s) and EMAIL ADDRESS (es):

1) HOME PHONE: _____

May we contact you/leave messages there? Yes No

2) HOME PHONE: _____

May we contact you/leave messages there? Yes No

1) WORK PHONE _____

May we contact you/leave messages there? Yes No

2) WORK PHONE _____

May we contact you/leave messages there? Yes No

1) CELL PHONE_____

May we contact you/leave messages there? Yes No

2) CELL PHONE_____

May we contact you/leave messages there? Yes No

E-MAIL ADDRESS (ES):

1)_____

May we contact you via email? Yes No

2)_____

May we contact you via email? Yes No

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____ Phone:_____

Do you/your partner have a history of medical problems? If so, please specify:

_____

_____

_____

Do you/your partner already have a mental-health diagnosis from a previous provider? If so, please specify:

_____

_____

_____

Do you/your partner take any medications? If so, please specify names/dosages:

_____

_____

_____

List briefly the presenting problem/reason for seeking counseling:

_____

_____

_____

_____

_____

_____

_____

_____

_____

REFERRAL INFORMATION:

Referred by: _____

May I thank this person for referring you? _____ Yes _____ No

If there was no referral, how did you hear about me?

Insurance: _____ Google Search: _____ Viera Voice Ad _____ Psychology Today _____

Word of Mouth _____ Other _____

Saw name at the Orthopedic or Eye Group Office in the building _____

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INFORMED CONSENT

This document is intended to inform you of our policies. Your therapist reserves the right to refer you out after the initial evaluation if she deems that you may benefit from the services of another provider or if your needs are outside of her clinical expertise or scope of practice.

- Therapy sessions are **45-50 minutes** in length. If you are a self-pay client, you may request longer sessions, which will incur additional charges in 1-hour increments.
- Punctuality is very important. I strive to be respectful and considerate of all schedules. If you are late for your session, you forfeit that time, as your session will end on time to attend to the next client. If you are more than 20 minutes late to your session, you may be asked to reschedule that session.
- The issue of repeat cancellations will need to be addressed and you may not be able to schedule additional sessions if this is an ongoing problem.
- Benefits and Risks of Therapy: Many people find relief from emotional suffering through the process of therapy. Other benefits may include expanded coping skills, improved self-confidence, healthier relationships, and/or ease with challenging life transitions. Your beliefs and behaviors may be challenged, and your therapist will make recommendations in order to generate positive change in these areas. Sometimes you may experience a worsening of your symptoms before they get better. The changes made may challenge and/or disrupt your current relationships.
- No promises can be made as to the results of treatment.
- ***The office does not participate in disability claims of any kind. This includes forms, evaluations, peer reviews and any other disability-related issues, whether FMLA, short-term, long-term or Social Security. The office is able to provide a copy of your office notes and/or a summary of your treatment, but no separate forms will be filled out from other entities.***
- Conditions under which your provider may deny further services to you:
  1 If you refuse to cooperate with your provider.
  2. If your needs are beyond the scope of what this psychotherapist may provide to you.
  3. If you refuse to pay for the services provided at the time that services are rendered.
  4. If you have repeat cancellations or missed appointments, or if you refuse to pay these fees.

CONFIDENTIALITY

Your verbal communication and clinical records are maintained in strict confidentiality, with the following exceptions:

1. When you provide written authorization to release information to another provider. In the case of couple's and family therapy signatures from both/all parties will be required to release information. Your consent is valid until you revoke this authorization by written notice.
2. When you request release of information from another provider.
3. When information you (or your child/others who participate in therapy sessions) report leads your therapist to believe that a minor, an elderly person or a disabled person is being abused, neglected or exploited. By Florida State Law I am mandated to report this information to the Department of Children and Family Services.
5. If/When you provide information that you are in danger of harming yourself or someone else, I may need to intervene to ensure your safety and/or the safety of others.
6. When required by law, if your therapist receives an order signed by a judge to appear before the court or

release records, to share information regarding your legal matters. Your therapist will inform you of such an occurrence.

7. When the client or their guardian feels that immediate attention is necessary due to an emergency, they understand that they are to contact the emergency services in the community such as Circles of Care at (321) 722-5257, or 211. You may also seek appropriate emergency services by calling 911 or by seeking services at the emergency room of the hospital nearest you. Gloria Rivera King, Ph.D. will follow those emergency services with standard counseling and support to the client and/or the client's family as soon as she is available. This includes emergencies when your therapist cannot be reached during work hours, emergencies after office hours, as well as the during therapist's vacation time.

CONSENT FOR TREATMENT

NOTE: By signing below, you affirm that you have read, understand, and provide informed consent:

_____ _____ _____

1) Signature Print Name Date

_____ _____ _____

2) Signature Print Name Date

CONSENT FOR APPOINTMENT REMINDERS

I consent to receiving Text or Email reminders sent to me at one of the following:

_____ A) Send Text Reminders to Cell Phone Number(s):

_____

OR

_____ B) Send Email Reminders to Email address (es):

_____

Signature 1)_____ Date_____

Signature 2)_____ Date_____

CONSENT FOR TEXT OR EMAIL RECEIPTS

I don't need a receipt. Please initial here: _____

I consent to receiving text or email payment receipts. _____ Text _____ Email

Signature 1)_____ Date_____

Signature 2)_____ Date_____

FINANCIAL POLICY:

- The standard fee is $170 for Individual Sessions and $185 for Couples Sessions; longer sessions beyond 50 mts are available upon request. * Please note these fees are subject to change at any time, and you will be given notice if that occurs. Forms of payment accepted include cash, check, and credit/debit card. The office is contracted with most major insurance companies.

