TINA DICICCO REYNOLDS, PSY. D.
LICENSED CLINICAL PSYCHOLOGIST

Today's Date: _____

COUPLES/FAMILY INFORMATION & HISTORY FORM

Client 1 Name:_____ Date of Birth: _____ Gender:_____
Address: _____ Preferred Phone Number: _____
_____ Alternate Phone Number:_____
Email address: _____ Relationship to Client 2 (3): _____
Driver's License#:_____

Client 2 Name:_____ Date of Birth: _____ Gender:_____
Address: _____ Preferred Phone Number: _____
_____ Alternate Phone Number:_____
Email address: _____

Client 3 Name:_____ Date of Birth: _____ Gender:_____
Address: _____ Preferred Phone Number: _____
_____ Alternate Phone Number:_____
Email address: _____

Emergency Contact:
Name: _____ Relationship to you:_____
Address: _____ Phone Number: _____
_____

I consent and authorize Dr. Tina DiCicco Reynolds to contact the above-designated person in the event of an emergency.

Signature: _____ Date:_____

Reason that you are seeking treatment at this time:

_____

_____

Have either of you experienced any of the following in the past year?

Anxiety/Panic	_____	Decreased Concentration	_____	Isolation/loneliness	_____
Depression	_____	Sleep Disturbances	_____	Loss of Interest	_____
Mood Swings	_____	Feelings of guilt/worthlessness	_____	Sexual Difficulties	_____
Fatigue	_____	Irritability	_____	Substance Abuse	_____
Low Self Esteem	_____	Aggression	_____	Other	_____

Current Medications & Dosages (please indicate which client) _____

_____

_____

Describe concerns about this relationship:_____

_____

_____

How long (approximately) have you had difficulties with this relationship? _____

List any recent stress/challenges/life events _____

_____

Describe current living situation:_____

_____

_____

List children (Names/ages):_____

_____

History

History of Previous Therapy/Psychiatric Medication: ☐ No ☐ Yes If yes, please describe: _____

_____

History of Psychiatric hospitalization/ suicide attempt: ☐ No ☐ Yes If yes, please describe: _____

_____

Any concerns about substance use? ☐ No ☐ Yes If yes, please describe_____

_____

Any legal history: ☐ No ☐ Yes If yes, please describe: _____

_____

History of psychiatric/psychological disorders in family: ☐ No ☐ Yes If yes, please describe: _____

_____

History of substance abuse in family: ☐ No ☐ Yes If yes, please describe: _____

_____

History of suicide in family: ☐ No ☐ Yes If yes, please describe: _____

_____

Please describe any other relevant information: _____

_____

_____

_____

_____

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"No Secrets" Policy for Family Therapy and Couples Therapy

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient.

Because you are seeking couple or family therapy, information that you share with Dr. Tina DiCicco Reynolds individually may not be kept confidential from your partner or family members who are also seeking therapy. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

During the course of my work with a couple or a family, I may see an individual for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization.

However, I may need to share information learned in an individual session with the entire treatment unit — that is, the family or the couple, if I am to effectively serve the unit being treated. I will discuss that with the individual who shared the information and decide the best way to bring that information to the whole unit. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit.

This "no secrets" policy is intended to allow me to continue to treat the couple or family unit by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

_____ _____

Print Name Signature Date

_____ _____

Print Name Signature Date

_____ _____

Print Name Signature Date

TINA DICICCO REYNOLDS, PSY. D.
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Consent and Psychological Services Agreement

Please read and initial each section and sign on the bottom of the page:

_____ I am voluntarily choosing to seek psychological services with Tina DiCicco Reynolds, Psy.D. The rights, risks, and benefits associated with psychological services have been explained to me. I understand that at any time, I have the right to discontinue psychological services.

_____Confidentiality of client records is protected by Federal and/or State laws and regulations. Current law requires clinicians to maintain complete confidentiality of information revealed in treatment as well as attendance or involvement in services, without written consent. Unless the disclosure is, 1) court ordered by a judge, 2) if Dr. Reynolds has reason to suspect potential for immediate harm to self or others, or 3) if Dr. Reynolds has reason to believe a child, elderly person, or handicapped adult, has been or is at risk for abuse or neglect. In any of the above-mentioned circumstances, normal assumptions of confidentiality will not apply and Dr. Reynolds is mandated by law to report these concerns.

