A New Tomorrow, PLLC Counseling Services
Dr. Susan Freedman

14499 N. Dale Mabry, Ste#164
Tampa, FL 33618
(813)501-2053

New Client Information

Date: _________

Client Name:____
Last First M.I.

Date of Birth: ____ /____ /______ Age: _____ SSN: _______-_____-_______

Gender: [ ] Male [ ] Female Last School Grade Completed: ____________

How do you prefer to be addressed (Name/Nickname)?_____________________________

Single	Married	Partnered	Separated	Divorced	Widowed
☐	☐	☐	☐	☐	☐

Ethnicity:_____________________________ Religion:_____________________________

Address: ____

City: ____ State: __________ Zip: _________

Home Phone: (___) ____-______ can a message be left at this number?_____yes_____no

Work Phone: (___) ____-______ can a message be left at this number?_____yes_____no

Ext.: _______________

Mobile Phone: (___) ____-______ can a message be left at this number?_____yes_____no

Email : ____

How do you prefer to be contacted? ____

Occupation: ____________________________ Employer: _____________________________

Referred by: ____

In Case of Emergency, Contact:

Name: _______________________________ Relationship: ____________________________

Phone: _______________________________

A New Tomorrow, PLLC Counseling Services

Medical/Mental Health History Self Report

Client's Name: ______________________________ Date of Birth: ________________

Allergies to Food, Medication, Other:____

Current Family Physician: ___________________________ Date of Last Physical Exam: __________

Are there currently or have there previously been problems with any of the following?

	Yes	No
Skin problems	☐	☐
Wounds not healing/easy bruising	☐	☐
Glaucoma/Vision	☐	☐
Gum(s)/Teeth	☐	☐
Hearing	☐	☐
Headaches	☐	☐
Head injuries	☐	☐
Black outs/Fainting	☐	☐
Numbness/Tingling	☐	☐
Thyroid problems	☐	☐
Blood sugar	☐	☐
Sickle cell	☐	☐
HIV/AIDS	☐	☐
Fatigue	☐	☐
Anemia/Low blood count	☐	☐
Breathing/shortness of breath	☐	☐
Fever	☐	☐
Gallstones	☐	☐
Cancer	☐	☐

	Yes	No
Eating	☐	☐
Alcohol	☐	☐
Street drugs	☐	☐
High blood pressure	☐	☐
Heart disease/Chest pain	☐	☐
Rheumatic fever	☐	☐
Nausea/Vomiting	☐	☐
Ulcers	☐	☐
Liver disease or jaundice	☐	☐
Kidney/Bladder problems	☐	☐
Pregnancy (if pregnant, due date ____________)	☐	☐
Sexual function	☐	☐
Difficulty walking/standing	☐	☐
Pain	☐	☐
Sleeping too much	☐	☐
Sleeping too little	☐	☐
Lead/Chemical exposure	☐	☐
Seizures	☐	☐
Change in weight	☐ Gain	☐ Loss

If change in weight: _______ lbs. In _______ time

Please describe:

____

____

Have any family members had any of the following?

	Yes	No	Who
Depression	☐	☐	______________________
Bipolar Disorder	☐	☐	______________________
Suicide or Suicide Attempt	☐	☐	______________________
Schizophrenia	☐	☐	______________________
Eating Disorder	☐	☐	______________________
Anxiety Disorder	☐	☐	______________________
Alcohol/Drug Problems	☐	☐	______________________
ADHD	☐	☐	______________________
Thyroid Problems	☐	☐	______________________
Asthma	☐	☐	______________________
Diabetes	☐	☐	______________________
Stroke	☐	☐	______________________
Dementia/Senility	☐	☐	______________________
Stomach Problems	☐	☐	______________________
Seizures (what kind)	☐	☐	______________________
Heart Problems	☐	☐	______________________
Cancer (what kind)	☐	☐	______________________
High blood pressure	☐	☐	______________________
Abnormal heart rhythm	☐	☐	______________________
Sudden cardiac death	☐	☐	______________________
Tics	☐	☐	______________________

Have there been **hospitalizations for any medical reasons** such as illness, accidents, operations, or tests?

Reason for Hospitalization	Date	How Long?

Continue on back of this sheet, if needed.

Current Medications (including any *over the counter* or *herbal preparations*):

Name of Medication	Dosage	For what reason?	How Long?	Side effects(if any)

Continue on back of this sheet, if needed.

Mental Health Care in the past? (such as psychiatrist, psychologist, social worker, nurse, counselor, or psychological testing)

By Whom?	When?	Diagnosis	Type of Treatment	Were you hospitalized?