- Please note that every so often I raise my prices according to inflation and my cost of doing business. Therefore, the current fee may change over the course of your services with me. However, you will be given reasonable notice if that change should occur.

- Letters and Phone Calls: If asked to write a letter documenting counseling for a particular purpose the fees are as follows:
  1) Simple letter documenting counseling = $40.00
  2) Comprehensive letter involving review of notes, analysis, and summarization = $100.00
     *Please note this varies on a case-by-case basis and can range from $160.00 – $200.00.
  3) Any emergency calls will be charged at $40.00 per 15 mts.

- Payment for services is to be made to Gloria Rivera King, Ph.D. or Dr. King at the time services are delivered. Any checks returned for insufficient funds will be charged an additional $40.00 fee each time they are submitted. This fee is due prior to obtaining additional services. ***Please be advised that you are required to provide and maintain on file a valid credit card number and authorization. This information will be maintained in strict confidentiality.***

- **If you need to cancel or reschedule an appointment, please give 24 hours advance notice of your appointment time, otherwise you will be responsible for the missed-appointment fee of $80.00. *Please note this fee is subject to change at any time and you will be notified if such change occurs.** You will be billed for the fee if you fail to observe this cancellation policy. If you have a Missed Appointment or Late-Cancellation your credit card on file will be charged for such fees. If you do not put a credit card on file, you will be required to pay the $80 fee via cash, credit/debit BEFORE future sessions can be conducted. Repeat cancellations or avoidance of payment may result in termination of services. Your cooperation regarding finances is sincerely appreciated. You may request a copy of this form.

FINANCIAL POLICY CONTINUED:

A CREDIT OR DEBIT CARD IS REQUIRED TO BE KEPT ON FILE

PRE-AUTHORIZED CREDIT/DEBIT CARD USE:

Client's name: _____

Cardholder's Name on Card: _____ Billing Zip Code: _____

Circle one of the two: Debit or Credit Card

Card type □ Visa □ Master Card □ Discover □ American Express □ Healthcare Svgs. Act.

Account Number_____

Expiration Date: _____ CVV Code: _____

By signing below, you affirm that you have read, understand, and agree to this policy and authorize the use of this credit/debit card (signature on file) for:

1. Payments for services rendered (at current fee).
2. Charges due to late-cancellations or missed-appointments (without 24 hours notice).
3. Returned checks due to insufficient funds plus a $35.00 processing fee.

_____ _____ _____

1) Print Signature Date

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HIPAA 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 IT CAREFULLY.

GLORIA RIVERA KING, PH.D. is committed to maintaining your health information in confidentiality. She will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes office policies related to the use and disclosure of your healthcare information.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION FOR THE PURPOSE OF PROVIDING SERVICES:

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow the use and disclosure of your health information for these purposes.

TREATMENT:

Your health information may be used or disclosed for the purpose of providing, managing, or coordinating your care or related services. This could include consultants and potential referral sources.

PAYMENT:

Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes will be used/disclosed. The office may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS:

We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which do not require your consent:

There are some instances where we may be required to use and disclose information without your consent, such as appointment reminders, rescheduling appointments, or treatment alternatives. Information may also be shared with law enforcement if a crime is committed on our premises or against our staff.

I (WE) ACKNOWLEDGE RECEIPT OF THE HIPAA NOTICE OF PRIVACY PRACTICES:

Signature 1)_____ Date _____

Signature 2)_____ Date _____

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TELE-HEALTH INFORMED CONSENT AND AGREEMENT

What is "Tele-Health? "Tele-Health", also referred to as telemedicine and tele-therapy, is the practice and delivery of medical, mental, or behavioral health treatment by a licensed provider where client/patient care, treatment, and/or services are provided through the use of real-time electronic communications in which the provider is located at a physical site that differs from the client/patient or recipient of those services.

Risks to Confidentiality, the laws that protect confidentiality of medical and mental health information disclosed between a provider and client/patient also apply to tele-heath. As such, all information transmitted via electronic means will be treated as confidential, except in the event of credible of harm to self or others and reports of child and/or elder abuse.

Risk to confidentiality as a result of participating in tele-health include disruption or distortion of transmitted communications due to technical failures, information interceptions by unauthorized persons, environmental barriers such as loud noises and/or lighting issues that occur outside of the provider's control, and technical difficulties due to operator error. Although risks exist, the provider agrees to make every effort to minimize risks, as well as have alternate plans for conducting sessions when technical barriers are present.

By signing this consent, you are hereby agreeing to the following terms and acknowledgements:

*I understand that tele-therapy/tele-health is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider, and I further give consent to participating in and receiving tele-health services from Gloria Rivera King, Ph.D.

*I understand that there are risks associated with participating in tele-health/tele-therapy including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: transmission of PHI could be disrupted or distorted by technical failures, the transmission could be intercepted by unauthorized persons and client's environmental factors may limited the effectiveness of treatment due to noise, lighting, or lack of privacy.

Your signature below indicates agreement with the above terms and conditions.

1) Print	Signature	Date

2) Print	Signature	Date