FLORIDA ART THERAPY SERVICES, LLC

Demographic Information

Date:_____

Client Name:_____

Address:_____

Street **Unit/Apt/Suite #**

_____

City **State** **Zip**

Date of Birth: ____/_____/_____ Age: _____ SSN:_____-_____-_____ DL:_____

Home Phone: (_____)-_____ Cell: (_____)-_____

Email:_____ Do you give permission to email? YES NO _____

Initials

Do you give permission to leave a voice message on you Home Phone? YES NO _____ Cell Phone? YES NO _____

Initials **Initials**

Do you give permission to send and receive text messages? YES NO _____

Initials

Responsible Party (Parent or Legal Guardian):_____

Name **Relationship**

Address if different from above:_____

Employer: _____Telephone:_____ May I call there? YES NO _____

Name **Initials**

Emergency Contact: _____

Name **Relationship** **Telephone**

Referred By:_____

Reason for Referral/ Presenting Problems: _____

_____

Insurance Company Name:_____ Phone Number:_____
Insured ID/Member Number_____ Group Number:_____
Billing Address:_____

Florida Art Therapy Services, LLC Policies, General Information & Consent to Provide Psychotherapy Services

Consent: I, _____, give my consent and approval for Reina Lombardi, MA, ATR-BC, ATCS, LMHC, Amy Strom, LCSW, MSSA, MEd, Victoria DeYoung, MA, Registered Mental Health Counselor Intern #IMH14132, or Monika Urbanska, MA, ATR-P, Registered Mental Health Counselor Intern #IMH15629, of Florida Art Therapy Services, LLC to provide psychotherapy services for myself.
OR I (We) as the parents/guardians of _____(client), give my consent and approval for Reina Lombardi, MA, ATR-BC, LMHC, Amy Strom, LCSW, MSSA, MEd, Victoria DeYoung, MA, Registered Mental Health Counselor Intern #IMH14132, or Monika Urbanska, MA, ATR-P, Registered Mental Health Counselor Intern #IMH15629, of Florida Art Therapy Services, LLC to provide psychotherapy services for my child or adult under my guardianship.
I understand that sessions with my child are confidential, and that I (we) will be involved in the treatment process as needed at the request of the therapist. By signing below we are stating approval of services and that I/we have legal guardianship over my child or adult or myself and I have read this policy, general information, and informed consent agreement. I understand that it is the policy of Florida Art Therapy Services, LLC to obtain consent from both parents and that my child will not be seen until this document is signed by both parents. _____(initial) _____ (initial)

Confidentiality: Florida Art Therapy Services is required to keep timely record of therapy and maintain confidentiality of all records. All information disclosed within sessions and the written records pertaining to those sessions and communication between client, parent/guardian, and the therapist are confidential and may not be disclosed to anyone without your (client's) and parent guardian written permission, except where required by law. In the even that a counselor is incapable of continuing therapy services due to illness or death, files will be accessed by a designated therapist who will keep the confidentiality of those files as expected and continue services if jointly agreed upon. Therapy files are kept for seven years after termination of services or seven years after the child turns eighteen years old. _____(initial) _____ (Initial)

Legal Requirements for Disclosure: The following circumstances legally require a breach of confidentiality:

1. When there is cause to suspect a child, adolescent, or elder has been or may be abused or neglected.
2. When there is reasonable cause to believe that someone poses risk of imminent harm to themself.
3. When there is reasonable cause to believe that someone poses risk of harm to another individual.
4. When there is a valid court order compelling records or witness testimony. _____ (initial) _____(Initial)

Confidentiality of e-mail, cell phone, and fax communication: It is very important to be aware that e-mail and cell phone (also cordless phones) communication can be relatively easily accessed by unauthorized people and, hence, the privacy and confidentiality of such communication can be easily compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong address. Please notify Florida Art Therapy Services at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes in emergency situations. _____ (initial) _____ (Initial)

Social Media Policy: In order to protect your confidentiality and maintain professional boundaries we do not accept connections on personal social media accounts with current or past clients. Clients that would like to stay connected to the practice may do so by following the Florida Art Therapy Services, LCC Business Facebook Page. _____ (initial)_____

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be confidential in nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and parenting disputes, injuries, lawsuits, etc...) neither you (client), parent/guardian, not your attorney, nor anyone else acting on your behalf will call upon Reina Lombardi to testify in court or at any other proceeding, nor will disclosure of the psychotherapy records be requested. If a parents or guardian is bringing his/her child to Florida Art Therapy Services, LLC to help during a stressful time such as court cases in the family's life, then the representatives of Florida Art Therapy Services, LLC work is directed toward helping the child in therapy. Therefore, the above mentioned representatives will not participate in court proceedings because it is counterproductive to the therapy process. Establishing this policy from the beginning, each parent's rights are being protected as well as keeping the therapy room a safe, confidential place for a child. In some situations, at counselor's discretion, the counselor may agree to parent/guardian's request to write a report about the client's progress in therapy. Both parents will receive a copy of that report. _____ (initial)_____(initial)

