Client Information

Client Name: _____* Today's Date:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone: _____ OK to leave message yes or no (circle one)
Cell Phone:_____ OK to leave message yes or no (circle one)
Male/Female (circle one) OK to send mail to home address yes or no (circle one)
Employer: _____
Work Phone:_____OK to leave a message yes or no (circle one)
Date of Birth: _____ Marital Status:_____ Anniversary:_____
Email Address: _____OK to Email yes or no (circle one)
*if counseling is for a child/teen under the age of 18 both parents/all guardians must sign all paperwork

How did you hear about the counseling center? _____
Referred By: _____

Guardian /Responsible Party Information and Emergency Contact

Guardian/Emergency Contact Name: _____
Relationship to client :_____
Address:_____ City:_____ State:_____ Zip:_____
Phone: _____ OK to leave message yes or no (circle one)
Date of Birth: _____ Male/Female (circle one)
Marital Status: _____* If divorced, do you have legal custody or shared custody?(circle one) Please supply Court Documentation for the file supporting your answer.
Email Address:_____ OK to Email yes or no (circle one)

FOR GUARDIANS REGARDING TEENAGE CLIENTS:
Is your teenager authorized to schedule and attend counseling appointments without your confirmation and/or acknowledgement? yes or no (circle one) _____

In a few words, please describe your main concern or reason for seeking Christian Counseling:

_____
_____
_____

Please list below all past and present counselors, therapists, psychologists, psychiatrists, social workers or any other mental health specialists you have seen in the past 10 years for any type of treatment.

Name:_____Phone:_____Dates:_____

Name:_____Phone:_____Dates:_____

Name:_____Phone:_____Dates:_____

Please also list any additional physicians you are currently seeing.

Physician Name and Phone Number **Reason**

_____

_____

_____

_____

By signing below I attest that previous written information is correct to the best of my knowledge.

_____ _____

Client Signature Date

Full Circle Ministries & Tampa Bay Christian Counseling Center

We require all clients to keep a credit card on file. The credit card will only be used in instances where an appointment is cancelled or no-showed outside the parameters of the 48 hour cancellation policy. Please note, reminder calls are a courtesy and keeping appointment times is the responsibility of the client. If an appointment is missed the client will be billed for that session.
Your credit card is part of your file and is therefore handled with complete confidentiality.

We thank you for your understanding in this matter. If you have any questions, please feel free to speak with Director Pastor Chris Cambas.

By signing below you understand the cancellation policy:

_____ _____

Client Signature Date

Credit Card Number: _____Exp._____

CVV Code (3-4 digits on back of card): _____

Billing Address (including zip):

_____

Payment in full is due prior to going into session with the counselor. Please note, our accepted forms of payment are: cash, credit/debit cards (excluding American Express) and checks. We regret that we cannot hold payment or post date checks, payment is due at the time services are rendered. Thank you!

Full Circle Ministries
3036 W Bearss Ave
Tampa, FL 33618
Telephone: (813) 964-5511

Authorization to Disclose Information

Client Name: _____

Counselor Name: _____

I herby authorize Full Circle Ministries to disclose my individually identifiable health information described below for counseling sessions with the above-named counselor on the following dates:
___Today____ through _Termination of counseling by either party in writing.

Specific purpose(s) of this disclosure: Testing/Supervision

Specific information to be disclosed: All file information

Persons/Organizations to whom this information may be disclosed:

Name : Dr Steven Kruse Phone Number: 813-954-9322 Address: 645 W Lumsden, Brandon, FL 33511

Name : Robbie Goss Phone Number: 813-964-5511 Address: 3036 W Bearss Ave Tampa Fl 33618

This Authorization will expire (date or event): Termination of counseling in writing by either party.

I UNDERSTAND THAT:

- I may refuse to sign this authorization and that my refusal to sign will not affect my care or treatment by FCM or my Christian counselor.
- This authorization is not for the use or disclosure of psychotherapy notes.
- I may revoke this authorization at any time by notifying the Privacy Official in writing, but the revocation will not have any affect on any actions the Provider took before it received the revocation.
- If the disclosure authorized above is not to an entity "covered" under HIPAA., the information that is used or disclosure pursuant to this authorization may be re-disclosed by the receiving persons or entity and the information will no longer be protected by the federal privacy regulations, unless such re-disclosure is expressly prohibited by other state or federal law (e.g., state federal laws regulation disclosure of information about substance abuse, HIV/AIDS, pregnancy and reproductive conditions, genetic testing, etc.

