Delphini Solutions Psychology

Elaine D. Kring, Ph.D., LMHC, NCC

*Welcome to **Delphini Solutions Psychology** with **Dr. Elaine Kring**.*

Please read carefully, fill out, and sign the following documents. Contact Dr. Kring with any questions or concerns.

- ❑ Intake Form
- ❑ Procedures and Policies Form
- ❑ Informed Consent Form
- ❑ HIPAA Notice of Privacy

Date: _____

Name: _____ Date of Birth: _____

Address: _____

_____

*** Your Right to request where I contact you**: *(please check)*

Home Call: Y / N Message: Y / N Number: _____

Cell Call: Y / N Message: Y / N Text: Y / N Number: _____

Work Call: Y / N Message: Y / N Number: _____

Email Y / N _____

Address for billing: _____

If not, how may I contact you_____

Occupation/Employer: _____

Current Marital Status: __single __engaged __married __separated __divorced __widowed

Spouse's / Partner's Name: _____

Spouse's / Partner's Contact Info: _____

Spouse's / Partner's Occupation / Employer: _____

Children: (names and ages) _____ _____

_____ _____

Can you briefly describe the reason for your visit?

_____

_____

_____

_____

_____

What do you hope to gain from this counseling experience?

_____

_____

_____

Your 3 main goals or changes you would like to accomplish through counseling:

1. _____
2. _____
3. _____

History of alcohol or drugs (self or family): Yes or No, *if yes please explain.*

_____

_____

_____

[SAMHSA's National Helpline, 1-800-662-HELP (4357), TTY: 1-800-487-4889, www.samhsa.gov]

HIstory of domestic violence or abuse (self or family): Yes or No, *if yes please explain.*

_____

_____

_____

[National Domestic Violence Hotline: 1−800−799−7233 or TTY 1−800−787−3224, www.thehotline.org]

What else would you like me to know?

_____

_____

_____

Have you seen a mental health professional in the past? _____

When and with whom? _____

Family Physician: _____ Phone number: _____

Psychiatrist: _____ Phone number: _____

Current Medications: _____

Are you now or have you ever experienced suicidal thoughts? _____

If yes, when?_____

[National Suicide Prevention Lifeline: 1-800-273-8255, https://suicidepreventionlifeline.org]

Are you now or have you ever experienced homicidal thoughts? _____

If yes, when? _____

Hospitalizations: (include dates and reasons as they relate to mental illness)

_____

_____

Delphini Solutions Psychology

Elaine D. Kring, Ph.D., LMHC, NCC

PROCEDURES AND POLICIES FOR COUNSELING SERVICES
Notice of Privacy Practices

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

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law *(See Notice of Privacy Practices form)*.

Payments & Insurance Reimbursement

Payments: Payments are due at the time of service. Clients are expected to pay the standard fee of $160.00 per 50 minute session. I accept checks and most major credit cards. There will be a $25.00 charge on any returned checks. As a rule, I do not charge for professional advice over the phone for a brief call, although those longer than 10 minutes may be charges by the per hour rate.

Invoices: Clients requesting to make payment by invoice are requested to complete a payment authorization form. The payment information provided will be used at the client's request or when there is non-payment for an appointment.

Insurance: My receipt can be submitted to your insurance company for reimbursement if you have out-of-network benefits.

Sliding Scale: Because of the unique needs and circumstances of my clients, I do work on a sliding scale. This is discussed on an individual basis only.

Office and Online Counseling Sessions are 50 minutes.
Household Income / Sliding Scale Fee:

$200,000 & above	*$160 / session*
$100,000 - $199,999	*$135 / session*
$75,000 - $99,999	*$110 / session*
$50,000 - $74,999	*$85 / session*
$49,999 & below	*$70 / session*

Cancellation

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. Unless we reached a different agreement, a half fee will be charged for late rescheduling or cancellation, and a full fee will be charged for sessions missed without such notification.

Telephone Emergency Procedures

If you need to contact me between sessions, please call 321-947-8170 and leave a message and I will return your call as soon as possible. If an emergency situation arises, please indicate it clearly on the message including a telephone number. If you are experiencing an emergency, please call 911.

Discussion of Treatment Plan

Within a reasonable period of time after the initial intake, the therapist will discuss with you her understanding of the problem, treatment plan, objectives and anything else related to the outcome of treatment. If you have any unanswered questions, please ask.

Dual Relationships

Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs the therapist's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. The therapist will assess carefully before entering into non-sexual and non-exploitive dual relationships with clients.