Currently using caffeine? □ Yes □ No If yes, how much, how often__________________ If no, past use?____________

Currently using cigarettes? □ Yes □ No If yes, how much, how often__________________ If no, past use?____________

Currently using alcohol? □ Yes □ No If yes, how much, how often__________________ If no, past use?____________

Currently using Marijuana? □ Yes □ No If yes, how much, how often__________________ If no, past use?____________

How often do you have the following problems?

Problem	Never	Rarely	Frequently	Always
Talking, thinking, and more active than normal; Can't be still or quiet				
Talking, thinking, and less active than normal; Can't do things				
Loss of interest in activities; Hard to have a good time				
Feeling sad or depressed; Feeling like crying				
Wishing I was dead				
Planning ways to kill myself or attempting to kill or harm myself				
Low energy, fatigue				
Trouble making decisions or concentrating				
Feeling worthless or guilty				
Eating and appetite more than normal or gained weight				
Eating and appetite less than normal or lost weight				
Trouble falling/staying asleep or early morning wakening				
Racing heart or chest pain (circle which)				
Lightheadedness, dizziness				
Nausea, vomiting, or diarrhea (circle which)				
Sweating or breathing fast and shallow (circle which)				
Tingling in hands, face, feet				
Hot or cold flashes (circle which)				
Trembling or shaking				
Racing thoughts				
Feeling "I'm going crazy" or losing control (circle which)				
Excessive worrying, fear, dread, feeling out of control				
Dream-like sensations or distortions in vision, hearing, etc.				
Frightening flashbacks to an earlier traumatic event				
Nightmares or frightening dreams (circle which)				
Having lots of aches/pains/physical complaints				
I have to do/say something to prevent bad things from happening				
Frequent, unwanted thoughts or images (circle which)				
Being afraid of certain things such as _______________ (fill in blank)				
Mood swings: really down for a time and then really up for a time				
Decreased need for sleep or can't sleep—too wound up				
People telling me "slow down, you are talking too fast"				
Feeling overjoyed with life/ on top of the world/like I can do anything				
Spending or giving away too much money for my financial situation				
Hearing things or voices other people don't hear (circle which)				
Seeing things other people don't see				
Smelling/tasting odd things others don't; things crawling on me				
Feeling that other people are controlling my thoughts				
Being physically or sexually abused (circle which)				
Getting into verbal and physical fights (circle which)				
Thinking about harming others				
Drinking alcohol or using drugs to relax, for pleasure, recreation				

What is the major reason you are seeking help at this time?

How long have you had these problems or symptoms?

How often do they occur?

Why did you decide to seek help now?

What have you tried, in the past, to help yourself?

Who lives with you at home?

Name of person	Relationship to you	Age	Occupation/School

Signature **Date**

A New Tomorrow, PLLC Counseling Services
Dr. Susan Freedman
14499 N. Dale Mabry, Ste#164
Tampa, FL 33618
(813)501-2053

CONTACT & EMERGENCY INFORMATION

You have been provided with my contact information, which is my cell phone number (813-501-2053).

Should you need to contact me between sessions, please leave a message or text me on my cell phone. While I monitor these messages frequently and strive to return calls promptly, I am often not immediately available by telephone. For example, I do not answer any calls when I am with a client.

I usually return phone calls within the same business day if the message is left during normal business hours. Otherwise, I will review and return my messages on the following business day.

If *your call involves a mental health emergency* and I cannot return your call promptly, please go to the nearest emergency room or call 911 immediately and then attempt to contact me again, if needed.

Even the best voice mail systems and attempts to return calls fail at times so please remember that the *emergency room is another resource*.

Please realize that if you are calling with a mental health emergency my response is likely to include use of the local emergency services and the nearest emergency room.

I have carefully read all the terms of the above guidelines and have had an opportunity to discuss any questions.

______________________________ ______________________________
Signature **Date**

FEE-FOR-SERVICE SCHEDULE AND PAYMENT AGREEMENT

FINANCIAL INFORMATION

Service	Fee
Initial Evaluation (50 minutes) (This includes an extended initial session, review of records, correspondence with referring physician, schools, or other agencies as requested and administrative time establishing file.)	$100
Weekly Individual Psychotherapy (50 minutes)	$100
Weekly Couples Psychotherapy (75 minutes)	$150
Extended Psychotherapy – Trauma/EMDR (75 minutes)	$150
Individual Phone Consultation (Calls that exceed 5 minutes are considered appointments billable at the regular session rate.)	$100

PROFESSIONAL FEES

The fee for an initial consultation is $100.00. The fee for follow-up sessions is $100 - $150.00. You will also be charged for other professional services at the rate of $100.00 per hour. These services include, but are not limited to report writing, telephone conversations that last longer than five (5) minutes, consultations with other professionals that you have authorized and preparation of records and/or treatment summaries. Should you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation for and attendance at these proceedings, even if I am compelled to testify by another party.