_____ _____

Date Client Signature/ Legal Guardian & Relationship to Client

_____ _____

Date Witness (TBCCC Staff Member/Counselor)

The client must receive a copy of this signed authorization

Full Circle Ministries

3036 W Bearss Ave
Tampa Fl 33618
(813)964-5511

Agreement to Participate in Christian Counseling with Registered Intern/Unlicensed Counselor

Client Name: _____ Authorized Rep: _____

Counselor Name: _____ Relationship of Rep: _____

PLEASE READ THIS AGREEMENT CAREFULLY BEFORE SIGNING

Christian Counseling – Benefits and Risks

Christian counseling is biblical in nature, and not like a doctor visit, nor is it like psychotherapy. Christian counseling is not easily described, and will vary considerably based on the personalities of the Christian counselor and the client. My Christian counselor, as a registered intern, may integrate some aspects of mental health counseling with those of Christian counseling, as appropriate to my situation. In order to receive any benefit, I understand that I must commit to open and honest communication with the Christian counselor, and to working on issues discussed, both during our sessions and while at home. I understand that regular attendance may lead to a more satisfying experience, but that I am free to discontinue the Christian counseling at any time.

Clients may expect some benefits from Christian counseling, but I fully understand that because of factors beyond the Christian counselor's control, no such benefits nor particular outcomes can be guaranteed. I understand that Christian counseling may involve discussing unpleasant aspects of my life, and that throughout the process of the Christian counseling I may experience uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness, and helplessness, and may lead to changes in my relationships with others, or I may choose to make life changes which could be distressing.

I understand that the Christian counselor is not providing an emergency service and I have been informed of whom to call upon in an emergency or during weekend and evening hours, including the use of "911" and/or "211."

Unlicensed Counselor

Chapter 491, Florida Statutes, provides an exemption from the licensure requirement for a graduate-level intern who is registered with the state of Florida, and who is performing counseling under the supervision of a licensed mental health professional. I understand that my counselor is a registered intern, but is not a licensed mental health professional, and that at any time I may decide, or my counselor may suggest, that I may receive greater benefit from counseling by a licensed professional.

Confidentiality

I understand that conversations with the counselor will be confidential, except for uses and disclosures allowed under the Notice of Privacy Practices of Full Circle Ministries ("Full Circle"), a copy of which I have received and reviewed. Specifically, I am aware and acknowledge that disclosure of my information may be required under federal and state law in certain situations, such as if my counselor has reasonable cause to suspect child or elder abuse or neglect, or where there is a clear and immediate probability of physical harm to the client, to other individuals or to society, and the counselor communicates the information only to the potential victim, appropriate family members, law enforcement or other appropriate authorities. I further understand that my counselor must discuss my situation with the counselor's licensed supervisor, and also may discuss my situation with other counselors of Full Circle, both licensed and unlicensed, in the interest of furthering the counseling of Full Circle's clients, and the knowledge and experience of its counselors. I understand that if I am signing this Agreement on behalf of a client who is a minor child, that the counselor will only discuss the counseling with me in general terms unless there is a danger to the life of the minor child or others.

Financial Obligations

I understand that I am financially responsible for the entire counseling fee, including any portion not reimbursed or covered by third parties. I also understand that I am expected to pay for the counseling fees at the time of the visit and any arrangement for payments by third parties will be made before the counseling session.

I understand that each appointment with the counselor is a contract whereby the client has exclusive use of the counselor's time for a scheduled appointment. I also understand that if I do not attend the session and have not cancelled at least 24 hours in advance, I will be held responsible for fee for that session.

Consent

I know of no reasons why I should not or cannot undertake this Christian counseling with an unlicensed counselor who is a registered intern, and I hereby agree to participate fully and voluntarily, and to be bound by the terms of this Agreement. I have had an opportunity to ask any questions prior to signing this Agreement. I understand and agree that this Agreement will remain valid unless or until it is revoked in writing, and that any such revocation will not effect counseling performed prior to the date of revocation.

Signature: _____ Date: _____
(Client or Authorized representative, who by signing accepts all responsibilities

Full Circle Ministries

3036 W Bearss Ave
Tampa Fl 33618
(813) 964-5511

Agreement to Participate in Professional Christian Counseling with Licensed Counselor

Client Name: _____ Authorized Rep: _____

Counselor Name: _____ Relationship of Rep: _____

PLEASE READ THIS AGREEMENT CAREFULLY BEFORE SIGNING

Christian Counseling – Benefits and Risks

Christian counseling is biblical in nature, and not like a doctor visit, nor is it like psychotherapy, although the Christian counselor may integrate Christian counseling with professional mental health counseling as appropriate. Christian counseling is not easily described, and will vary considerably based on the personalities of the Christian counselor and the client. Professional Christian counseling integrates Christian counseling with professional mental health counseling. In order to receive any benefit, I understand that I must commit to open and honest communication with the Christian counselor, and to working on issues discussed, both during our sessions and while at home. I understand that regular attendance may lead to a more satisfying experience, but that I am free to discontinue the sessions at any time.