_____ Payments, copayments, and deductibles are due at the time of service. All fees are due at the beginning of each session. I understand that if I am using an insurance plan, payment by insurance company cannot be guaranteed therefore **I accept responsibility unpaid balances not by my insurance company.**

____I acknowledge that since my appointment time has been reserved exclusively for me**, I am required to cancel or reschedule appointments at least 24 hours in advance to avoid a $55 cancellation fee**. I am aware that my insurance company will not pay for missed appointments.

____I understand that Dr. Tina DiCicco Reynolds does not provide on-call service. If I need to contact Dr. Reynolds between my sessions, I will leave a message and she will return my call in a timely manner. If an emergency arise in which I believe that I am a danger to myself or others or my child may be a danger to him/herself or others, I must call 911, Henderson Mental Center Crisis Response Team (954) 463-0911 or go to the nearest emergency room.

My signature below indicates that I have read, understand, and agree to abide by the above stated policies and agreement.

_____ _____

Print Name Signature Date

My signature below acknowledges that I have received a copy of Notice of Mental Health Practitioner's Policies and Privacy Practices regarding the use and disclosure of my Protected Health Information. My signature authorizes Dr. Tina DiCicco Reynolds to bill my insurance carrier and to communicate with my insurance carrier under the limitations of the HIPAA notice.

_____ _____

Print Name Signature Date

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Consent For TeleHealth

Benefits and Risks of Telehealth

Telehealth refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of Telehealth 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. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of Telehealth, there are some differences between in-person psychotherapy and Telehealth, as well as some risks. For example:

- Risks to confidentiality: Because Telehealth 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. I will take reasonable steps to ensure your privacy. However, 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 Telehealth. 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: Telehealth is not the most appropriate for clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in Telehealth, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our Telehealth work.

- Treatment Limitations: Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider. In addition, the inability of your Provider to conduct certain tests or assessments in-person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment for you.

- Efficacy: Most research shows that Telehealth 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 Communication and Confidentiality

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Dr. Reynolds, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages.

The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with Dr. Reynolds
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes. 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. If a life-threatening crisis should occur, contact a crisis hotline, call 911, or go to a hospital emergency room. Should your clinician determine that you are at risk, he/she may call local police to assess your safety in person.

You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for Telehealth sessions and having passwords to protect the device you use for Telehealth). The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent still apply in Telehealth. Please let me know if you have any questions about exceptions to confidentiality.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting Telehealth than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in Telehealth services. If an emergency arises in which you are a danger to yourself or others, you must call 911, Henderson Mental Center Crisis Response Team (954) 463-0911 or go to the nearest emergency room.

My signature below indicates that I have read, understand, and agree to abide by the above stated policies and agreement.

_____ _____

Print Name Signature Date

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LICENSED CLINICAL PSYCHOLOGIST

Health Insurance Information and Consent

Patient's Name _____ Date of Birth _____
Primary Insurance Company_____
Insurance Company Contact Number(s)_____
Policy Number _____ Group Number_____
Name of Insured _____ Insured's Date of Birth_____
Insured's SS Number _____ Employer _____
Patient's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Do you have secondary insurance? If so, please complete the following:
Secondary Insurance Company_____
Insurance Company Contact Number(s) _____
Policy Number _____ Group Number_____
Name of Insured _____ Insured's Date of Birth_____
Insured's SS Number _____ Employer _____
Patient's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

I authorize Dr. Tina DiCicco Reynolds to obtain insurance benefits, submit claims, and receive payments of medical/mental health benefits on my behalf. By choosing to use my insurance for psychological services, my practitioner may be required to release certain information to the insurance company at their request. Information, which may be requested, includes types of services, dates/time of services, diagnosis, treatment plans, descriptions of impairment, progress of therapy, and, at times, case notes and summaries. If it is the case that my insurance company utilizes a managed care company, my therapist/examiner may need to discuss my treatment with a case manager. I understand that my confidentiality may be compromised in such a case. I realize that his/her doing so is a necessity in the efforts to secure ongoing care.

_____ _____
Patient's Name Date

_____
Insured's Signature (If different than patient) Date

_____
Parent/Guardian's Signature Date

TINA DICICCO REYNOLDS, PSY. D.
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Notice of Mental Health Practitioner's Policies & Privacy Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TOTHIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The law requires that you be provided with this Notice of the legal duties and the privacy practices with respect to your PHI (Protected Health Information). Dr. Reynolds is committed to maintaining the privacy of your health information and Dr. Reynolds has implemented numerous procedures to ensure that Dr. Reynolds does so.