ACCOUNT BALANCES

Unless otherwise agreed, fees are due and payable prior to services being rendered. A $50.00 fee will be assessed for all returned checks. Services will be discontinued if proper payment is not received in a timely fashion. Delinquent accounts will be turned over to a collection agency.

PAYMENT AND INSURANCE

Currently we do not accept insurance and all fees are on a self-pay basis. We accept cash, all major credit cards, checks or Pay Pal. Please make checks out to **"A New Tomorrow"**. If you are using Pay Pal payment is due 24 hours prior to your session to allow for processing time.

Please initial

_______I understand that fees are due as stated and are payable *at the beginning of the assessment or evaluation session* (this allows her to focus entirely on my problems, needs, and concerns during the session).

_______ When you schedule an appointment with me, I am reserving that time exclusively for you. **If you need to cancel an appointment, please let me know at least two business day (48 hours) in advance**. Understanding this, I agree to accept financial responsibility for any missed appointment/ "no show" **Late cancellations or "no show" appointments (not due to an emergency) will result in your being charged for a full session.**

Please initial

_______I understand and agree that fees for services provided me by Susan Freedman, M.S. RMHCI are due and payable prior to services being rendered. Services will be discontinued if proper payment is not received in a timely fashion. Delinquent accounts will be turned over to a collection agency.

***Payment in the form of personal check, credit card, cash, or PayPal is required in order to schedule and confirm your appointment. Payment must be made prior to services being rendered. You can make payment online using Paypal at: **http://www.anewtomorrow.net/MakeaPayment.en.html**
I have read and understand the information in this agreement. All of my questions and concerns have been discussed with Susan Freedman, M.S., RMHCI, CHT. My signature below indicates that I consent to this office policy.

_______________________________________ _______________________________

Signature of Client or Responsible Party **Date**

INFORMED CONSENT

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and the client and the particular problems you are experiencing. There are many different methods that may be used to deal with the problems you hope to address. Psychotherapy is not like a visit to your medical doctor. To be most beneficial, therapy calls for an active effort on your part both during our sessions and at home. Psychotherapy can have risks and benefits. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. However, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few meetings will involve an evaluation of your needs. At the end of this process, we will work together as a team to establish clear goals and formulate a treatment plan. If you have questions about my procedures, I will discuss them with you in detail. Should we both decide that I am the best person to provide the services you need to achieve your goals, I will schedule your first therapy session.

THERAPY SESSIONS

Services are available by appointment. Initial consultations are scheduled for one hour. Thereafter, we will usually meet once a week for a 50 minute session. The law protects the privacy of all communications between you and your psychotherapist. In most situations, information about you and your treatment can only be released to others with your written consent. There are, however, limits to confidentiality. Please consult the Notice of Privacy Practices (below) for the requirements of legal disclosure of information about you.

I have read and have understood the above and I hereby **consent** to psychological treatment by Susan Freedman, M.S., RMHCI, CHT. I understand that if she is NON-PARTICIPATING in my insurance plan I agree to undertake full responsibility for payment of the fees incurred at the time of the assessment/treatment. I am seeking treatment from Susan Freedman, understanding that if she does not accept my insurance.

_______________________________________ _______________________________

Signature of Patient or Responsible Party **Date**

Online Policies

Text and Email Privacy

Although the Internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than in person. I understand that I am responsible for securing my own computer hardware, Internet access points, and email. If I choose to communicate via text or email other than Hushmail, I understand these are unsecured methods of communication, and it is possible that hackers or other unauthorized personnel may see my communications. If I prefer all email communications to be secure, I will notify my counselor and I will create a Hushmail account and use it for all of my email communications. In addition, I will not use email for urgent or confidential matters.

Text and Email Potential Risks

The potential risks of using email to communicate with my counselor include: (1) messages not being received and (2) confidentiality being breached through use of unencrypted email or text messaging, lack of password protection or leaving information on a public access computer in a library or internet café. Messages could fail to be received if they are sent to the wrong address (which might also breach confidentiality) or if they accidentally get forwarded by the counselor's email software to the trash folder. Confidentiality could be breached in transit by hackers or Internet service providers or at either end by others with access to the client's account or computer. If I access the Internet from public locations such as a library, computer lab or café I will consider the visibility of my screen to people around them and I will position myself to avoid peeping by those around me.