Clients may expect some benefits from Christian counseling, but I fully understand that because of factors beyond the Christian counselor's control, no such benefits nor particular outcomes can be guaranteed. I understand that Christian counseling may involve discussing unpleasant aspects of my life, and that throughout the process of the Christian counseling I may experience uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness, and helplessness, and may lead to changes in my relationships with others, or I may choose to make life changes which could be distressing.

I understand that the counselor is not providing an emergency service and I have been informed of whom to call upon in an emergency or during weekend and evening hours, including the use of "911" and/or "211."

Confidentiality

I understand that conversations with the counselor will be confidential except for uses and disclosures allowed under the Notice of Privacy Practices of Full Circle Ministries ("Full Circle"), a copy of which I have received and reviewed. Specifically, I am aware and acknowledge that disclosure of my information may be required under federal and state law in certain situations, such as if my counselor has reasonable cause to suspect child or elder abuse or neglect, or where there is a clear and immediate probability of physical harm to the client, to other individuals or to society, and the counselor communicates the information only to the potential victim, appropriate family members, law enforcement or other appropriate authorities. I further understand that my counselor may discuss my situation with other counselors of Full Circle, both licensed and unlicensed, in the interest of furthering the counseling of Full Circle's clients, and the knowledge and experience of its counselors. I understand that if I am signing this Agreement on behalf of a client who is a minor child, that the counselor will only discuss the counseling with me in general terms unless there is a danger to the life of the minor child or others.

Financial Obligations

I understand that I am financially responsible for the entire counseling fee, including any portion not reimbursed or covered by third parties. I also understand that I am expected to pay for the counseling fees at the time of the visit and any arrangement for payments by third parties will be made before the session.

I understand that each appointment with the counselor is a contract whereby the client has exclusive use of the counselor's time for a scheduled appointment. I also understand that if I do not attend the session and have not cancelled at least 24 hours in advance, I will be held responsible for fee for that session.

Consent

I know of no reasons why I should not or cannot undertake this Christian counseling and I hereby agree to participate fully and voluntarily, and to be bound by the terms of this Agreement. I have had an opportunity to ask any questions prior to signing this Agreement. I understand and agree that this Agreement will remain valid unless or until it is revoked in writing, and that any such revocation will not effect counseling performed prior to the date of revocation.

Signature: _____ Date: _____
(Client or Authorized representative, who by signing accepts all responsibilities herein on behalf of the Client)

Full Circle Ministries

Acknowledgement of Notice of Privacy Practices

Client Name: _____

Date: _____

I acknowledge receiving a copy of the HIPAA Notice of Privacy Practices for Full Circle Ministries, which was effective on January 1, 2009.

_____
Client Signature

_____
Client's Legal Representative

_____
Relationship/Authority to sign for Client
(attach a copy of authority document if not already in Client chart)

This acknowledgment is to be retained in client record.

Internal Use Only

Staff: If this acknowledgment is not signed, provide a description of your efforts to obtain client's signature, and the reason(s) why a signed acknowledgement was not obtained:

_____

_____

_____

_____

Staff Name: _____

NOTICE OF PRIVACY PRACTICES
FOR FULL CIRCLE MINISTRIES

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

THIS NOTICE IS EFFECTIVE ON JULY 1, 2007

This Notice describes the privacy policies of Full Circle Ministries, and applies to the licensed and unlicensed spiritual counselors, employees, staff and other personnel who provide services at Full Circle Ministries (collectively "FCM"). The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by the terms of this notice. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

This notice applies to any information in our possession that would allow someone to identify you and learn something about your physical or mental health. It is intended to describe the policies that protect information relating to your past, present and future physical or mental conditions, counseling, and payment for that counseling **(Protected Health Information** or "**PHI").** It does not apply to information that contains nothing that could reasonably be used to identify you.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your PHI.
- We are required to provide this notice of our privacy practices to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

HOW WE MAY USE OR DISCLOSE YOUR PHI.

We may use your PHI, or give it out to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. Any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

Treatment. We will use your PHI to provide you with counseling and related services. This means that our employees and Staff and others who work under our direct control may read or discuss your PHI to learn about your physical or mental condition and use it to make decisions about your counseling plan or other care. For instance, a counselor may read your chart in order to counsel you properly, or may discuss your situation with other counselors to better our counseling to all clients. We will also give your information to others who need it in order to provide you with physical or mental treatment or services. For instance, we may share your PHI with your mental health providers.

