Mary Beth Griffis, MA, LMHC MH8742

Wise Life Counsel Inc
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WiseLifeCounsel.com

Welcome

Welcome to my office. If this is your first time to counseling you may have questions. Please feel free to ask anything that comes to mind. There are no inappropriate questions here. People come to this office "as is" and I hope you will be at ease. Together we will seek the answers to your concerns.

Most clients who come to counseling find a once/week visit to be the most helpful. Others come every other week or as needed. As we work together, we will find a schedule that is right for you.

Most sessions run approximately 55 minutes including time to make payment. I will do my best to get you out on time, but session can run over from time to time. Please let me know if you have a tight schedule.

I reserve a time for you that will fit into both of our schedules. I do not double book appointments. Therefore, I will charge you my regular appointment fee if I do not receive at least 48 hours notice of a cancellation. Of course there are times when things come up, such as illness, where no fee will be incurred.

The best way to reach me is by phone at 407-782-0134. I check my phone regularly and will do my best to get back to you within 24 hours. You may call me to make appointment changes. If you choose to contact me by email or text please remember email and texting do not meet HIPPA guidelines and confidentiality is not assured. I do not check my email daily and, therefore, I may not respond within 24 hours. I do however check my text messages often, so feel free to text me any appointment changes if you choose.

My regular fee is per counseling hour. Your insurance may cover all or part of this fee. You will need to contact them for this information.

Please take a few minutes to read and fill out this packet. Some of this paperwork helps me identify the issues you are dealing with and will help us set up goals for counseling. Some of this paperwork is mandated by the state of Florida. We can address together any questions or concerns you have about any of this paperwork.

I look forward to meeting and working with you.

Mary Beth

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Intake Information

Please fill out the following information.

Today's Date _____ Date of Birth _____

CONTACT INFORMATION

Name _____
first *middle* *last*

Address _____
street *city* *zip code*

May I send mail here? □ Yes □ No

Please provide that information below that you would ***prefer*** for me to use.

Home Phone: _____ May I leave a message here? □ Yes □ No

Mobile Phone: _____ May I leave a message here? □ Yes □ No

Work Phone: _____ May I leave a message here? □ Yes □ No

Email address _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

PRESENTING ISSUES AND GOALS

Please describe the circumstances that contributed to your seeking counseling at this time.:

_____

_____

What do you hope to gain or change while coming to counseling?

_____

_____

_____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

RELATIONAL INFORMATION

Current Relational Status: □Single □Dating □Engaged □Married □Separated □Divorced □Widowed

Are you content with your current status? □ Yes □ No. If No, Briefly Explain: _____

_____

How long have you been with your current partner? _____

Number of Previous partners for You: ____ For Your Partner: ____

If Separated or Divorced, How Long: _____If Widowed, How Long: _____

Partner's Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Rev.

_____

What words would you use to describe your partner?

_____

Is your partner supportive of your seeking counseling? □Yes □No □Unsure □Partner Doesn't Know

With whom do you currently live? (Check All that Apply):

□ Alone □ Spouse □ Children □ Parent(s) □ Sibling(s)

□ Boyfriend □ Girlfriend □ Roommate □ Other: _____

Do you have a personal support system? □ Yes □ No. If yes, please state who and their relationship to you.

_____

SUBSTANCE USE

Do you drink alcohol? □ Yes □ No If yes, how much? _____ How often? _____

Have you ever felt the need to cut down on your drinking? □ Yes □ No If yes, please explain.

_____

Have you felt annoyed by someone criticizing your drinking? □ Yes □ No If yes, please explain.

_____

Have you ever felt bad or guilty about your drinking? □ Yes □ No If yes, please explain.

_____

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? □ Yes □No

Do you use caffeine? □ Yes □ No Drink caffeinated beverages? □ Yes □ No If yes, how much per day? _____

Do you use illegal substances? □ Yes □ No If yes, which ones and how often? _____

Have you used illegal substances in the past? □ Yes □ No.
If yes, please explain how much and how often and if you stopped what led you to stop.

_____

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine):

_____

Are you currently receiving medical treatment? □ Yes □ No. If Yes, Please Specify:

_____

Please list any conditions, illnesses, surgeries, hospitalizations, traumas or related treatments you have had.