Text and Email Safeguards

I am responsible for creating and using additional safeguards when the computer used to access services may be accessed by others, such as creating passwords to use the computer, keeping my email IDs and passwords secret, and maintaining the security of my wireless internet access points (where applicable).

Newsletters/Informational Emails

My therapist will periodically send me emails with resources and relevant articles and a quarterly newsletter of general mental health related information. I agree to receive these emails and I have provided in my intake paperwork the email address that I give my permission for this correspondence can be sent to.

Social Media

I understand that my counselor does not accept "Friend" requests on her Facebook profile; so if I want to connect with her on Facebook I will "like" her business page www.facebook.com/anewtomorrow. I understand that this page is used to post information and generate conversation about general mental health and intimacy topics, and it is not meant to provide personal psychotherapy.
To protect my privacy, I will not share clinical information on social media.

I understand and agree to these policies and fees:

Printed Name:_______________________________________

Signed: ____ Date: ______________________________

NOTICE OF PRIVACY PRACTICES Page 1 of 5

As of April 14, 2003, the federal government requires us to disclose our privacy policies to all patients (HIPAA 04/14/03). 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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice that describes the health information privacy practices of A New Tomorrow, PLLC. A copy of our current notice will always be available in our office at A New Tomorrow, PLLC. You will also be able to obtain your own copy by calling our office at (813) 501-5023 or by asking for one at the time of your next visit. If you have any questions about this notice or would like further information, please contact our privacy officer, Susan Freedman, M.S., RMHCI, CHT, at (813) 501-5023.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing you with healthcare. Some examples of protected health information are:

- information indicating you are a client of our practice;
- information about your health condition (such as diagnosis);
- information about health care products or services you have received or may receive in the future (such as an operation or diagnostic imaging);
- information about your health care benefits under an insurance plan

When combined with:

- demographic information (such as your name, address, insurance status);
- unique numbers that may identify you (such as social security number, phone number, or drivers license number); or
- other types of information that may identify who you are.

REQUIRED PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We will obtain a one-time general written consent (at the end of this Notice of Privacy Practices) to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct our business operations. This general written consent will be obtained the first time we provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

We will generally obtain your written authorization before using your health information or sharing it with others. You may also ask that we transfer your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it or taken action to do what you previously requested. To revoke a written authorization, please write our Privacy Officer at:

Dr. Susan Freedman
A New Tomorrow, PLLC
14499 N. Dale Mabry Hwy, ste#164
Tampa, FL 33618

INITIAL________

NOTICE OF PRIVACY PRACTICES Page 2 of 5

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment, Payment, and Business Operations

With your general written consent, we may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another healthcare provider or payer. Below are further examples of how your information may be used and disclosed for these purposes.

Treatment. A New Tomorrow (ANT) and its staff of may share your health information with each other for the purpose of treating you. ANT may also share your health information with a doctor or other professional outside of this practice to determine how best to diagnose or treat you. Your doctor may also share your health information with another doctor or professional to whom you have been referred for further heath care.

Business Operations. In the course of providing treatment to you or your family member, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you. At times we may use a **cellular phone** to contact you or return your calls. Please be aware that I will not notify you when I am using such a device. If the information you are discussing requires a more secure level of confidentiality, please let us know so arrangements can be made to contact you in another way. We generally discourage **e-mail** as a mode of communication due to confidentiality concerns. We may reply to e-mails but when doing so make an effort to limit the type of information discussed. However, we must stress that e-mail is not a confidential mode of communication. We routinely use email and or fax in communications with other agencies. We will only release information that you have authorized to release and do send these with a cover sheet that includes a confidentiality statement. However, the cover sheet cannot ensure that the fax is received in the proper place or handled in a confidential matter once it is received. You may pick up and hand-carry documents to agencies if you wish. We will also mail documents on special request. We can do all of these things if you have signed a general written consent form. Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent. You may revoke your general written consent at any time except to the extent that we have already relied upon it. To revoke your general written consent, please write to:

Dr. Susan Freedman
A New Tomorrow, PLLC
14499 N. Dale Mabry, Ste #164
Tampa, FL 33618

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NOTICE OF PRIVACY PRACTICES Page 3 of 5

2. Emergencies or Serious Threats/Public Need

As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or to the public. We will not be required to obtain your general written consent before using or disclosing your information for these reasons. We will, however, obtain your written authorization for, or provide you with an opportunity to object to, the use and disclosure of your health information in these situations when state law specifically requires that we do so.

