Date: ________________

RESOLUTION COUNSELING CENTER
7765 SW 87 Ave Suite 104
Miami, Florida 33173
Tel: 305-412-8440 | Fax: 305-412-8447

New Patient Information

CLIENT INFORMATION

Client Name (First) _______________________________ (Middle) _______ (Last) __________________

Street ________________________________ City ________________ State ______ Zip _____________

Phone (H) _____________________________ (W)_________________ (Other) ____________________

Soc. Sec # __________________________ D.O.B. _______________ Relationship Status _____________

Occupation _________________________ Employer/School ___________________________________

Employer Address ____

Medications currently taken ______________________________ _________________________________

Reason for medication ______________________________ _________________________________

E-mail ______________________________

Other household members

Name	D.O.B	Sex	Relationship

Reason for visit

____
____
____

EMERGENCY INFORMATION In the event of emergency please contact:

Name ____ Relationship ____________________________

Phone (H) _____________________________ (W)_________________ (Other) ____________________

Street ________________________________ City ________________ State ______ Zip _____________

HOW DID YOU HEAR ABOUT US? ____

Date: ________________

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Consent to Treatment

PART I.

This is to certify that I,
Print client(s) name (s)

____

____

acknowledge with my signature below that:

- I have reviewed, I received, an understand the documents and information I was given, pertaining to the therapy I am considering;
- I have reviewed, received, and understand the "Notice of Privacy Practices" and that I have had all of my questions relating to confidentiality, fees, treatment, client rights and responsibilities and therapist rights and responsibilities fully;
- I agree that, in case of emergency, other therapists at Resolution Counseling Center may obtain my individually identifiable health information from my medical record in order to contact me.
- I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process;
- I understand that no promises have been made as to the results of treatment or of any procedures provided by this therapist and that I may stop treatment with this therapist at any time. The only thing I will be responsible for is paying for the services already received.
- I understand that my therapist may consult with the other therapists at RCC in regards to my case. My therapist will, to the extent possible, conceal my identity when consulting. The same rules and laws in regards to maintaining confidentiality bind the other therapists.
- I understand that in the event of any legal proceedings, neither Resolution Counseling Center, not any of its affiliates, will become involved in direct court situations. Any psychotherapy reports/summary can be furnished for an additional fee. Appropriate referrals for court appearances will be made, as needed.

- I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

- I understand that cancellation of a virtual session is non-refundable. For in-person sessions, all appointments cancelled less than 24 hours prior to your appointment time will be billed at the full session fee. If you paid online for an in-person session and you cancel 24 hours in advance, you will be refunded the session fee you paid within 5-7 business days. Monday appointments must be cancelled, at the latest, the Friday prior to your session.

- I understand that I am responsible for all charges that may be incurred for the treatment given to me and that I have truthfully provided my insurance information and/or financial situation, and have agreed to payment as outlined below. I understand that the therapist may stop treatment if payment for the services I receive here is not made.

- I understand that if we have a dispute that cannot be resolved between us, we both agree to submit the dispute to binding arbitration. If an arbitrator and simple arbitration rules cannot be agreed upon by us, we agree in advance to be bound by the rules of the American Arbitration Association and will accept a randomly selected arbitrator from a list of approved arbitrators maintained by the Circuit Court.

Client Name: ____

PART II.

The fee for each session is based upon a rate of $ _____________ per session.

☐ I will pay the fee for each session in full. If I request them, I will be provided with the appropriate forms and information needed to obtain reimbursement form my insurance company.

☐ *I understand that I assume financial responsibility for payment of any and all bills. Gilza Fort-Martínez would like to emphasize that her relationship is with you, the patient, and not with your insurance company. With my signature below I understand that Gilza Fort-Martínez cannot be held responsible for any loss of benefits, and that it is my responsibility to know my policy and whether or not I can submit a claim after a session, for reimbursement.*

SIGNATURE: ________________________

INITIAL: ________________________

☐ Other payment arrangements:____
____
____

INITIAL: _______________

I understand that any outstanding or cancellation balances will be billed to me and I agree to make payment within 30 days of receipt of such bill. In the event I have not made payment within this 30-day period, I will be charged interest on my outstanding balance at an annualized rate of 10%.

I have received the following documents (these may differ, based on insurance coverage, referral source, treatment received, and/or reason for therapy):

- ☐ **Notice of Privacy Practices** (required for all clients receiving services with RCC)
- ☐ Other: ____
- ☐ Other: ____
- ☐ Other: ____

I do hereby seek and consent to take part in the treatment by the therapist named below. My signature below shows that I understand and agree with all of the statements above.

____

Printed Name   Relationship to client (if necessary)

____

Signature of client (or person acting for client)   Date

____

Printed Name   Relationship to client (if necessary)

____

Signature of client (or person acting for client)   Date

____

Printed Name   Relationship to client (if necessary)

____

Signature of client (or person acting for client)   Date

I have discussed the issues above with the client (and/or his or her parent, or guardian, if necessary). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent to treatment.