Supervision & Consultation: Reina Lombardi and Victoria DeYoung may participate in supervision and consultation with another mental health professional regarding client care; however, during that process identifying information is not discussed. The client's identity remains anonymous and the confidentiality is maintained. Supervision ensures the highest quality services and care. _____ (initial) _____ (initial)

Your Rights: As a client, you have the right to terminate treatment at any time and request appropriate referrals from Florida Art Therapy Services, LLC. You have the right to review or receive a summary of your records, except in limited legal or emergency circumstances or when Florida Art Therapy Services, LLC assesses that releasing such information might be harmful in any way. In such a case, Florida Art Therapy Services will provide the records to an appropriate and legitimate mental health professional of your choice. You have the right to request an amendment of your records in writing. We may deny your request under certain circumstances. _____ (initial) _____ (initial)

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 exploitative in nature. Lee County is a small community and many clients know each other and their counselor from the community. Consequently, you may bump into someone you know in the waiting room or into your counselor out in the community. Your counselor will never acknowledge working therapeutically with anyone without his/her written permission. Many clients choose their counselor as their therapist because they know her before they enter into therapy with her and/or are aware of her stance on the topic. Nevertheless, your counselor will discuss with you, their client(s), the often-existing complexities, potential benefits, and difficulties that may be involved in such relationships. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to your counselor if the dual relationship becomes uncomfortable for you in any way. Your counselor will always listen carefully and respond accordingly to your feedback. Your counselor will discontinue the dual relationship if she finds it interfering with the effectiveness of the therapeutic process or the welfare of the client and, of course, you can do the same at any time. _____(initial) _____(initial)

Termination: During the first couple of sessions, your therapist will be assessing if they can be of benefit to you. If following the assessment the counselor feels that another provider may be a more appropriate match, the therapist will provide you with referrals for you to contact that specialize in your area of concern. If at any point during therapy, your counselor assesses that they are not effective in helping you reach your therapeutic goals, they are obligated to discuss it with you and if appropriate, terminate treatment and refer you elsewhere to appropriate services. You have the right to terminate therapy at any time. _____ (initial) _____ (initial)

Payment: Payments are due at time of service. Clients are able to pay by cash, check, or credit card. Retuned checks require a $25.00 per check charge in addition to any fees accrued. I understand that I am responsible for any fees *NOT* covered by my insurance plan. _____ (initial) _____ (initial)

Fees: Individual/Family Session (60min) at the rate of _____ per hour session. Telephone conversations, emails, site visits, school observations, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. may be charged at the same rate as indicated and agreed upon. _____ (initial) _____ (initial)

Appointments & Cancellations: Appointments are scheduled specifically for you, therefore a 24 hour cancellation notice is required if you are unable to attend a scheduled appointment. In the event that you do not show up for an appointment or do not provide the 24 hour advanced notice, you will be charged for the full amount of your cancelled session. If you cancel or fail to attend two consecutive appointments or demonstrate a pattern of canceling or not showing up for appointments, Florida Art Therapy Services, LLC may terminate your case due to noncompliance with treatment. Please arrive on time for your scheduled appointment. If you arrive more than 10 minutes late for an appointment, you will be responsible for full payment of session. Most insurance companies do not reimburse for missed sessions, and you will be responsible for payment of missed or cancelled sessions._____ (initial) _____ (initial)

Mediation and arbitration: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Florida Art Therapy Services, LLC and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Lee County, Florida in accordance with the rules of the American Arbitration Association, that are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Florida Art Therapy Services, LLC can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum. _____ (initial) _____ (initial)

Insurance: I hereby authorize payment of medical benefits to Florida Art Therapy Services, LLC. I hereby accept responsibility for payment for any services provided to me or my child that I not covered by my insurance. I also accept responsibility for the fees that exceed the payment made by my insurance, if Florida Art Therapy Services, LLC does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time service is rendered. _____ (Initial) _____ (initial)

***Telephone and emergency procedures*:** In case of emergency with the therapist, she will contact you to notify you of any appointment changes that may occur. If you need to contact Florida Art Therapy Services, LLC between sessions, please leave a message on her voice mail (239)297-7099. Your call will be returned as soon as possible or within 24 business hours. Mrs. Lombardi checks her messages a few times a day (but never during the nighttime), unless she is out of town. Mrs. Lombardi checks the messages less frequently on weekends and holidays. In the case of an emergency that is a threat to life or death, please call the Police (911), or contact the local crisis line at Salus Care 239-275-3222. _____(initial) _____(initial)

I have read the about Agreement and Policies and General Information carefully. I understand them and agree to comply with them. I consent to treatment.

_____

Signature of Client Date

_____

Signature of Mother /Guardian Date

_____

Signature of Father /Guardian Date

_____

Signature of Reina Lombardi, MA, ATR-BC,ATCS, LMHC Date
Board Certified Registered Art Therapist & Art Therapy Certified Supervisor #10-038
Licensed Mental Health Counselor #MH 12643

_____

Signature of Date