Emergencies. We may use or disclose your health information in order to treat you, to obtain payment for that treatment and to conduct our business operations if you need emergency treatment or if we are required by law to treat you but are unable to obtain your general written consent as soon as we reasonably can after we treat you.

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- to comply with a court order, warrant, subpoena or law that we are required to follow;
- to locate a suspect, fugitive, or missing person;
- to report a crime that occurred in this facility;
- to take protective action (which, if applicable under the law, may include notifying the police, warning the intended victim and/or seeking the patient's hospitalization) to prevent a person from harming him/herself or others.

Victims of Abuse, Neglect, or Domestic Violence. We may release your health information to report suspected case of abuse, neglect or domestic violence to agencies authorized to receive such reports. We will only make such disclosures if you agree or when required/authorized by law. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of the practice. These government agencies monitor the operation of the health care system, government benefit programs, and compliance with regulatory programs and civil right laws.

3. Lawsuits and Disputes

We may disclose your health information if we are ordered to do so in a court or administrative tribunal that is handling a lawsuit or other dispute. We will only do so after attempting to contact you, consulting your attorney (if possible) and/or seeking a court order to protect the requested information.

4. Worker's Compensation and similar benefit programs

We may release protected health information about you to programs that provide benefits for work-related injuries and illness or disability.

INITIAL______

Notice to Minors. If you are under eighteen years of age, please be aware that your parents have a right to receive general information on the progress of the treatment. Your parents may also request a copy of your record.

Medical Records. We are required to maintain complete treatment records for approximately ten years after your last clinical contact with A New Tomorrow, PLLC. After that time has elapsed, the record will be shredded, burned or otherwise destroyed in a way that protects your privacy.

Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information.

Group Reporting of Assessment Data. We assess many clients using the *Beck Depression Inventory* and the *Beck Anxiety Inventory*. We sometimes also use the *Beck Hopelessness Scale* and the *Beck Scale for Suicide Ideation,* when appropriate. We may aggregate data from all these instruments and report it as group, not individual data, on our website and in our office in graphic form to depict the effect of Cognitive-Behavioral Therapy for patients, as a group, over time. *The identity of any individual patient is completely protected since the data is reported only in group form*. Your signature, below, signifies that you understand that we collect data and report it in group form, that your identity is protected, and that you consent to our inclusion of your data in the patient group and in any graphic representations we may use in any venue (website, presentations, published articles, posted in office, etc.).

PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION

Right to Request Restriction You may request limitations on your mental health information we may disclose, but we may not agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Confidential Communication. You may request communication in a certain way or at a certain location, but you must specify in writing how or where you wish to be contacted.

Right to Inspect and Copy You may request the opportunity to inspect and copy your mental health information regarding decisions about your care. **Psychotherapy notes, however, may not be inspected and copied.** Under certain circumstances, your request may be denied. You may request a review of the denial by a licensed mental health professional designated by A New Tomorrow, PLLC. We may charge a fee for supplies, copying and mailing.

Right to Amend the Record Your request to change your protected health information must be in writing and provide a reason to support the requested correction. We may deny your request.

Right to Accounting of Disclosures You may request a summary of certain disclosures of your protected health information that have been made within the last six (6) years.

Right to a copy of this Notice At any time, you may request a paper copy of this Notice even if you have agreed to receive the Notice electronically. A New Tomorrow, PLLC (ANT) reserves the right to change the terms of this Notice. Revised policies will be available in the office or ANT and on our website.

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NOTICE OF PRIVACY PRACTICES Page 5 of 5

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with Susan Freedman, M.S., RMHCI, CHT the privacy officer of A New Tomorrow, PLLC, or with the Secretary of Health and Human Services toll free at1-877-696-6775. This complaint must be in writing. You will not be penalized or retaliated against for making a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND CONSENT FOR TREATMENT

By signing below, I acknowledge that I have read, initialed each page of, and have been provided a copy of this **Notice of Privacy Practices** and have therefore been advised of how health information about me may be used and disclosed by A New Tomorrow, PLLC and how I may obtain this information. Finally, by signing below, I **consent** to the use and disclosure of my health information to treat me and to arrange for my mental health care, to seek and receive (or help me seek/receive) payment for services given to me, and for the business operations of this practice.

____ ________________________

Signature of Patient or Patient’s Representative **Date**

You will receive a copy of all five pages of this Privacy Notice to keep for future reference.