(please use the back of this paper if necessary)

_____

_____

May I contact your physician to consult with him/her about your treatment? _____

MEDICATIONS

Please list all current medications you are taking, including those you seldom use or take only as needed (Use the back of this paper if necessary)

Medication: _____ Dosage: _____ □ Improves □ Prevents □ Controls: _____

Medication: _____ Dosage: _____ □ Improves □ Prevents □ Controls: _____

Medication: _____ Dosage: _____ □ Improves □ Prevents □ Controls: _____

Medication: _____ Dosage: _____ □ Improves □ Prevents □ Controls: _____

Are you taking these medications according to your doctor's recommendations? □ Yes □ No

If no, please briefly explain: _____

PHYSIOLOGICAL SYMPTOMS

Please check any of the following physiological symptoms/sensations that apply to you presently or in the recent past:

Headaches……...	□ Past □ Present	Dizziness……..	□ Past □ Present
Stomach Trouble….	□ Past □ Present	Visual Trouble…….	□ Past □ Present
Sleep Trouble……..	□ Past □ Present	Trouble Relaxing….	□ Past □ Present
Weakness……	□ Past □ Present	Tension…….	□ Past □ Present
Rapid Heart Rate…	□ Past □ Present	Difficulty Breathing..	□ Past □ Present
Intestinal Trouble….	□ Past □ Present	Hearing Noises……	□ Past □ Present
Change in Appetite.	□ Past □ Present	Tiredness……..	□ Past □ Present
Pain……...……□	Past □ Present	Other_____	□ Past □ Present

Have you had a significant (10 pounds or more) weight loss or gain within the past year? _____ If yes, please explain_____

_____

CURRENT STATUS

Please check any of the following problems which pertain to you:

Stress……	□ Past □ Present	Nervousness…...……	□ Past □ Present
Anxiety…….	□ Past □ Present	Panic……...…….	□ Past □ Present
Unhappiness……	□ Past □ Present	Depression…...……...	□ Past □ Present
Guilt……..□	Past □ Present	Apathy……...……...□	Past □ Present
Feeling controlled...	□ Past □ Present	Grief……...……..	□ Past □ Present
Hopelessness…..…..	□ Past □ Present		
Compulsive behavior (sexual behaviors, thoughts, eating) ……..……□	Past	□ Present	
Inferiority Feelings..	□ Past □ Present	Unwanted memories.....□	Past □ Present
Loneliness……	□ Past □ Present	Shyness……...…	□ Past □ Present
Fears…….	□ Past □ Present	Relational Problems.....	□ Past □ Present
Communication……	□ Past □ Present	Physical Abuse…...…	□ Past □ Present
Obsessive Thoughts	□ Past □ Present	Emotional Abuse.....…	□ Past □ Present
Verbal Abuse…..…..	□ Past □ Present	Sexual Abuse…...…..	□ Past □ Present
Temper…….	□ Past □ Present	Anger……...…….□	Past □ Present
Aggressiveness….....	□ Past □ Present	Bad Dreams……...….	□ Past □ Present
Concentration……..	□ Past □ Present	Unwanted Thoughts.....	□ Past □ Present
Memory problems....	□ Past □ Present	Loss of Control…...…	□ Past □ Present
Impulsive Behavior..	□ Past □ Present	Sexual compulsions …..	□ Past □ Present
Hallucinations.....□	Past □ Present	Sexual Problems.....…	□ Past □ Present
Pregnancy Problem ...□	Past □ Present	Hearing voices.....□	Past □ Present

Trauma…….	□ Past □ Present	Eating Problems.....….	□ Past □ Present
Indecisiveness.....□	Past □ Present	Work Stress.....…..	□ Past □ Present
Career Choices….....	□ Past □ Present		
Verbal Abuse.....□	Past □ Present	Parenting concerns.....	□ Past □ Present
Difficult Children.....□	Past □Present	Financial Concerns.....□	Past □ Present
Recent Loss……..	□ Past □ Present	Disaster……...….□	Past □ Present
Fatigue……..□	Past □ Present	Sleep problems.....	□ Past □ Present
Worthlessness.....□	Past □Present	Chronic pain.....	□ Past □ Present
Recent Death…….....□	Past □ Present	Marital Problems.....□	Past □ Present
Legal Matters…....□	Past □ Present	Abortion……...……	□ Past □ Present

CURRENT LEVEL OF DISTRESS

Indicate how distressed you are today by circling the appropriate number below. (1 = Very Little Distress; 10 = Extreme Distress):

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing suicidal thoughts? □Yes □ No

Have you experienced suicidal thoughts in the past? □ Yes □ No

Have you ever attempted suicide? □Yes □No. If please state when and how: _____

_____

Have any of your friends or family attempted suicide? □ Yes □ No

If yes, when and who? _____

PREVIOUS COUNSELING

Please list any previous counseling, psychiatric treatment, or residential treatment, or residential/in-patient care you have received (use the back of this paper if necessary.)