____

Printed Name

____

Signature of therapist   Date

- ☐ Copy accepted by client
- ☐ Copy kept by therapist

This is a strictly confidential client medical record.
Client Name: ____

Date: ________________

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Social Media Policy

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Facebook Page

I keep a Facebook Page for my professional practice to allow people to share my blog posts and practice updates with other Facebook users. All of the information shared on this page is available on my website. You are welcome to view my Facebook Page and read or share articles posted there, but I do not accept clients as Fans of this Page. I believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and I feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list.

Following

I publish a blog on my website, I post psychology news on Twitter, and psychology related posts on Instagram. I have no expectation that you as a client will want to follow my blog, Twitter stream, or or Instagram profile. However, if you use an easily recognizable name on Twitter or Instagram and I happen to notice that you've followed me there, we may briefly discuss it and its potential impact on our working relationship.

Social Media Policy

My primary concern is your privacy. If you share this concern, there are more private ways to follow me on Twitter (such as using an RSS feed or a locked Twitter list), which would eliminate your having a public link to my content. You are welcome to use your own discretion in choosing whether to follow me. Note that I will not follow you back. I only follow other health professionals on Twitter and I do not

follow current or former clients on blogs or Twitter. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Interacting

Please do not use messaging on Social Networking sites such as Twitter, Facebook, Instagram, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone. Direct email at contact@gilzafort.com is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

Use of Search Engines

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Google Reader

I do not follow current or former clients on Google Reader and I do not use Google Reader to share articles. If there are things you want to share with me that you feel are relevant to your treatment whether they are news items or things you have created, I encourage you to bring these items of interest into our sessions.

Business Review Sites

You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

I follow the The American Association for Marriage and Family Therapy (AAMFT) Code of Ethics. While you have a right to express yourself on any site you wish, it is important that you understand that due to

confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you, and I cannot stress enough that your confidential information may be in jeopardy once you decide to make public expressions.

You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum.

I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection. If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Board of Clinical Social Work,

Marriage & Family Therapy and Mental Health Counseling, which oversees licensing, and they will review the services I have provided.

Address:

Department of Health
Board of Mental Health Professions
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258
(850) 245-4292

Location-Based Services

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Yelp, Google Maps, Foursquare, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive location-based services app enabled on your phone.

Email

I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, unless previously agreed to. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the

system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Conclusion

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

Hold Harmless

I agree to indemnify and hold harmless the provider and its trustees, officers, directors, employers, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages, and costs, including attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the provider, and any breach by me of these restrictions and conditions.

My signature below shows that I understand and agree with all of the statements above:

PATIENT'S/GUARANTOR'S SIGNATURE DATE

PATIENT/GUARANTOR'S NAME (PRINTED) DATE

Date: ________________

RESOLUTION COUNSELING CENTER
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Notice of Privacy Practices

This Notice of Privacy Practices ("Notice") describes how private healthcare information about you may be used and disclosed, and how you can get access to this information.

Please review this information carefully.

The law requires that we protect the privacy of your Protected Health Information (PHI) and that we give you a Notice of our legal duties and privacy practices with respect to PHI. PHI contains information that may identify your past, present or future physical or mental health conditions or healthcare services. This Notice explains how we can use or disclose the PHI in course of providing treatment, collecting payment and managing healthcare operations, and for other specific purposes permitted or required by law.

Protected Health Information includes:

- **Information we place in your mental health record**
- **Conversations your therapist has about your care or treatment with others**
- **Information about your health and healthcare in our computers**
- **Billing information we maintain about you at our practice**

The Notice also explains your health information privacy rights. The privacy practices described in this Notice will be followed by all of the therapists at Resolution Counseling Center. We will not use or disclose your PHI without your written authorization, except as described in this Notice.

Your Health Information Privacy Rights

You have the rights to:

1. **Receive the Notice of our Privacy Policies (this Notice) that tells you how your health information may be used and shared.** In most cases, this Notice should be made available to you on your first visit, and you can ask for a copy of it at any time.
2. **Inspect and obtain a copy of your health records.** You can ask to see and get a copy of your PHI. You may be charged a fee for the cost of copying and mailing necessary to fulfill your request. We may deny your request to inspect and obtain a copy of your PHI in certain limited circumstances. For example, if your therapist decides something in your file might endanger you or someone else, the therapist may not give this information to you. You have the right to appeal the denial.
3. **Amend your health information.** You may request that we amend any incorrect or incomplete PHI that we maintain about you. For example, if we both agree that your file has the wrong test

result, we will change it. In certain cases, we may deny your request for amendment. If we deny your request for amendment you have the right to disagree with our decision.