- The Central Florida community can be a small community in which many clients know each other and the therapist. Consequently you may bump into someone you know in the waiting room or see your therapist out in the community.
- I will never acknowledge working therapeutically with anyone without your permission. Dual or multiple relationships can enhance therapeutic effectiveness, but can also distract from it and often it is impossible to know that ahead of time.
- If at any time a dual or multiple relationships becomes uncomfortable for either party, it is the responsibility of the one who is uncomfortable to communicate to the other in this matter.

I have read the <u>Agreement and Procedures and Policies</u> carefully. I understand them and agree to comply with them.

(If a client is a minor, print both the minor's name and the parent's name, with parent's signature for both.)

_____ _____ _____

Print Client Name Date Signature

_____ _____ _____

Print Client Name Date Signature

_____ _____ _____

Print Client Name Date Signature

Elaine D. Kring, Ph.D., LMHC, NCC

<u>#MH4982</u>_____ _____

Therapist Date Signature

Delphini Solutions Psychology

Elaine D. Kring, Ph.D., LMHC, NCC

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ **MasterCard** ☐ **VISA** ☐ **Discover** ☐ **AMEX** ☐ **Other** _____
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):

I, _____, authorize *Delphini Solutions Psychology* to charge my credit card above for agreed upon purchases and services. I understand that my information will be saved to file for future transactions on my account.

Customer Signature _____ **Date** _____

We Appreciate Your Business

Delphini Solutions Psychology

Elaine D. Kring, Ph.D., LMHC, NCC

Informed Consent and Client Participation

I understand that my participation is purely voluntary and that I may withdraw whenever I wish. All records are the property of ***Delphini Solutions Psychology***.

Delphini Solutions Psychology is dedicated to maintaining strict confidentiality of all communications between you, your therapist, and any referring professional involved in your treatment. As a client, you control whether or not and to whom confidential information will be disclosed. There are expectations to confidentiality mandated by Florida Law. Under the following circumstances, confidentiality will be breached:

1. Where there is reason to suspect a child, adolescent, or elder has been or will be abused.
2. Where there is reasonable cause to believe that you pose a risk of imminent harm to yourself or to someone else.
3. Where there is a valid court order compelling records or witness testimony.

I consent to participate in mental health treatment with ***Delphini Solutions Psychology*** for myself, and/or minor child

_____.

(please print name of yourself or minor child)

I have clarified any questions that I may have with my therapist or staff and I understand and agree to abide by the policies and procedures outlined above.

I understand that if I am unable to keep my appointment, I must contact ***Delphini Solutions Psychology*** 24 hours in advance to cancel or reschedule, or I will be held responsible for payment of that missed session. A late cancellation fee is $80.00 and a “No Show” fee is $160.00.

Client Name: _____

Minor Child’s Name: _____

Client / Parent Signature: _____

Therapist Signature: _____

Date: _____

Delphini Solutions Psychology

Elaine D. Kring, Ph.D., LMHC, NCC

I have read the HIPAA Notice of Privacy Practices carefully. I understand I may request a copy to keep.

(If a client is a minor, print both the minor's name and the parent's name, with parent's signature for both).

_____	_____	_____
Print Client Name	Date	Signature
_____	_____	_____
Print Client Name	Date	Signature
_____	_____	_____
Print Client Name	Date	Signature

Elaine D. Kring, Ph.D., LMHC, NCC
#MH4982

_____	_____	_____
Therapist	Date	Signature

Delphini Solutions Psychology

Elaine D. Kring, Ph.D., LMHC, NCC

3662 Avalon Park E Blvd Suite 2028 Orlando, FL 32828

HIPAA DISCLOSURE

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how medical information about you, including that involving mental health treatment and psychological services may be used and disclosed, and how you can gain access to this information. Please review it carefully.

HIPAA PRIVACY INFORMATION

HIPAA (Health Insurance Portability and Accountability Act) is a federal law that defines Protected Health Information (PHI) and mandates its protection by the providers of certain health care services. It is important that you know the general rights and obligations directed by this law. In addition to the following HIPAA rules, the laws of the state of Florida, including F.S. Ch. 491, the Code of Ethics of the Board of Mental Health Counselors also guide my practice. Mental health practitioners have traditionally maintained much stricter control of patient information than other health providers and that will continue to be the case with my practice. Please contact my office if you have any questions about PHI and our confidentiality practices.