Therapist: _____ Location: _____

Dates: _____ Reason: _____

Therapist: _____ Location: _____

Dates: _____ Reason: _____

SPIRITUAL BACKGROUND

Would you like your faith to be a part of the counseling process? □ Yes □ No If yes, with which religious organization do you identify? _____

INFORMED CONSENT

By signing below you indicate the following:

I understand the law protects the relationship between a client and a psychotherapist and information cannot be disclosed without written permission unless there is a court order, I am a danger to myself or others, or there are indications of child abuse or elder abuse.

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred. I further understand that without 48-hour notice of intention to cancel, I will be charged the full counseling fee.

I understand my therapist may not be available after regular business hours and on weekends by phone. In case of emergency I may need to contact 911 or a local mental health facility or hospital.

I understand that my participation is purely voluntary and that I may withdraw whenever I wish. All records are the property of Mary Beth Griffis, MA, LMHC.

I have read and understand the information on this form. I give consent for treatment of myself or the client indicated below. I understand that I may discuss with my therapist all aspects of my treatment and any issues on this form.

Signed _____ Date _____

My name (please print) _____

Mary Beth Griffis, MA, LMHC

MH8742

Notice of Privacy Practices

Protected Health Information (PHI)

This notice describes how psychological and medical information may be used and disclosed and how you can access this information. Individually identifiable information about your past, present, or future health concerns, the provision of healthcare to you, or payment for healthcare is considered "Protected Health Information" (PHI). By law I am required to insure that your PHI is kept private. This notice explains how, when, and why I may use or disclose the *minimum necessary PHI* to accomplish the intended purpose of the use or disclosure. **Please review it carefully.**

1. **How I May Use and Disclose Your Protected Health Information**

I use and disclose PHI for a variety of reasons. I may use and/or disclose your PHI for purposes of providing or coordinating treatment to obtain payment for services provided, and to complete healthcare operations related to the performance or operation of this practice. The following offers more description and some examples of the potential uses and disclosures of your PSI:

1. **Uses and disclosures related to treatment, payment, or health care operations do not require your prior written consent**.
   A. **For treatment.** I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care. I will get your written permission before I do this.
   B. **For health care operations.** With your written consent, I may disclose your PHI to your your insurance company for the purposes of fee reimbursement.

2. **Uses and Disclosures for Which Special Authorization Will Be Sought**. For uses beyond treatment and operations purposes, I will ordinarily seek to obtain your authorization before disclosing your PHI. However, disclosure of your PHI may be made without your consent or authorization when:
   A. To report known or suspected child abuse or neglect to the Florida Department of Children and Families as required by law.
   B. To report known or suspected abuse of neglect of an elderly or disabled person to the Central Abuse Hotline as required by law.
   C. When there is serious threat to the health or safety of yourself or others. If a client intends to harm himself or herself, I will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, I will take further measures without their permission that are provided to me by law to ensure their safety. If a client is threatening serious bodily harm to another person/s, I must notify the police and inform the intended victim.
   D. In certain judicial or administrative proceedings such as Health Oversight activities, unopposed subpoenas or court orders, certain law enforcement activities and Worker's Compensation claims.

As a mental health worker I am a mandatory reporter in cases of abuse of a minor or an elderly person and am required by law to report knowledge of this information.

4. **How You May Have Access to or Control of Your Protected Health Information.** The following is a description of the steps you may take to access or otherwise control the disposition of your PHI:

A. **To request restrictions on uses/disclosures**: You may ask that I limit how I use or disclose your PHI. I will make every effort to honor your request, but I am not legally bound to agree to the restriction. To the extent that I do agree to such restrictions, I will abide by such restrictions except in emergency situations. I cannot agree to limit uses/disclosures that are required by law.

B.

C. **To choose how I contact you**: You may ask that I send you information at an alternative address or by alternative means. I will agree to your request so long as it is reasonably easy for us to do so.

D.

E. **To inspect your PHI**: You have a right to receive a treatment summary of you PHI. If you request a treatment summary one will be provided to you, however there may be a reasonable charge.

F.

G. **To request amendment of your PHI**: If you believe that there is a mistake or missing information in our record of your PHI, you may request in writing that I correct or add to the record. If I approve the request for amendment, I will change the PHI and so inform you. I will also inform any others who have a need to know about such changes.

H.

I. **To receive this notice**: You may receive a paper or electronic copy of this notice upon request.

5. **Concerns**: If you are concerned that there has been a violation of your privacy rights or if you disagree with decisions made about access to your records, you may contact me directly or send a written complaint to the Secretary of the US Department of Health and Human Services.

6. **This notice of privacy is available in its entirety at your request. This notice is effective April 14, 2003**.

7. **Acknowledgment:** I have reviewed a copy of this notice:

Printed Name: _____

Signature: _____

Date: _____