4. **Authorize disclosure of your PHI.** Your health information, including psychotherapy notes, will not be given to your employer, used or shared for thinks like sales calls or advertising, or used or shared for many other purposes unless you give your permission by signing an authorized form.
5. **Request a report on how we disclosed your health information.** Under the law, your health information may be used and shared for particular reasons, like billing your insurance provider, ensuring quality care, or making required reports to the authorities, such as reporting abuse, neglect, or exploitation of a child or a vulnerable adult. You can request a list of all non-authorized disclosures and who your health information has been shared with.
6. **Request to be contacted at different address or in a different way than we contact you now.** You have the right to ask us to contact you about your PHI at a different address or in a different way than we contact you now. For example, you can ask your therapist to only call you on your mobile phone instead of at your home. These requests are often made when a person feels his or her health or safety is in danger if PHI is sent to his or her home address. We will do our best to accommodate all reasonable requests.
7. **Request restrictions on certain use or disclosure of PHI.** You can request additional restrictions on the use or disclosure of your PHI. However, we are not required to agree with your request for additional restrictions.
8. **Request a restriction on disclosure of PHI to a health plan** with respect to health care for which you are paying out of pocket in full. You have to make this request before services are provided.
9. **Ask for additional information or file complaints.** If you believe your health information was used or share din a way that is not allowed under the privacy law, or if you were not able to exercise your rights, you can file a complaint with us or with the U.S. Government. This Notice tells you who to talk to and how to file a complaint.
10. **You have the right to be notified about data breaches** of your uncensored PHI.

We ask that you exercise your rights in writing. We offer forms and templates to help you exercise your privacy rights and to help us protect your health information. Your therapist will make these forms available to you upon your request.

Reasons and Examples of How We May Use or Disclose Your PHI

- **Treatment** – so you can get therapeutic services. For example, we may share your confidential information with your doctor so that they can give you medical care and the right medicine. We may also call or write to provide reminders or to tell you about changes in appointments or other events.
- **Payments** – so we can determine health plan coverage, billing/collection, and to assist another health care provider with payment activities or recover payment from medical insurance. For example, the information accompanying the bill or insurance verification request may identify you as well as your treatment.
- **Operations** – so we can perform our duties. For example, we may use or share your information to assess quality of care, or to manage your care. We may also disclose PHI to an oversight agency in course of adults, complaint investigations and inspections necessary for our licensure, to satisfy government monitoring activities and regulatory compliance.

- If there are any services provided for us through contracts with Business Associates, for example billing, scheduling or transcription services. When these services require access to PHI we will disclose only minimum necessary information, so the Business Associate may perform their job. To protect your PHI we require Business Associates to sign confidentiality agreements to safeguard PHI appropriately.
- To comply with the law. We may share your PHI to comply with legal proceedings, or in response to valid court or administrative order or subpoena.

For other reasons. Examples include:

- We may disclose PHI to support law enforcement (e.g. government authority such as police, social services) to protect someone's health and safety (e.g. victims of abuse, domestic violence);
- We will use our professional judgment and may share information with a family member, or other relative to help you obtain necessary treatment;
- We may share PHI to notify a family member, relative, personal representative or other person responsible for your care about your general condition and location;
- To a personal representative you appoint or a court appoints for you can help you get health benefits;
- To protect you against a serious threat to your health or safety, or the health or safety of others;
- To support a government agency overseeing our services. For example, we may disclose your PHI to the Florida Agency for Healthcare Administration or the Florida Department of Children and Families.
- We may disclose your PHI as authorized or necessary to comply with worker's compensation laws or other similar programs;
- For lawful national security purposes including intelligence or national security activities;
- For public health purposes to prevent or control disease; and
- For military purposes, if you are a member of the armed forces.

We will obtain your written authorization before using or disclosing your PHI for most purposes, including some of those described in this Notice, or as otherwise permitted by law.

You will be able to revoke this authorization at any time.

Changes to this Notice

We will reserve the right to change this Notice and to make the revised Notice effective for all health information we create or maintain. Upon request we will make the revised Notices available to you. The revised Notices will be posted and available in our office.

For More Information or to Report a Problem

If you have questions and would like to obtain additional information about our privacy practices, please contact our Privacy Officer, Gilza Fort-Martinez, LMFT, at 305-412-8440; 7765 SW 87th Ave. Suite 104, Miami, Florida 33173.

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

This Notice of Privacy Practices is effective as of April 14, 2003.

The Notice of Privacy was last revised on September 16, 2013.

Date: ________________

RESOLUTION COUNSELING CENTER
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Informed Consent for Telepsychology

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my 'Client Consent for Treatment Form' still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (305-412-8440).

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. Currently, we are not accepting insurance coverage, but I can provide you with a receipt that could allow you to file a claim with your insurance for reimbursement if electronic psychotherapy services are covered under your plan. It is your responsibility to check with your specific insurance company the type of coverage available. You will be solely responsible for the entire fee of the session.

*** It is critical that you, as a patient, understand that if you decide to go through your health care coverage, therapists who accept insurance are required to provide a "Diagnostic and Statistical Manual of Mental Disorders (DSM)" diagnosis when the billing is done to the insurance company. Every situation is different, but you must understand that depending on your particular situation, your privacy may be less protected when health care coverage is used for therapy services.*

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.
Your signature below indicates agreement with its terms and conditions.

___________________________ ___________________________
Client Date

___________________________ ___________________________
Therapist Date