Florida Law and Health Insurance Portability & Accountability Act of 1998 (HIPAA) require practitioner's to maintain the confidentiality of all your health care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally, is a federal law that gives you significant new rights to understand and control how your health information is used.

I. USES AND DISCLOSURES FOR TREAMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Your **protected health information** (PHI) may be **used** or **disclosed for treatment, payment,** and **health care operation purposes** with your **consent.** In order to provide you with or coordinate health care treatment and services, Dr. Reynolds may review your health history to form a diagnosis and treatment plan, consult with other practitioners about your care, delegate tasks to ancillary staff, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other providers, etc.

In order to bill or collect payment from you, an insurance company, a managed care organization, a health benefits plan, or a third party may need to verify your insurance coverage. Dr. Reynolds may also need to submit your PHI on claim forms in order to be reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan. You may be contacted by telephone, mail, or e-mail. Please inform the office of the numbers that you want to be reached at and the procedure, you want us to follow when or if another individual answers the call. Dr. Reynolds will automatically leave a message with the numbers you provide and mail information to the address you list us unless you indicate otherwise.

II. USES AND DISCLOSURES REQUIRING AUTHORIZAION

You may request **"authorization"** to use or disclose information for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An **"authorization"** is written permission beyond the general consent that permits only specific disclosures. In those instances when your practitioner is asked for information for purposes outside of treatment, payment, and health care operation, they will obtain an authorization from you before releasing your psychotherapy notes.

"Psychotherapy notes" are notes that have made about conversations during a private, group, joint, or family counseling session, consultation, or testing administration which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation in writing. You may not revoke an authorization to the extent that (1) the practitioner has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer to the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

Exceptions to maintaining privacy occur under state law and under strictly limited circumstances. Under these circumstances, your PHI may be used or disclosed without your permission, consent, or authorization for the following purposes:

Serious Threat to Your Health or Safety or the Health or Safety of Other Persons: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, communication and relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities will be disclosed.

Child Abuse: If there is a reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that the practitioner report such knowledge or suspicion to the Florida Department of Child and Family Services.

Adult and Domestic Abuse: If there is a reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, the law requires the practitioner to report such suspicion to the Central Abuse Hotline.

Health Oversight: If a complaint is filed against your mental health practitioner with the Florida Department of Health on behalf of the Board of Psychology, the Board of Clinical Social Work, Marriage & Family Therapy & Mental Health Counseling, or Florida Board of Medicine and Nursing, the Department has the authority to subpoena confidential mental health information from the practitioner relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, information will not be released without the written\authorization of you or your legal representative, or a subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Worker's Compensation: If you file a worker's compensation claim for a work related injury or illness, your PHI, and relevant records must be furnished upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier.

To Family Members, Friends and Others: If you are in an emergency situation involving you or another person (e.g. your minor child) and you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, Dr. Reynolds has been unable to locate you, Dr. Reynolds may, based on professional judgment and the surrounding circumstances, determine that disclose is in the best interests of you or the other person. In these emergencies, your PHI will be disclosed, but only as it pertains to the care being provided and you will be notified of the specific disclosures as soon as possible after the care is completed.

IV. PATIENT'S RIGHTS

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Dr. Reynolds is not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen. Upon your request, your bills will be sent to another location).

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in the mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, your practitioner will discuss with you the details of the request process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. This request may be denied. On your request, you will have a discussion with your practitioner about the details of the amendment process.

Right to **an Accounting:** You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, you practitioner will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the Notice even if you have agreed to receive the notice electronically.

V. COMPLAINTS

If you are concerned that your privacy rights have been violated, or you disagree with a decision that was made about access to your records, you may contact the Security of Department of Health & Human Services. There will not be any retaliation against you for exercising your right to file a complaint.

VI. EFFECTIVE DATE RESTRICTIONS AND CHANGES TO PRIVATE POLICY

This notice is currently in effect and has been so since May 1, 2006. Your practitioner reserves the right to change the terms of this notice at any time as authorized by law and to make the new notice provisions effective for all PHIs that the office maintains. The changes will be effective immediately. If changes are made, they will be posted along with its effective date, in the business office. In addition, upon request, you will be given a copy of the current Notice.