# Debra A. Gwynn, L.M.F.T.

**Licensed Marriage and Family Therapist**

**1 W. Park Ave., Suite B**

**Eustis, Fl. 32726**


Client Name_____

Address:_____

City:_____Zip Code_____

Home phone:_____ Cell Phone: _____

Birthdate:_____Age:_____

Email address:_____

**Sex: M_____ F_____ Marital Status: Single_____ Married _____ Divorced_____**

**Domestic Partnership_____Widowed_____ Number of times married:_____**

Employer:_____

If Student, School Attending:_____

**If dependent child, are custodial parents: Married_____ Separated_____ Divorced_____**

**Other_____**

*IN CASE OF AN EMERGENCY NOTIFY*:
Name_____

Relationship_____

**Phone: ( )_____**

Referred here by:_____

Today's Date:_____

**Debra A. Gwynn, L.M.F.T.**

## Health History

Name:_____D.O.B._____Age_____

How would you describe your health? Excellent___Good___Fair___ Poor_____

Physician:_____Last exam:_____

Psychiatrist:_____Last exam:_____

Have you ever been treated for any type of mental illness?_____

Do you have a family history of any mental illness?_____

Please list all current medications including over the counter medications:

_____

_____

Are you currently being treated for any physical illness?_____

If yes, please describe_____

Do you live with any chronic pain?_____

Substance history: Do you currently smoke? Y_____N_____How much?_____

Drink Alcohol of any kind? Y_____N_____How often?_____

Have you ever been told you drink too much? Y___ N____ DUI? Y____ N_____

Do you feel suicidal today? Y____ N___History of suicide attempts? Y___ N_____

Have you ever been a victim of abuse? Y__ N__ Domestic Violence: Y__N__

Briefly describe what brings you here today:

What would you like to accomplish by coming for therapy at this time? (Goals for Coming) _____

Is there anything else you would like for me to know about you?_____

_____

Client Signature_____Date:_____

# Debra A. Gwynn, L.M.F.T.

## Office Policies and Procedures

Thank you for choosing Debra A. Gwynn, L.M.F.T. for your counseling needs. We are committed to giving you the best care possible. To further acquaint you with the policies and procedures of our office, we are providing the following information:

**Appointments:**

Appointments are 55 minute sessions. Please have your co-pay ready to collect at the beginning of your session. Beginning and ending sessions on time is expected in order to be courteous to the client scheduled after your session.

If you need to cancel your appointment, a minimum of 24 hours notice is required. **There will be a $50 charge if your appointment is cancelled less than 24 hours** before your scheduled, confirmed appointment time. **I am not able to bill your insurance company for a missed appointment. The responsibility will be yours. *In the evenings or on the weekend, you may leave a voicemail which will accurately record the date and time of your call.**

The reminder call/text that you receive the day before your scheduled apt is just a courtesy. **Please consider it your responsibility to know when your appointment is scheduled. Less than 24 hours notice does not allow sufficient time to offer that session to another client in need.**

**Emergencies**:

**In the case of a life-threatening emergency, please call 911.** To leave a message for your counselor, please call 352-551-5610 and you will receive a call on the next business day. Office hours are Monday–Thursday from 8:00 am. to 7:00 p.m. We are closed on Friday, Saturday, and Sunday.

## Debra A. Gwynn, L.M.F.T.

## Office Policies and Procedures, Continued

**Financial Responsibility:**

You are financially responsible for all services rendered. Full payment is expected at the time of service. **Please make checks payable to: Debra Gwynn, L.M.F.T.** We also accept credit card payments with Visa, Master Card, and Discover. By signing at the end, you hereby authorize the assignment of insurance benefits (if applicable) to: Debra A. Gwynn, L.M.F.T.

**Confidentiality:**

Everything about your care will be held in the strictest confidence (with the exception of situations which are required by law to report, such as suspected or reported child abuse, elder abuse, homicidal or suicidal threat). If you choose to have your therapist keep a third party informed of your progress in counseling, it will be necessary to complete a separate ***Release of Information*** form that will be kept on file.

Your client records are the property of Debra A. Gwynn, L.M.F.T. and shall be treated as confidential. To comply with state and federal laws regarding client confidentiality, your records will not be released without proper written consent from you, or a court order.

***Please sign below to indicate that you have read and understood the above and are consenting to receive treatment by Debra A. Gwynn, L.M.F.T.***

Client Signature_____Date:_____

## Debra A. Gwynn, L.M.F.T.

## Confidential Client Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up, possibly among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payments from third party payers (Insurance Companies).
- Conduct normal healthcare operations such as quality assessments and referrals.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, obtain payment, or healthcare operations. I also understand that you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Client Signature_____Date:_____