FLORIDA-HIPAA PRIVACY NOTICE FORM

Notice of Mental Health Practitioners Policies and Practices to Protect the Privacy of Your Health Information

This notice describes use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment, and conducting healthcare operations are necessary for quality care. State and federal laws allows me to use and disclose your health information for these purposes. Mental health, psychological, and medical information about you may be used and disclosed and how you can gain access to this information.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

My practice or I may use or disclose your protected health information (PHI) for treatment, payment, and health care operation purposes with your consent. To help clarify these terms, here are some definitions:

1. Protected health information (PHI) refers to information in your record that could identify you.
2. Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health professional.
3. Payment refers to the fees you pay me for services. Health care operations are activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
4. Use applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
5. Disclosure applies to activities outside this practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes contain documentation of my work with you and include, but are not limited to, our conversations during individual, group, joint, and family counseling sessions, which I have kept separate from the rest of your medical record. These notes are given greater degree of protection than PHI. You may revoke all such authorizations at any time, providing each revocation in writing.

III. Uses and Disclosures with Neither Consent Nor Authorization

My practice and I may use or disclose PHI without your consent or authorization in the following circumstances:

1. *Child Abuse*: If I know, or have 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 I report such knowledge or suspicion to the Florida Department of Child and Family Services.

2. *Adult and Domestic Abuse*: If I know, or have reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected or exploited, I am required by law to report such knowledge or suspicion to the Central Abuse Hotline.

3. *Health Oversight*: If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Mental Health Counselors, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

4. *Judicial or Administrative Proceedings*: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment records, such information is privileged under state law. I will not release this information without a written authorization from you or your legal representative, or a subpoena of which you have been properly notified. The privilege does not apply when you are being evaluated for a third party or when the evaluation is court-ordered. You will be informed in advance if this is the case.

5. *Serious Threat to Health Safety*: When you present a clear and immediate probability of physical harm to yourself, to other individuals or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, law enforcement agency or other appropriate authorities.

6. *Worker's Compensation*: If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient Rights

1. *Right to Request Restriction*: You have the right to request restrictions on certain uses and disclosures of protected health information about you. This request to restrict requests must be made in writing. However, I am not required to agree to a restriction request.

2. *Right to Receive Confidential Communication 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 seeing me.

Upon your request, I/we will send your bills to another address.

Right to request where I contact you as follows: (please check)

Home __yes __no Number:_____ Address for billing:_____

Cell __yes __no Number:_____ _____

Work __yes __no Number:_____ _____

If not, how may I contact you_____

3. *Right to Inspect and Copy:* You have the right to inspect or obtain a copy of PHI in my mental health and billing records for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may be denied access to Psychotherapy Notes if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. I shall notify you or your representative if I do not grant complete access. On your request, I will discuss with you the details of the request and denial process. I do charge an administrative fee for copying of pages 1-25 at 50 cents and each additional page at $25 cents. Also, if any copies need to be mailed there will be a charge for postage. Upon your request, I will discuss with you the details of the request process.

4. *Right to Amend:* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

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

6. *Right to Paper Copy:* You have the right to obtain a paper copy of the notice from me, upon request, even if you have agreed to receive the note electronically.

V. Mental Health Practitioner Duties

1. My practice and I are required by law to maintain privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
3. If I revise my policies and procedures, I will provide a revised notice in person or through mail.

VI. How to Complain About My Privacy Practices

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, I ask that you notify me (Elaine D. Kring, Ph.D., LMHC, NCC) first at Delphini Solutions Psychology 3662 Avalon Park E Blvd Suite 2028 Orlando, FL 32828. You may also send a written complaint to the Secretary of Department of Health and Human Services at: 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VII. Person to Contact For Information About This Notice Or to Complain About My Privacy Practices

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of Department of Health and Human Services, please contact me first at Delphini Solutions Psychology 3662 Avalon Park E Blvd, Suite 2028 Orlando, FL 32828.

CONSENT TO TREATMENT

Your signature below indicates that you have read the office policies, have been offered a copy of the HIPAA document, understand the Notice of Privacy Practices, and that you are completely responsible for full payment of fees - you are responsible to understand exactly what services your insurance policy covers. Insurance Claims: I authorize the release of any medical or other information necessary to process insurance claims. I also consent to payment of insurance benefits to the provider accepting assignment of said benefits.

_____ _____

Client Signature Date

_____ _____ _____ _____

Client Name (Please PRINT) Date Witness Date