Payment. We will use your PHI, and disclose it to others, as necessary to obtain payment for the services we provide to you. For instance, an employee in our business office may use your PHI to prepare a bill. And we may send that bill, and any PHI it contains, to your insurance company. We may also disclose some of your PHI to companies with whom we contract for payment-related services. We may give information about you to a health plan that pays for your benefits. We will not use or disclose more information for payment purposes than is necessary.

Operations. We may use your PHI for activities that are necessary to operate this organization. This includes reading your PHI to review the performance of our counselors or staff. We may also use your information and

the information of other patients to plan what services we need to provide, expand, or reduce. For example, we may disclose your PHI to a company that assists us with quality assurance. We may disclose your PHI as necessary to others who we contract with to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants, for instance.

To Business Associates. We may hire third parties that may need your PHI to perform certain services on behalf of FCM. These third parties are **"Business Associates"** of FCM. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, FCM.

Family and Friends. We may disclose your PHI to a member of your family or to someone else who is involved in your counseling or payment for counseling. We may notify family or friends if you are in the hospital, and tell them your general condition. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to such family or friends that you object to in writing. We may also disclose to your personal representatives who have authority to act on your behalf (for example, to parents of unemancipated minors or to someone with a power of attorney).

Public Health Oversight. We may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; licensure or disciplinary actions (for example, to investigate complaints against health care providers); inspections; and other activities necessary for appropriate oversight of government programs (for example, to investigate Medicaid fraud).

To Report Abuse. We may disclose your PHI when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your PHI, and the information of others, if we are audited by Medicare or Medicaid.

Law Enforcement. We may disclose your PHI for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your PHI to a federal or state agency investigating our compliance with applicable privacy regulations.

For Lawsuits and Disputes. We may disclose PHI in response to an order of a court or administrative agency, but only to the extent expressly authorized in the order. We may also disclose PHI in response to a subpoena, a lawsuit discovery request, or other lawful process, but only if we have received adequate assurances that the information to be disclosed will be protected.

Specialized Purposes. We may disclose your PHI for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security and intelligence purposes. We may disclose the PHI of members of the armed forces as authorized by military command authorities. We also may disclose PHI about an inmate to a correctional institution or to law enforcement officials to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your PHI to your employer for purposes of workers' compensation and work site safety laws (OSHA, for instance). We may disclose PHI to organizations engaged in emergency and disaster relief efforts.

To Avert a Serious Threat. We may disclose your PHI if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Research. We may disclose your PHI in connection with medical research projects if allowed under federal and state laws and rules. FCM may disclose PHI for use in a limited data set for purposes of research, public health or health care operations, but only if a data use agreement has been signed.

Information to Patients. We may use your PHI to provide you with additional information. This may include sending you appointment reminders. This may also include giving you information about treatment options or other services that we provide.

YOUR RIGHTS

Authorization. We will ask for your written authorization if we plan to use or disclose your PHI for reasons not covered in this notice. If you authorize us to use or disclose your PHI, you have the right to revoke the authorization at any time. If you want to revoke an authorization, send a written notice to the Privacy Official listed at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have already given out your information or taken other action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

Request Restrictions. You have the right to ask us to restrict how we use or disclose your PHI. We will consider your request, but we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

Confidential Communication. You have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send mail to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your PHI by mail. We will not ask you to explain why you are making the request. We will agree to reasonable requests.

Access to and Copies of PHI. You have a right to access the PHI about you that we have in our records. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes counseling summary and billing records. We may charge a fee for the cost of copying and mailing the records, to the extent allowed by state and federal law. To ask to inspect your records, or to receive a copy, send a written request to the Privacy Official listed at the end of this notice. Your request should specifically list the information you want copied. We will respond to your request within a reasonable time, but no later than 30 days. We may deny you access to certain information, including certain psychotherapy notes; If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

Amend PHI. You have the right to ask us to amend PHI about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your PHI to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no

charge. We may charge you for any additional lists you request during the following 12 months. You must request this list in writing. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before July 1, 2007. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or operations; disclosures for national security purposes; certain disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed at the end of this notice.

Complaints. You have a right to complain if you think your privacy has been violated. We encourage you to contact our Privacy Official. You may also file a complaint with the Secretary of the Department of Health and Human Services. **We will not retaliate against you for filing a complaint.**

OUR RIGHT TO CHANGE THIS NOTICE.

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any PHI which we already have, as well as to PHI we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. We will post the new notice in our reception area. The new notice will include an effective date.

CONTACT THE PRIVACY OFFICER FOR MORE INFORMATION

If you have any questions regarding this Notice or if you wish to exercise any of your rights described in this Notice, you may contact the Privacy Official at:

Chris Cambas
Full Circle Ministries
3036 W Bearss Ave
Tampa Fl 33618

Copies of this notice are also available at the front reception desk.